AMENDMENT NO. 11
TO THE EIGHTH DISTRICT ELECTRICAL BENEFIT FUND
SUMMARY PLAN DESCRIPTION /PLAN RULES AND REGULATIONS
For Active Employees, Early (non-Medicare-eligible) Retirees and Medicare-eligible Retirees effective January 1, 2014

Effective January 1, 2017, the Summary Plan Description/Plan Rules and Regulations is amended as follows:

Article VII, the Weight Management row of the Schedule of Medical Plan Benefits, is amended to add the text in italics and delete the text in strike-through:

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

This chart explains the benefits payable by the Plan. All benefits are subject to the Deductible except where noted. See also the Exclusions and Definitions Articles of this document. ***IMPORTANT: Out-of-Network and Out of Area providers are paid according to Allowed Charges as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	**In-Network** Preferred Provider (PPO) in the PPO Area	**Out-of-Network** Non-Preferred provider in the PPO Area	**Out of Area** Non-Preferred Provider in the Non-PPO area or services unavailable through the PPO
Weight Management • Surgical treatment of morbid obesity.	• The Plan pays for one surgical procedure for the treatment of Morbid Obesity per person per lifetime. ~~Benefits will only be allowed for obesity when a surgical procedure is required due to **morbid** obesity. Morbid obesity is a condition in which persistent and uncontrollable weight gain causes a threat to life. See also the definition of Morbid Obesity in the Definitions Article of this document~~. • *The Plan covers bariatric surgery for the treatment of morbid obesity for individuals age 18 years and older, when such treatment is considered medically necessary by the Utilization Management Company.* • **Surgery benefits will not be allowed unless written authorization (precertification) is received by the Utilization Management Company in advance of the date of surgery, regardless of the medical necessity for the surgery**. See Article IX for information on precertification. The contact information for the Utilization Management Company is listed on the Quick Reference Chart.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

Article IX, Section 5 is amended to add the text in italics and delete the text in strike-through.

Section 5: PRECERTIFICATION (PRESERVICE) REVIEW

a. **How Precertification Review Works:**

Precertification Review is a procedure, administered by the Medical Review firms under contract to the Plan, including the Utilization Management firm and Prescription Drug Program, to assure that health care services meet or exceed accepted standards of care and that health care services are medically necessary.

Prior notification does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations. *If you fail to get the requested services preauthorized before receiving such services, the Plan may still cover the service if it meets the Plan's medical necessity criteria, subject to any benefit limitations.*

You or your Physician must precertify (pre-approve) the following services BEFORE the services are provided:

WHAT SERVICES MUST BE PRECERTIFIED:	MEDICAL REVIEW FIRM TO BE CONTACTED	PENALTY FOR FAILURE TO PRECERTIFY[1]
If you use a CIGNA participating provider, your doctor will work with CIGNA to arrange precertification. If you use a Wise provider, you or your provider will need to call the Utilization Management Company whose name and phone number are listed on the Quick Reference Chart in the front of this document. If you use a provider who does not participate in CIGNA or Wise, YOU are responsible for obtaining precertification of these services: 1. All Elective Hospital admissions, including an admission for mental health and/or substance abuse. (Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section). 2. Partial hospitalization, residential treatment program admission, skilled nursing facility admission and inpatient rehabilitation admission. (Note that there is no coverage for a non-network residential treatment program, skilled nursing facility or inpatient rehabilitation facility even if precertified.) 3. An upcoming transplant as soon as the participant is identified as a potential transplant candidate. *Transplantation-related outpatient services and admission to a hospital for a transplant may require precertification.* 4. The following procedures: Surgical treatment of morbid obesity/bariatric surgery, such as gastric bypass, lap band, etc.; Cord Blood Harvesting; Pharyngoplasty; Outpatient Vein therapy procedures; Spinal procedures; Brachytherapy; Sleep Management; Potential experimental or investigational treatments. 5. ~~All~~ Home Health Care services and Home Infusion services 6. Outpatient injectable drugs administered in an outpatient facility. 7. ~~All~~ Diagnostic radiology type services (such as MRI, CT scan, PET scan, nuclear radiology service, etc.). 8. Speech therapy. 9. Orthotic devices ~~over $500 per item~~. 10. Prosthetic devices including implantable hearing aids such as cochlear implant. 11. Durable Medical Equipment ~~over $1000 per item~~. 12. For individuals who will participate in a clinical trial, precertification is required in order to notify the Plan that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.	**The Utilization Management (UM) Company** whose name and phone number are listed on the Quick Reference Chart in the front of this document.	**If you fail to notify the Utilization Management Company before receiving any services requiring precertification (noted to the left) then, benefits will *may* NOT be paid for the related expenses.**
Certain Specialty prescription drugs	**Prescription Drug Program** whose name and phone number are listed on the Quick Reference Chart in the front of this document.	**If you fail to notify the Prescription Drug Program before receiving any services requiring precertification then benefits will *may* NOT be paid for the related expenses.**

In addition to the edits to precertification in Section 5 above, similar wording edits are made in each place of the document where precertification is mentioned (such as in the Schedule of Medical Benefits), removing the word "all" from sentences that reference the need to obtain precertification.

Article XIV, Claim Filing and Appeal Information, Section 9, is amended to add the text in italics and delete the text in strike-through:

Section 9: AUTHORIZED REPRESENTATIVE

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an adverse benefit determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a Health Care Professional. The Plan requires a written statement from an individual that he/she has designated an authorized representative along with the representative's name, address, phone number and duration of representation. (Except that under this Plan, a Health Care Professional does not require a written statement in order to appeal ~~a~~ *an urgent care, preservice or concurrent care* claim for a plan participant, *but does require a written authorization for a health care provider to appeal a post-service claim*.) To designate an authorized representative, you must submit a completed authorized representative form (available from the Appropriate Claims Administrator).

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.* notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal Spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form, future claims and appeals-related correspondence will be routed to the authorized representative and not the individual as specified on the authorized representative form. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Administrative Office.

~~In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form~~.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Article XVII, the definition of Morbidly Obese, is removed from the Plan document:

~~**Morbidly Obese, Morbid Obesity**: Under this Plan the term means the~~

~~1. Presence of morbid obesity that has persisted for at least 5 years, defined as either:~~
   ~~a. body mass index (BMI) (term defined at the end of this definition) exceeding 40; or~~
   ~~b. BMI greater than 35 in conjunction with ANY of the following severe comorbidities:~~
      ~~(1) coronary heart disease; or~~
      ~~(2) type 2 diabetes mellitus; or~~
      ~~(3) clinically significant obstructive sleep apnea; or~~
      ~~(4) high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic) AND~~
~~2. Individual has completed growth (18 years of age or documentation of completion of bone growth); AND~~
~~3. Individual has participated in a physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:~~
   ~~a. Participation in nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; AND~~

~~b. Nutrition and exercise program must be 6 months or longer in duration; AND~~

~~c. Nutrition and exercise program must occur within the two years prior to surgery; AND~~

~~d. Participation in physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who does not perform bariatric surgery. Note: A physician's summary letter is not sufficient documentation.~~

~~NOTE: BMI is calculated by dividing the individual's weight (in kilograms) by height (in meters) squared: BMI = (weight in kilograms) divided by (height in meters) times (height in meters) or compute using the Obesity Education Initiative website: http://www.nhlbisupport.com/bmi/. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254. Surgery benefits will not be allowed unless written authorization is received in advance of the date of surgery, regardless of the medical necessity for the surgery~~.

CONFIRMATION

The undersigned Chairman and Secretary of the Board of Trustees of the Eighth District Electrical Benefit Fund do hereby certify that the foregoing Amendment #11 to the 2014 Plan was duly adopted and executed at a meeting of the Board of Trustees called and held on December 15, 2016.

By: _____
Chairperson

By: _____
Secretary

5462123v3/01990.001