April 1, 2021

TO ALL PLAN PARTICIPANTS:

The information contained in this booklet is a summary of your Health and Welfare Plan and is effective April 1, 2021. 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.

Preferred Provider Network

The Plan is part of a preferred provider arrangement with Blue Cross Blue Shield of Minnesota. Blue Cross provides a broad network of doctors and hospitals (called the Aware Network in Minnesota and the BlueCard network nationally) who have agreed to provide quality medical services to you and your family members. In exchange for network membership, the doctors and hospitals agree to charge less for those services, as described below. The network allows the Plan and you to better manage and control costs for medical services. Please remember, though, you always have the choice of whether to obtain medical services in or out of the network.

There are advantages for you and your family if you choose to use the network. The most significant advantage is that the Plan generally pays a greater portion of charges for treatment provided by network members. This means that the portion of charges you must pay is reduced. For each type of covered benefit, this booklet describes the amount the Plan will pay for both in-network and out-of-network charges. If there is no distinction made in the booklet, this means the coverage is the same in or out of the network.

Even if the Plan's payment is not different in or out of the network, the doctors and hospitals will usually provide discounts from the charges they would otherwise make for services. The providers in the network have agreed to a different schedule of charges for patients who use the network. If the cost of care for covered services is lower (which it usually is) in the network, both you and the Plan should save money.

In addition, if you use a doctor or hospital that is part of this network, they will directly submit your claim for benefits to the Plan Administrator - you will not have to handle that paperwork.

For non-network providers, you may need to submit the unpaid bill directly to the Administrator. Check with the provider to confirm the correct process. This information and a chart describing the payment rules are set forth in the **Submitting Claims** section of the booklet.

Nearly all doctors and hospitals in the State of Minnesota are included in the network. A directory of providers in the Plan's preferred provider network is available at:

https://www.bluecrossmn.com/find-a-doctor.

You can also ask your doctor if he or she is part of this network. In addition to finding network providers, the web site allows you to view and track claims and review plan benefits.

Make sure you show your network membership card each time you visit a doctor or hospital. By doing so, you can assure yourself that you are receiving any discounts to which you are entitled. If you misplace your network membership card, call the Plan Administrator (952) 854-0795 for a replacement card.

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 TEAM, Inc. TEAM 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.

TEAM's 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 TEAM for help.** The Trustees urge you to do that, before a small problem becomes a big one. You may contact TEAM at (651) 642-0182 or visit their web site at http://www.team-mn.com.

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

TABLE OF CONTENTS

DEFINITIONS

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

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

Cosmetic Surgery means surgery which is chiefly intended to improve appearance.

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

Custodial Care means care which is designed chiefly to assist a person with the activities of daily living and meet her or his personal needs as defined by Medicare guidelines. The care is of a nature that does not require the continuing attention of trained medical or paramedical personnel. Custodial Care is not Skilled Nursing Service or skilled care. Custodial Care services can be provided by persons without professional skills or training. Custodial Care includes: giving medicine that can usually be taken without help, preparing special foods, or helping the patient walk, get in and out of bed, dress, eat, bathe, and use the toilet.

Deductible means the amount stated in the applicable Schedule of Benefits which is applicable to you and each eligible dependent in each calendar year for covered expenses incurred by that person. After the Deductible amount is satisfied, the covered percentage for eligible expenses will be paid.

Dependent or Eligible Dependent means the employee's spouse and the employee's dependent children from birth to the end of the month in which they attain age 26.

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.

Employee means 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.

Essential Health Benefits means 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.

Medical Emergency means 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 means service or treatment which is appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the state in which the service is rendered, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; is not chiefly custodial care; and, as to inpatient care, could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or quality of care received.

Out-of-Pocket Maximum means the most you must pay per person or per family per calendar 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 office visit and emergency room copayments.

Participating Provider means a Provider within the Blue Cross Blue Shield Aware network in Minnesota or the BlueCard network nationally that agrees to provide Medically Necessary care and treatment at set rates.

Plan Member means 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.

Prescription Drug means a drug which is required by federal or state law to be dispensed only by prescription by a health professional who is authorized by law to prescribe the drug. This term includes insulin.

Provider means 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.

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

Totally Disabled means 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 the normal activities of a person of like age in good health.

Usual and Customary Charge means 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 administrator. Only usual and customary charges for eligible health services will be covered under this Plan.

ELIGIBILITY AND PARTICIPATION

Eligibility For Bargaining Unit Employees

Initial Eligibility

You will qualify for coverage on the first day of the second month (Initial Eligibility Date) following any period of 3 or fewer consecutive months for which you have been credited with at least 400 hours of work. Once initial eligibility has been established, coverage will be effective for the 3-month period beginning on the Initial Eligibility Date, and for each subsequent 3-month period (Coverage Quarter) for which you are credited with sufficient hours as described under Ongoing Eligibility.

> **Example:** Joe Smith works and is credited with 400 hours for the months of June and July and therefore has an Initial Eligibility Date of September 1. His initial eligibility extends for the Coverage Quarter of September through November. Assuming Joe is credited with sufficient hours in the following Eligibility Quarters, his coverage for corresponding Coverage Quarters will be as follows:

Hours credited during the following *Eligibility Quarter*:	Determine eligibility for benefits during this corresponding *Coverage Quarter*:
8/1 to 10/31	12/1 to 2/28
11/1 to 1/31	3/1 to 5/31
2/1 to 4/30	6/1 to 8/31
5/1 to 7/31	9/1 to 11/30

The Eligibility and Coverage Quarters will vary from person to person, depending upon their work history. Each of these quarters may begin in any calendar month.

NOTE: For purposes of determining eligibility, you will be credited with hours you have worked for which your employer makes a contribution to the Trust. Hours transferred to other funds due to reciprocity agreements will not be considered in making this determination. Hours are credited to the month in which the payroll period ends as reported by the employer, regardless of when they are actually worked. However, the Administrator is authorized to credit hours to a participant for the month in which the hours are actually worked, if: (a) such participant's employer pays wages to bargaining unit employees covered by this Plan on other than a weekly pay cycle; (b) the participant provides evidence from their employer establishing that the participant did, in fact, work the hours claimed during the month claimed; and, (c) contributions for the hours in question are actually received by the Trust Fund on behalf of the participant.

Ongoing Eligibility

Ongoing eligibility will be determined quarterly based on the number of hours with which you are credited in each 3-month period (Eligibility Quarter) commencing on the first day of the month preceding your Initial Eligibility Date. (The example demonstrates the relationship between Eligibility Quarters and Coverage Quarters.) You will continue to be eligible under the Plan as long as you are credited with at least 400 hours in each subsequent Eligibility Quarter.

All Participants who had coverage effective July 1, 2001 shall continue to have their ongoing eligibility determined based on Eligibility Quarters that correspond to calendar quarters. If coverage for such a

Participant terminated after July 1, 2001, that Participant must re-qualify based on the rules described above and any subsequent qualification may or may not be based on the calendar quarter.

Reserve Hours Bank

Hours credited in excess of 400 in any Eligibility Quarter will be added to a reserve hours bank. This reserve hours bank may accumulate up to a maximum of 1,200 hours. If you are credited with less than 400 hours in any Eligibility Quarter, hours in your reserve hours bank will be withdrawn to make up the difference between credited hours and the 400 hours required for ongoing eligibility.

If the sum of your credited hours for an Eligibility Quarter plus the total hours in your reserve hours bank is less than 400, your coverage ends on the last day of the Coverage Quarter for which you last met the ongoing eligibility rule described above, unless you self-pay for coverage.

> **Example:** Joe Smith is currently eligible in the Plan and has a reserve hours bank balance of 525 hours. Through employer contributions, Joe is credited with 330 hours for the Eligibility Quarter of August through October. His reserve hours bank automatically will be reduced by 70 hours to give him 400 hours necessary for coverage in the Coverage Quarter beginning December 1. His remaining reserve hours bank balance of 455 hours (525 - 70) will be available to help pay for future quarters of coverage.

Forfeiture of Reserve Hours Bank Upon Taking Certain Jobs

Effective on and after June 1, 2006, if you stop working under a collective bargaining agreement requiring contributions to the Plan, your reserve hours 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), <u>if all the following are true</u>:

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 reserve hours banks 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 a forfeiture of a participant's reserve hours 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 reserve hours bank since you last worked in covered employment.

Self-Pay Coverage

You may have the right to continue coverage on a self-pay basis as described in the section titled Continuation Coverage. If you are a bargaining unit employee and your coverage terminates due to a shortage of hours in any Eligibility Quarter, your cost for continuation coverage for the corresponding Coverage Quarter will be reduced by the sum of hours credited for the Eligibility Quarter plus any hours in your reserve hours bank times the current Health & Welfare hourly contribution rate. If you elect to continue coverage under this self-pay option, your reserve hours bank will be reduced to zero.

Your continuation coverage will terminate as described in the section titled Duration of Continuation Coverage, or when you are credited with at least 400 hours in a subsequent Eligibility Quarter.

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 meets each of the requirements stated above at the time of his 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 regarding 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%

Years of Credited Service	Age 52 - 61	Age 62 - 65
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 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 (post-65 coverage)

Benefit Eligibility: 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 the end of the month you attain age 75;

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 you attain age 72.

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 they have other group coverage from a 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 hours 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 are sufficient employer contributions for your coverage; or,

      ii. You may choose not to access your reserve hours 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 reserve hours 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 reserve hours 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 workday 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 stepchild 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 workday 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 Coverage Quarter for which you have not been credited with the required hours in the corresponding Eligibility Quarter 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 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 Hours: If a bargaining unit employee's coverage terminates due to a shortage of hours worked, the cost of continuation coverage will be reduced by the amount of contributions received for the preceding eligibility quarter and shall also be reduced by the dollar value of hours credited to the participant's reserve hours bank multiplied by the then-current hourly contribution rate.

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.

   The one exception to the above noted six (6) months of coverage rule is if a bargaining unit employee is determined to be Totally Disabled on and after November 1, 2020 and such Total Disability is determined to be a terminal illness by the Board of Trustees, the employee will be able to continue their coverage at no cost for up to twenty-four months (24) months from the end of the month in which they last worked.

   Hours Credit: While an employee is Totally Disabled, the employee will receive hours credit at the rate of 31 hours 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).

   Hours 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 Hours Bank hours will be available for use to reduce COBRA premiums as described below, but such Hours Bank hours 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 quarter, the premium amount will be reduced by the sum of the employee's hours actually worked, hours bank hours and disability credit hours. Thereafter, the employee will have to establish Active eligibility status via employer contributions or, if unable to obtain enough hours to establish Active eligibility, continue their coverage by making the required full COBRA premium payment.

Hours Bank - Return After End of 18-month COBRA Coverage Period: If the employee reaches 18-months and has not yet returned to active employment, their Hours Bank hours will be reduced to zero and will not be available for use to continue coverage if an employee returns to Active eligibility status.

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.

MEDICAL BENEFITS

Medical Schedule of Benefits

The Schedule of Benefits shown below outlines the medical coverage provided by this Plan. Two different levels of benefits are provided under the Plan:

1. The in-network benefit level will be payable for services rendered by a Participating Provider.

2. The out-of-network benefit level will be payable for services rendered by a provider who is not a Participating Provider.

The Plan provides coverage for the following services and supplies when ordered by a physician because of an injury or illness. Benefits are subject to the terms of the Schedule of Benefits, maximums, exclusions, and limitations of the Plan. The Deductible, benefit maximums, limitations, and other provisions are combined calendar year maximums for services provided by all providers, both in the network and outside of the network, unless otherwise specified.

Expense	In-Network	Out-Of-Network
Annual Deductible	$400 per Individual; $800 per Family	$800 per Individual; $1,600 per Family
Covered Percentage of Expenses	After Deductible, 80% of most eligible services	After Deductible, 70% of most eligible services
Out-of-Pocket Maximum for Medical Benefits, each calendar year	$2,400 per Individual; $4,800 per Family (incl. Deductible)	$4,800per Individual; $9,600per Family (incl. Deductible)
Out-of-Pocket Maximum for Prescription Drug Benefits, each calendar year	$5,000 per individual; $10,000 per family	No Benefit Provided
Preventive Care (exams, tests, and immunizations)	100%	70% after Deductible
Diagnostic Screening	80% after Deductible	70% after Deductible
Vision (exams, frames, and lenses)	Participants, spouses, and Dependents age 19 and older: $200 per calendar year Dependents under age 19: Exams are covered at 100%. The Plan will provide 100% coverage on the first $200 towards the cost of contact lenses or one pair of eyeglasses every two years, and then 50% of the remaining cost	No Benefit Provided

Expense	In-Network	Out-Of-Network
Physician Office Visit Copayment	You pay $20/visit; then Plan pays 100%	70% after Deductible
Physician's Visit Inpatient	80% after Deductible	No coverage
Other Physician or Surgeon	80% after Deductible	70% after Deductible
Inpatient Hospital Services	80% after Deductible	No coverage
Outpatient Hospital Services	80% after Deductible	70% after Deductible
Telehealth Visits for Medical and Behavioral Health (including Doctor on Demand)	100%	No coverage (other than Covid-19 related visits as long as required by law)
Emergency Room	$100 co-pay/visit then 100%	$100 co-pay/visit then 100%
Second Surgical Opinions	100%	100%
Chiropractic Care	20 visits per year subject to the Deductible and Coinsurance of 80%.	20 visits per year subject to the Deductible and Coinsurance of 70%.
Skilled Nursing Facility Coverage	80% after Deductible	No coverage
Pre-scheduled Outpatient X-Ray, Laboratory, Pathology, Radiation Therapy and Chemotherapy	80% after Deductible	70% after Deductible
Physical, Speech, and Occupational Therapy	$30 co-pay/visit; then Plan pays 100%	70% after Deductible
Prescription Drugs (Retail Pharmacy; up to 34-day supply)	Participant Co-Pay 15% copayment subject to the minimums below: $5 – Generic $20 – Brand Name (formulary) $35 – Brand Name (non-formulary)	No Benefit Provided
Prescription Drugs (Mail Order/Retail up to 90-day supply)	Participant Co-Pay is 15% copayment subject to the minimums below: $10 – Generic $40 – Brand Name (formulary) $70 – Brand Name (non-formulary)	No Benefit Provided
Inpatient Mental Health Care	80% after Deductible.	No coverage
Outpatient Mental Health Care	80% after Deductible. * *Clinic Office Visits are only subject to $20 copayment.	70% after Deductible
Inpatient Chemical Dependency Treatment	80% after Deductible.	No coverage

Expense	In-Network	Out-Of-Network
Outpatient Chemical Dependency	80% after Deductible. * *Clinic Office Visits are only subject to $20 copayment.	70% after Deductible
Home Health Care	80% after Deductible; Maximum 180 visits per calendar year	70% after Deductible; Maximum 180 visits per calendar year
Durable Medical Equipment and Medical Supplies	80% after Deductible	70% after Deductible
Ambulance	80% after Deductible	

Inpatient Hospital Coverage

Hospital charges for a semi-private room will be covered according to the Schedule of Benefits. If confinement is in a private room, the hospital's average semi-private room charge will be used as a basis for payment and the balance is the patient's responsibility unless a private room is approved as Medically Necessary. Coverage will also be provided for necessary intensive care or coronary care units. If a hospital has only private rooms, 80% of the lowest private room charge will be eligible. Inpatient Hospital Coverage is only covered at in-network facilities. There is no out-of-network inpatient coverage under the Plan.

Coverage will be provided for all other eligible hospital services and supplies furnished and billed for by the hospital such as oxygen, drugs, dressings, x-ray and laboratory services, operating room charges, licensed ambulance service, blood and blood products, and routine hospital care of a newborn child while the mother is hospital-confined following the delivery.

Outpatient Hospital Coverage

When the hospital visit does not result in a room and board charge, benefits will be paid according to the Schedule of Benefits for eligible emergency room and outpatient services when authorized by a physician.

Skilled Nursing Facility Coverage

Eligible services and supplies will be covered when furnished while the patient is confined as a bed patient in an approved bed in an approved non-acute care facility (also called a skilled nursing facility or extended care facility). The confinement must take the place of a hospital confinement or must start within fifteen consecutive days after a confinement of at least three days in a hospital for the same illness. Twenty-four hour per day nursing care must be required for treatment of the illness. The care must be ordered and approved by a physician and must not be Custodial Care.

Eligible expenses will include the facility's charge for a semi-private room and all other eligible services and supplies furnished by the facility during the time the patient is entitled to room and board allowance. All coverage is subject to the maximum stated on the Schedule of Benefits for skilled nursing facility services. Skilled Nursing Coverage is only covered at in-network facilities. There is no out-of-network skilled nursing facility coverage.

In-Hospital Medical Service Coverage

Coverage will be provided for physician visits when the patient is confined in a hospital or approved non-acute care facility and eligible services are provided.

Substance Abuse and Chemical Dependency Treatment

Services and supplies for treatment of alcoholism, chemical dependency or drug addiction will be limited to the maximums for this treatment as specified in the Schedule of Benefits. The treatment must be recommended by a physician and the treatment plan must be completed in order to be eligible for coverage. All care must be provided by licensed eligible Providers: hospitals or residential treatment programs for inpatient care, or nonresidential treatment programs, including hospital centers, treatment facilities, physicians, and qualified employees of the centers or facilities for outpatient care. Inpatient services are covered only at in-network facilities. There is no out-of-network inpatient coverage.

Mental Illness and Nervous Disorder Treatment

Eligible expenses for consultation, diagnosis, or treatment of any nervous or mental disorder are covered up to the maximums stated on the Schedule of Benefits when the services are rendered by a hospital, a physician, or licensed consulting psychologist (LCP), a psychiatrist, a licensed psychologist, or a mental health facility. The provider must be approved or licensed by the state in which the services are rendered. Inpatient services are covered only at in-network facilities. There is no out-of-network inpatient coverage.

Physician Service Coverage

Coverage will be provided for professional physician services for diagnosis, treatment, and surgery necessary for an illness or injury.

Physical, Speech, Occupational and Inhalation Therapy

Coverage will be provided for physical, speech, occupational or inhalation therapy rendered by a registered or licensed therapist when necessary to restore a functional disorder due to an illness or injury and when ordered by a physician. The care must be expected to result in significant improvement within a reasonable period of time.

Maternity Care

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (that is, an individual licensed under state law who is directly responsible for providing maternity or pediatric care to a mother or newborn child), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Group health plans may impose deductibles or other cost-sharing provisions for hospital stays in connection with childbirth only if the deductible, coinsurance, or other cost-sharing for the later part of a 48-hour (or 96-hour) stay is not greater than that imposed for the earlier part of the stay.

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).

The Plan acts in compliance with each of these requirements.

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.

1. Payment of Benefits (Retail Pharmacy Program)

   When an Eligible Individual 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 an Eligible Individual to obtain Prescription Drug Benefits from a participating pharmacy is:

   a. Present the identification card to the pharmacist with the prescription.

   b. Verify and sign the claim voucher prepared by the pharmacist.

   c. 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:

      i. Generic drugs $ 5.00

      ii. Brand name drugs $20.00 (formulary)
      $35.00 (non-formulary)

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

      iv. Over-the-Counter Medications: You may purchase certain over-the-counter (OTC) medications at the generic minimum co-pay level of $5. To do so, you must present a prescription from your doctor for the OTC drugs to be covered.

      v. Specialty Drugs. All specialty drug prescriptions must be filled through ProAct Rx's Specialty Drug Program (Noble Pharmacy). Specialty drugs are subject to the 15% minimum coinsurance payment. 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 Fund Office. 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.

2. Payment of Benefits (Mail Order Program)

Eligible Individuals 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:

i. Generic drugs $10.00

ii. 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 Fund Office or by going online to www.proactrx.com.

Durable Medical Equipment and Prosthetics

When Medically Necessary and ordered in writing by a physician, eligible durable medical equipment will be covered. Eligible equipment includes: casts, splints, trusses, braces, crutches, oxygen equipment, wheelchair, and other similar medical equipment used exclusively for medical treatment. Durable medical equipment includes only Medically Necessary medical equipment that is prescribed by a physician for a specific therapeutic purpose in the treatment of an illness, and which is designed for prolonged use, is useful only to a person who is ill, is appropriate for use in the patient's home, and is used primarily and customarily for a medical purpose. Coverage is provided for the rental or purchase of the equipment, as appropriate, and only for the initial piece of equipment; replacements and repairs are not eligible for coverage.

Artificial limbs, eyes, and prosthetic appliances used only for medical treatment are also eligible. Other eligible medical supplies, such as diabetic or ostomy supplies, are covered when Medically Necessary and ordered by a physician.

Home Health Care

Coverage will be provided according to the Schedule of Benefits for home health agency care for treatment of an illness when Medically Necessary. The care must take the place of a hospital or skilled nursing facility confinement, and the care must be ordered in writing by a physician. The following services by employees of a home health agency are eligible: skilled part-time or intermittent nursing service by a licensed nurse; therapy by a licensed or registered physician, speech, occupational, or respiratory therapist; services of a medical social worker; eligible medical supplies and drugs; services of a nutritionist; and intermittent home health aide services. Each visit of up to four hours by a member of a home health agency team is considered one visit. The patient must be under the continuing care of a physician. Coverage is not provided for Custodial Care.

Ambulance Services

Medically Necessary services furnished by a licensed ambulance to the nearest facility qualified to treat the injury or illness is covered in an emergency situation. Air ambulance services are eligible only when it is the only medically acceptable means of transporting the patient or when called on a first response basis.

Routine Newborn Infant, Well Baby, and Child Care

Well baby care for children under age 3 will be covered as a Preventive Services Benefit as described in the Medical Schedule of Benefits.

Routine care for children ages 3 and older is covered as a part of the Preventive Care benefit until the child ceases to be an eligible Dependent.

Nurse Anesthetist, Nurse Midwife, and Nurse Practitioner

Anesthesia services rendered by a nurse anesthetist and obstetrical services rendered by a nurse midwife that are within the scope of her or his license are eligible. Care by a licensed nurse practitioner is also eligible.

Hospice Care

Hospice care is a coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition. Such a program is designed to meet the special physical, psychological, spiritual, and social needs of terminally ill individuals. A terminally ill patient is defined as an individual who has six months or less to live. Confinement in a licensed hospice facility or convalescent home will be considered an eligible expense under the hospice benefit. Eligible expenses also include nursing care by or under the supervision of a registered nurse, physical or occupational therapy, medical social services, home health care by a trained aide, counseling, drugs, medical supplies, and other eligible hospice services and supplies.

Preventive Care

The Plan provides Preventive Care coverage for those services as they are defined under the Patient Protection and Affordable Care Act and as further detailed in the Medical Schedule of Benefits. Such coverage is provided for items such as routine physical exams and related charges, including laboratory and x-ray services; pulmonary function tests; immunizations; vaccinations; and well child-care until the child ceases to be an eligible dependent.

Preventive care also includes charges incurred for the following cancer screening tests: mammography's, Pap smears, and prostate specific antigen (PSA) tests.

The Plan will pay for Preventive Care according to the Schedule of Benefits and when provided on an in-network basis, will be paid at 100%. Examinations delivered through an organization with whom the Plan has a contract for health screening services will also be paid in full. Health screening in this context includes pulmonary function examinations that may be required of employees in the industry or industries covered by the Plan, and drug use screening. This benefit applies to medical examinations only and does not cover vision or dental exams.

Vision Benefit

Vision care expenses up to the maximum specified in the Schedule of Benefits are covered. Eligible expenses include vision exams performed by a licensed ophthalmologist or optometrist, frames, and corrective lenses (including contact lenses), as well as prescription safety and sunglasses.

Vision exams may include an ocular case history, external examination, refraction, binocular measure, tonometry, ophthalmoscopic examination or any other vision test considered Medically Necessary, prescription for corrective lenses, summary and findings, and inspection of any corrective lenses prescribed. Exams for dependents under age 19 are covered at 100% separate of the $200 annual vision benefit.

The following expenses are not eligible under this vision benefit:

1. Vision exams and non-prescription safety glasses required by an employer as a condition of employment.

2. Charges for services or supplies which are covered in whole or in part under the Medical Benefits portion of the Plan including medical or surgical treatment, or supplies furnished for the treatment of eye disease and/or injury.

3. Vision care expenses for which you would not be required to pay if there were no coverage.

4. Vision care expenses which were not recommended and approved by a licensed ophthalmologist or optometrist.

5. Sunglasses without a prescription (tinted glasses with a tint above number two will be considered sunglasses for this purpose).

6. Orthoptics and vision training.

7. Subnormal vision aids such as ocular microscopes, ocular telescopes, or hand-held magnifiers.

To obtain reimbursement for your vision claims, subject to the maximums provided in the Schedule of Benefits, you must submit a claim form that is available from the Fund Administrator. You can obtain the Vision Claim Form by calling Wilson-McShane Corporation at 952-851-5948.

Other Covered Health Services

1. Chiropractic care, including Medically Necessary examinations, manipulations, and x-rays, are covered according to the Schedule of Benefits.

2. Anesthesia, oxygen, and their administration.

3. X-ray and laboratory examinations for diagnosis and treatment; x-ray, radium, and radioactive isotope therapy.

4. Elective sterilizations.

5. Infertility testing and treatment.

6. Second surgical opinions: It is recommended, though not required, that you obtain a second surgical opinion.

7. Approved methods of surgical and non-surgical treatment of temporomandibular joint disorders (TMJ).

8. Breast pumps are reimbursable up to $250 per pregnancy. To receive reimbursement the participant must submit a reimbursement form and receipt to the Plan Administrator. The participant can receive reimbursement no sooner than one-month prior to the mother's expected due date.

Alternative Care

Alternative care may be recommended by the claims administrator and covered when health services are still Medically Necessary for the patient's condition and alternative care is available that maintains the same quality of care and is of equal or lower cost than the care being provided. Alternative care will be covered to the same extent that coverage is provided for the care being received so that the patient does not have to pay more for the alternative care. Each case will be considered individually, and an alternative care decision in one instance will not obligate the Plan to provide alternative care in another situation. These decisions will not affect the Plan's strict adherence to all Plan provisions for future cases.

Major Organ Transplant Expense Coverage

The Plan covers expenses for services, supplies, drugs, and related aftercare for certain human organ, tissue, and bone marrow transplant, stem cell support and umbilical cord blood procedures which are Medically Necessary, which are not Experimental or Investigative, which are payable under all other provisions of this Plan document, and which meet the following Special Requirements for Transplant Procedures. (Charges incurred for kidney and cornea transplants are covered on the same basis as any other Covered Expense and are not subject to the Special Requirements for Transplant Procedures listed below.) For kidney transplants done in conjunction with an eligible major transplant or other kinds of transplants, please refer to this "Major Organ Transplant Expense Coverage."

Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P.O. Box 64179, St. Paul, Minnesota, 55164, or faxed to 651-662-1624.

Covered Transplant Procedures:

The following transplant procedures have been determined by the Plan's Board of Trustees not to be Experimental or Investigative and are approved for coverage subject to the Special Requirements for Transplant Procedures listed below:

1. Allogeneic and syngeneic bone marrow transplant, peripheral stem cell and cord blood transplant procedures.

2. Autologous bone marrow transplant and peripheral stem cell transplant procedures.

3. Heart.

4. Heart - lung.

5. Liver - deceased donor and living donor.

6. Lung - single or double.

7. Pancreas transplant - deceased donor and living donor segmental.

8. Pancreas Transplant Alone (PTA).

9. Simultaneous Pancreas -Kidney transplant (SPK).

10. Pancreas transplant After Kidney transplant (PAK).

11. Small-bowel and small-bowel/liver

The Plan's Board of Trustees reserves the right to change (but are not required to change) the above list of transplant procedures which are approved for coverage.

Special Requirements for Transplant Procedures:

1. All transplants and stem cell procedures must be performed by a *participating transplant provider* unless the recipient is a non-Minnesota resident, and the services are received from a provider located closer to the residence of the recipient than the closest participating transplant center.

2. A *participating transplant provider* means a hospital or other institution that has a contract with the local Blue Cross and Blue Shield Plan to provide human organ, bone marrow, cord blood and peripheral stem cell transplant procedures.

3. A *Blue Distinction Centers for Transplant (BDCT)* means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures. These providers have been selected to participate in this nationwide transplant network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Once selected for participation, institutions are re-evaluated annually to ensure that they continue to meet the established criteria for participation in this network.

4. When you travel more than 50 miles to obtain transplant care at a BDCT the Plan will cover the patient up to $50 per day for lodging when purchased at the transplant facility. The Plan covers a companion/caregiver up to $50 per day for lodging when the patient is not hospitalized. Lodging is eligible when staying at apartments, hotels, motels, or hospital patient lodging facilities and is eligible only when an overnight stay is necessary.

5. In providing the travel benefit, the Plan covers the lesser of: (1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, (2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.

6. Benefits are based on the *transplant payment allowance* for participating transplant centers, and are subject to all other terms of coverage, including deductibles, co-pays, and coinsurance. Benefits for covered services of any provider will not exceed the *transplant payment allowance* payable to a transplant center for the same procedure. *Transplant payment allowance* means the amount the Plan pays for covered services to a *BDCT* provider or a *participating transplant provider* for services related to human organ, bone marrow, cord blood and peripheral stem cell transplant procedures in the agreement with that provider. If you do not use a *BDCT* provider or a p*articipating transplant provider*, you are responsible for all charges that exceed the *transplant payment allowance*.

7. Coverage is limited to two transplant procedures for the same condition per person per lifetime.

8. If the transplant recipient is covered by this Plan, but the donor is not, medical expenses of the donor will be eligible for payment by the Plan, but only to the extent they are not covered by any other Plan of benefits and will be limited to (a) testing and other reasonable expenses to identify if the donor is suitable; (b) the expense of life support for a donor pending the harvesting of a usable organ; (c) transportation for a living donor; and (d) transportation of an organ or donor on life support. If the transplant donor is covered by this Plan, but the recipient is not, benefits for the donor will be considered for payment under the Plan only to the extent they are not payable under any other health plan. Benefits for expenses incurred by the recipient, if the recipient is not covered by this Plan, will not be payable.

The Plan does not cover:

1. Services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Covered Transplant Procedures section above.

2. Services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants.

3. Services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered.

4. Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary.

5. Living donor organ and/or tissue transplants unless otherwise specified in this Summary Plan Description.

6. Transplantation of animal organs and/or tissue.

7. Travel benefits when you are using a non-BDCT provider.

8. Please refer to the General Exclusions section.

Diagnostic Screening Benefit

Subject to the deductible and coinsurance requirements, the Plan covers expenses for services, supplies, drugs, and related aftercare for diagnostic screening services.

Cochlear Implants and Bone-Anchored Hearing Aids

The Plan will provide Cochlear Implant and Bone-Anchored Hearing Aid benefits, subject to the provisions and limitations below.

Cochlear Implants – The Plan will cover unilateral or bilateral implantation of an FDA approved cochlear implant device if Medically Necessary in patients twelve months or older if the following criteria are met:

1. The patient suffers from severe to profound pre- or post-lingual (sensorineural) hearing loss defined as a hearing threshold of 70 db (decibels) or greater; and

2. The patient has experienced limited or no benefit from the use of hearing aids; and

3. The implant that is proposed to be used is FDA approved for the age of the patient.

The plan will cover the initial installation of the cochlear implant and one upgrade due to technical advances only.

Bone-Anchored Hearing Aids – The Plan will consider an implantable bone-anchored hearing aid a Medically Necessary prosthetic for persons age five (5) years and older with a unilateral or bilateral conductive or mixed conductive and sensorineural hearing loss who have any of the following conditions which prevent the restoration of hearing using a conventional hearing aid:

1. Congenital or surgically induced malformations of the external ear canal or middle ear;

2. Dermatitis of the external ear, including hypersensitivity reactions to ear molds used in air conduction hearing aids;

3. Hearing loss secondary to otosclerosis in persons who cannot undergo stapedectomy;

4. Severe chronic external otitis or otitis media;

5. Tumors of the external ear canal and/or tympanic cavity; or

6. Other conditions in which an air conduction hearing aid is contraindicated.

Before you can receive either Cochlear Implant or Bone-Anchored Hearing Aid benefits, you must have first tried to use a conventional hearing aid and such device must have failed to provide for a proper level of hearing.

Medical Benefit Exclusions

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

1. Cosmetic Surgery except to repair a defect caused by an injury within twelve (12) months of the date of the injury, or to repair a dependent child’s congenital anomaly if the child is under age 16.

2. Reconstructive surgery except to correct a functional physical defect resulting from an injury or from a dependent child's congenital anomaly, or when incidental to or following surgery resulting from illness of the involved body part. In addition, the Plan *shall* cover as a part of this exception: (a) surgery to reconstruct a breast following a mastectomy procedure on the affected breast which is intended to provide symmetrical appearance; (b) any costs for prostheses related to the mastectomy procedure (i.e., implants, special bras); and (c) the treatment of any physical complications associated with the mastectomy procedure.

3. Arch supports, foot orthotics, and orthopedic shoes, unless the shoe is an integral part of a brace.

4. Any dental care, treatment, implants, surgery, or supplies except for: (a) prompt and initial repair within twelve months of injuries to sound natural teeth caused from being accidentally struck from outside the mouth while covered under the Plan; (b) orthodontia related to and oral surgery for treatment of cleft lip and palate, or (c) charges for medical facilities and anesthesiology services which are received during a dental procedure which is determined to be Medically Necessary. However, dental care is provided separately under the Plan (see the appropriate section).

5. Routine hearing examinations; hearing aids or any related expenses except as covered by the Cochlear Implant and Bone-Anchored Hearing Aid benefit.

6. Vision services for the treatment of refractive errors such as radial keratotomy and Lasik vision correction.

7. Transportation, other than local ambulance service, for a Medical Emergency to the nearest hospital that can render care.

8. Charges for therapeutic acupuncture.

9. Repeat bariatric surgery regardless of the reason.

10. Exams or treatment received as the result of a court order or any third-party request, except for an emergency situation.

11. Nursery charges beyond the point of confinement of the mother and child or after the end of the period that either the mother or newborn child is no longer medically required to remain in the hospital. In determining a mother's maximum period of medically required confinement, the period of a normal maternity confinement is used. In the event of termination of nursery charges for a newborn child, benefits are payable for the newborn child only if all other eligibility rules of the Plan have been met for that child.

12. Any diagnostic admission if such diagnostic tests can be performed on an outpatient basis.

13. Room and board expenses at a non-medical facility, such as a hotel.

14. Services furnished chiefly for rest cures, Custodial Care, domiciliary care, or the ease of a household; maintenance or custodial therapy; private duty nursing services.

15. Charges incurred with any injury or illness which is not under the regular care of a physician.

16. Charges incurred for any services or treatments not prescribed by a physician, e.g., over-the-counter drugs and their generic equivalents, vitamins, cough medicine, aspirin, Nicorette gum, cosmetics, soap, toothpaste, etc.

17. Other non-covered items including, but not limited to, cosmetics, newspapers, magazines, laundry services, guest trays, or beds or cots for guests or family members.

18. Other non-covered items including, but not limited to, whirlpools, swimming pools, humidifiers, de-humidifiers, allergy-free pillows, orthopedic mattresses, exercise equipment, vibratory equipment, elevators or stair lifts, stethoscopes, thermometers, and scales.

19. Charges for recreational or educational therapy (including education, training and room and board while a person is confined in an institution which is primarily a school or institution of learning) or forms of non-medical self-care or self-help training, including, for example, health club memberships, weight loss programs and diagnostic testing associated with such programs;

    Exception: Charges for smoking cessation products and programs shall be covered by the Plan.

20. Charges related to organ transplants except as specified under the Major Organ Transplant coverage provisions.

21. Charges for artificial organs, devices, or systems used to assist or replace a natural body organ (such as an artificial heart), and any related services or supplies.

22. Service and supplies related to artificial insemination, in vitro fertilization, and other means of assisted reproductive technologies.

23. Charges incurred for dependent children for vasectomies or other sterilization procedures unless recommended by a physician for therapeutic purposes of the patient.

24. Services for the reversal of sterilization.

25. Services of the clergy.

26. Charges for telephone consultations unless otherwise covered by the telehealth benefit.

27. The completing of claim forms (or providing any forms or information required by the Plan for processing claims) by a physician or other provider of medical services.

28. Expenses for care or treatment received outside of the United States if the sole reason for travel was to obtain medical services.

29. Routine physical exams and any related expenses when requested by any third party such as a school, an employer, or an insurance company.

30. Any charge for treatment, services or supplies which are not Medically Necessary, usually and customarily priced, or usual to the treatment of an illness as determined by an independent medical physician review panel or a physician designated by the Plan Administrator; any care which is not recommended and approved by a licensed physician.

31. Charges for surgery, services, and drugs which are experimental, investigative, unproven, or not approved by the Food and Drug Administration for a particular use.

For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, facility, drug, equipment, device, or supply) is considered to be Experimental or Investigative if the use is not yet generally recognized as accepted medical practice, or if the use requires federal or other governmental agency approval and the approval has not been granted at the time the service or supply is provided, or if the use is not supported by Reliable Evidence which shows that, as applied to a particular condition, it:

a. Is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty;

b. Has a definite positive effect on health outcomes;

c. Over time leads to improvement in health outcomes under standard conditions of medical practice outside clinical investigatory settings (i.e., the beneficial effects outweigh the harmful effects); and

d. Is at least as effective as standard means of treatment in improving health outcomes or is usable in appropriate clinical contexts in which standard treatment is not employable.

Reliable Evidence includes only:

a. Published reports and articles in authoritative medical and scientific literature;

b. The written investigational or research protocols and/or written informed consent used by the treating facility or of another facility which is studying the same service, supply, or procedure; and

c. Compilations, conclusions, and other information which is available and may be drawn or inferred from (a) or (b), above.

Consideration may be given to whether:

a. The treatment cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the treatment is furnished; or

b. Reliable Evidence shows that the treatment is the subject of ongoing Phase I, II or III clinical trials and under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or

c. Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.

d. The mortality rate of the treatment; the cure rate and the survival rate for patients using the treatment for the particular injury, sickness or condition as compared with rates for similarly situated patients using no treatment or using existing treatments which are generally accepted by the Food and Drug Administration, and; the number of patients who have received the treatment for the same injury, sickness or condition.

Final determination of whether the use of a treatment is Experimental or Investigative rests solely with the Trustees.

32. 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.

33. Charges which a no-fault insurer has determined not to be medically necessary or a reasonable and customary charge.

34. Notwithstanding any other provision hereof to the contrary, all benefits shall be limited to being in excess of those benefits which are payable by any other group plan or group insurance policy which is or purports to be an excess policy or excess plan paying benefits only in excess of benefits provided by another plan or policy.

    In the event that the entity or insurer underwriting such other group excess only plan or group excess policy agrees to pay benefits as if it were not an excess plan or policy, this Plan's benefits will be payable without regard to this section, subject to this Plan's coordination of benefits provision.

35. Charges that would not have been made if this Plan did not exist.

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.

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 calendar 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. ^Any participant who started orthodontia treatment prior to April 1, 2021, will remain subject to the prior $2,000 lifetime maximum.	 $1,500 per lifetime** $1,500 per calendar year***
Routine Preventive and Diagnostic	100% (no Deductible) (does not apply toward $1,500 calendar year limit for dependents age 18 or younger)
Regular and Special Restorative	80% following the Deductible
Prosthetics, and, effective May 1, 2004, 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 calendar year and bitewing x-rays once per calendar year;

2. Full mouth x-rays (once each 3 years unless special need is shown);

3. Dental prophylaxis up to two per calendar year;

4. Topical fluoride once per calendar 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. 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 For Illness	 1st day of disability 8th consecutive day of disability
Benefit Amount: Weekly Benefit Daily Benefit	 $350 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 established airports;

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

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. However, the Plan will consider the charges only if no insurance or other form of compensation is available to the victim providing the participant and/or dependent (the individual responsible for payment of expenses) signs an acknowledgment of the Fund's first priority right to subrogation and reimbursement. You must, to the Plan's satisfaction, show that you have made a diligent effort to determine if a homeowners' or premises liability policy exists from which a recovery may be made.

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. Health services necessitated by attempting to commit or committing a felony, or engagement in an illegal occupation.

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; or (d) the eligible person does not first exhaust any medical payment and/or disability coverage on the vehicle(s) involved in the accident.

10. Any loss, expense or charge for which a third party may be liable and for which the eligible person on whose behalf the claim was filed did not submit the required acknowledgment of the Fund'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 Fund's right of subrogation or reimbursement rights has been received, (b) the fund 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 Fund 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 Fund's rights of subrogation or reimbursement or otherwise failed to cooperate with the Fund. The Fund has the right to deny future related and unrelated benefits payments for charges excluded under this paragraph.

Submitting Claims

Each time you receive medical or dental services, present your Plan I.D. card. If the provider is part of the Blue Cross Blue Shield network, Delta Dental network or a participating network pharmacy, that's all you do – the provider will handle all the paperwork.

If the provider is not part of the network, you or the provider must file the claim with the Plan Administrator. For dental services, you must first pay the provider's bill and then submit the claim for

reimbursement from the Plan as described below. The following table identifies which bills must be paid prior to submission to the Plan Administrator.

Provider	Provider Location (inside or outside of network area)	Payment Process
Medical – In-network	inside	Claim submitted by provider; Plan pays directly to provider
Medical – Out-of-Network	inside	Patient or Provider submits claim to Plan; Plan pays to Patient unless benefits assigned to provider
Medical – Out-of-Network	outside	Provider submits claim to local BC/BS Plan; Plan pays patient who must pay provider unless benefit payment is properly assigned to provider
Dental – In-network	inside	Claim submitted by provider; Plan pays directly to provider
Dental – Out-of-Network	inside or outside	Patient pays provider; Patient submits claim to Plan; Plan pays patient

Claims will be paid in the following manner:

1. For benefits charges incurred with participating providers, the Plan will pay a discounted amount. These providers have agreed to accept payment from the Plan as payment in full, except for applicable co-payments, deductibles, coinsurance, maximum benefit limitations or other similar limitations under the Plan;

2. For benefits charges incurred with non-participating providers within the geographic area of the Blue Cross Blue Shield Minnesota AWARE Network, the Plan will pay the Reasonable and Customary Charge, or if applicable, a separately negotiated amount to the non-participating provider. You will be responsible for applicable co-payments, deductibles, coinsurance, maximum benefit limitations or other similar limitations under the Plan and may be balance billed by the non-participating provider;

3. Benefits charges incurred with non-participating providers outside the geographic area of the Blue Cross Blue Shield Minnesota AWARE Network will come through Blue Cross' Blue Card program. The Plan will pay the Reasonable and Customary Charge as provided by the Blue Card Host Plan in the Blue Card system or, if applicable, an amount separately negotiated with the non-participating provider. You will be responsible for applicable co-payments, deductibles, coinsurance, maximum benefit limitations or other similar limitations under the Plan and may be balance billed by the non-participating provider.

Typically claims will be submitted by the provider. If you need to file a claim, the claim forms needed to apply for benefits may be obtained from the Plan Administrator. To expedite claim processing be sure all questions on the claim form are answered fully, including the completion or attachment of any required medical statement or bills. If you are required to pay that bill before submitting your claim, please be sure to include a copy of the bill marked as Paid. To expedite claim payment, make sure all bills include:

1. Employee's name and home address.

2. If claim is for a dependent, their name, employer, and age.

3. Employer's name - Heat & Frost Insulators Local #34.

4. Name and address of the dentist, doctor, or hospital.

5. Doctor's diagnosis.

6. Itemization of charges.

7. Date injury or sickness began.

Follow-up statements and second billings generally do not contain this information and therefore are not acceptable.

Mail the claim forms and bills to:

Heat and Frost Insulators Local 34 Administration Office
3001 Metro Drive, Suite 500
Bloomington, MN 55425
(952) 854-0795

Claims must be submitted within 90 days of the time the charges are incurred or as soon thereafter as reasonably possible, and in no event later than 12 months from the date the claim was incurred. A charge is considered incurred on the date a service or supply is received.

Claim Processing and Appeal Procedures

Time Limits for Deciding Claims

If the Plan denies coverage for a medical claim, it will do so within 30 days of the Plan's receipt of the claim from you or your provider. In certain situations, the Plan may extend this by an additional 15 days; if it does, it will notify you of the extension within the original 30 days and will tell you the reasons for the extension and when the Plan expects to make a decision on your claim. If the extension is needed because you failed to submit the necessary information to the Plan, the Plan will tell you of the information it needs and will give you 45 days to provide the needed information to the Plan.

Claim Denials

1. If your claim is denied, the Plan will notify you within the time frames stated above. The Plan will also:

2. Tell you the specific reasons your claim was denied;

3. Reference the specific Plan provision(s) on which the determination was based;

4. Describe any additional material or information for you to complete the claim and an explanation of why the material or information is necessary;

5. Describe the Plan's review procedures and the time limits for these procedures (which are also stated below), plus provide you a statement concerning your rights under federal law if your claim is denied on review;

6. If an internal rule was relied upon by the Plan in making the decision, either provide you a description of the rule or a notice that you can request a copy of the rule from the Plan; and

7. If the claim decision was based on a medical necessity or experimental treatment exclusion, either provide you an explanation of the scientific or clinical judgment for the determination or a statement that the explanation will be provided to you upon your request.

8. If the claim is a disability claim, a description of the review process applicable to disability claims and a discussion of the decision including an explanation, if applicable, of the basis for disagreeing with or not following:

    a. The views presented by your health care and vocational professionals;

    b. 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

    c. Your disability determination from the Social Security Administration.

Claim Appeal Procedure

If all or part of your claim is denied after the Plan has received all necessary claim information, you have the right to appeal the decision 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 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) The terms of the Plan;

5) Evidence-based practice guidelines;

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

7) 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.

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.

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 consider 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

If you and your spouse or children are covered by this Plan and another plan providing medical or dental benefits the benefits will be coordinated between the two plans. This provision is commonly called "coordination of benefits" or C.O.B. and limits total benefits payable under this Plan and other plans to 100% of eligible charges.

When there are medical expenses for a family member that are covered by two different group plans, you should file the claim with both plans. Make sure you provide all requested information to both plans. Then the claim departments will decide which plan is "primary" (pays benefits first) and which plan is "secondary" (pays eligible benefits not paid by the primary plan).

Definitions Applicable to These Coordination of Benefits Provisions

These definitions apply only to this section.

The term **"Plan"** is any of the following that 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, individual practice coverage, and group coverage other than school accident-type coverage. Group coverage is always primary and pays first.

2. Coverage under a government plan or one required or provided by law.

"Plan" 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).

"Plan" does not include Medicare (Title XVIII, United States Code, as amended from time to time) for Medicare benefits paid or payable to any person for whom Medicare is primary. **"Plan"** does not include any benefits that, by law, are excess to any private or other non-government program.

If any of the above coverages include group and group-type Hospital indemnity coverage, **"Plan"** only includes that amount of indemnity benefits which exceeds $100 a day.

Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two parts and this section applies only to one part, each of the parts is a separate plan.

"This Plan" means the part of the group contract that provides health care benefits.

"Primary plan/secondary plan" is determined by the "Order of Benefits Rules."

When this plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits.

When this 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 you are covered under more than two plans, this plan may be a primary plan as to some plans and may be a secondary plan as to other plans.

"Allowable expense" means the necessary, reasonable, and customary item of expense for health care, covered at least in part by one or more plans covering the person making the claim. "Allowable expense" does not include an item of expense that exceeds benefits that are limited by statute or this plan.

The difference between the cost of a private and semiprivate Hospital room is not considered an allowable expense unless Admission to a private Hospital is Medically Necessary under generally accepted medical practice or as defined under this 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.

"Claim determination period" means a Calendar Year. However, it does not include any part of a Year the person is not covered under this plan, or any part of a Year before the date this section takes effect.

Order of Benefits Rules

General. When a claim is filed under this plan and another plan, this plan is a secondary plan and determines benefits after the other plan, unless:

1. The other plan has rules coordinating its benefits with this plan's benefits; and

2. The other plan's rules and this plan's rules, described below, require this plan to determine benefits before the other plan.

Rules. This plan determines benefits using the first of the following rules that applies:

1. **Non-dependent/dependent**. The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.

2. **Dependent child of parents not separated or divorced**. When this plan and another plan cover the same child as a dependent of different persons, called "parents":

    a. The plan that covers the parent whose birthday falls earlier in the Year determines benefits before the plan that covers the parent whose birthday falls later in the year; but

b. If both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

However, if the other plan does not have this rule for children of married parents, and instead the other plan 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 determines the order of benefits.

3. **Dependent child of parents divorced or separated**. If two or more plans cover a dependent child of divorced or separated parents, we determine benefits in this order:

   a. First, the plan of the parent with custody of the child;

   b. Then, the plan that covers the spouse of the parent with custody of the child;

   c. Finally, the plan that covers the parent not having custody of the child;

   d. In the case of joint custody, number 2) above will apply.

   However, if the divorce decree requires one of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period of a plan Year during which any benefits are actually paid or provided before the plan has that actual knowledge.

   When we pay the Provider at the request of the custodial parent, we have met our obligation under the contract.

4. **Joint Custody**. If the specific terms of the divorce decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 2 under the discussion of Rules under this Order of Benefits Rules section.

5. **Active/inactive employee**. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent).

6. **Continuation coverage**. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following is the order of benefit determination:

   a. The benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

   b. The benefits under the continuation coverage.

   The continuation plan is only primary for services due to a preexisting condition.

   If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. **Longer/shorter length of coverage**. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member, or enrollee longer are determined before those of the plan which covered that person for the shorter time.

Effects on Benefits of This Plan

1. This section applies when the "Order of Benefits Rules" above require this plan to be a secondary plan. Benefits of this plan may be reduced.

2. Reduction in this plan's benefits. When the sum of:

    a. The benefits payable for allowable expenses under this plan, without applying coordination of benefits, and

    b. The benefits payable for allowable expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan are reduced so that benefits payable under all plans do not exceed allowable expenses.

When benefits of this plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of this plan.

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, homeowner's 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.

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. 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 will take any and all action necessary to protect its subrogation and reimbursement rights 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, deny all claims related to the incident in which a recovery was received in addition to non-related claims submitted by the Subrogee, or terminate coverage of the Subrogee or Subrogees.

3. Subrogee Constructive 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 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 Administrator, 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 Administrator, 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). 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. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date for 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 1,2021, 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	Don Gaughan Enervation 1601 67th Avenue North Brooklyn Center, MN 55430
Samuel Schultz Heat & Frost Insulators Local 34 95 Empire Drive St. Paul, MN 55103	William Grimm Management Guidance LLP 1270 Northland Drive, Suite 150 Mendota Heights, MN 55120
Lee Houske 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
Alternate:	Alternate:
Eric Houske Heat & Frost Insulators Local 34 JAC 95 Empire Drive St. Paul, MN 55103	Martha Henrickson Management Guidance LLP 1270 Northland Drive Suite 150 Mendota Heights, MN 55120

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.

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 Benefits	Insured by:	SELF-FUNDED from Plan assets
	Administered by:	Wilson-McShane Corporation, Inc. 3001 Metro Drive, Suite 500 Bloomington, MN 55425

Medical benefits are paid from Plan assets, but are administered by Wilson-McShane Corporation, Inc. The Plan utilizes the network of providers available through Blue Cross Blue Shield of Minnesota.

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.

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 01-015053-00. 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 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"). While the Plan has always taken care to secure your health information, the 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.