AMENDMENT NO. 2
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, 2015 the Summary Plan Description/Plan Rules and Regulations is amended as follows:

Article III, Eligibility, Section 4 is amended to add the text in italics and delete the text in strike-through:

c. **Termination of Eligibility of a Dependent of a Bargaining or Non-Bargaining Employee.** The eligibility with respect to a Dependent (Spouse or Dependent Child) of a Bargaining or Non-Bargaining Employee shall automatically terminate upon the occurrence of the first of the following events:

1. the ~~date when~~ *last day of the month in which* the Dependent ceases to be eligible as a Dependent as set forth under the definition of Dependent;
2. when the Dependent Spouse enters full-time military service;
3. expiration of the period of coverage stated in the QMCSO;
4. the date the Plan is discontinued;
5. *the end of the month in which* ~~when~~ the Eligible Employee's eligibility terminates.

d. **Termination of Eligibility of a Domestic Partner.** The eligibility with respect to a Domestic Partner, shall automatically terminate upon the occurrence of the first of the following events:

1. when the Domestic Partner ceases to be eligible as a Domestic Partner as set forth under the definition of Domestic Partner (such as the Domestic Partnership is terminated);
2. when the Domestic Partner enters full-time military service;
3. the date the Plan is discontinued;
4. *the end of the month in which,* ~~when~~ the Eligible Employee's eligibility terminates.

e. **Termination of Eligibility of a Domestic Partner's Dependent Child.** The eligibility with respect to a Dependent of Domestic Partner, shall automatically terminate upon the occurrence of the first of the following events:

1. the *last day of the month in which* ~~date~~ the Dependent Child ceases to be eligible as a Dependent of a Domestic Partner, as set forth under the definition of Domestic Partner's Dependent Child;
2. expiration of the period of coverage for the Dependent of a Domestic Partner as stated in the QMCSO;
3. the date the Plan is discontinued;
4. *the end of the month in which* ~~the date~~ the Domestic Partnership is terminated;
5. *the end of the month in which* ~~when~~ the Eligible Employee's eligibility terminates.

f. **Coverage for Dependents of a Deceased Active Employee.** If termination of an Active Employee's coverage is due to the Employee's death, coverage for Dependents of a deceased employee (the surviving Spouse and Dependent Children or Domestic Partner or Domestic Partner Dependent Child) shall remain in effect until **the earlier of**:

1. the deceased Bargaining Employee's hour bank account has been exhausted. Coverage under the hour bank terminates the last day of the month in which there is less than one (1) month's charge-off amount remaining in the deceased Bargaining Employee's hour bank account;
2. the last day of the **second** month following the death of the non-bargaining employee;
3. ~~the date~~ *the end of the month in which* the Dependent meets any of the provisions for Termination of a Dependent of a Bargaining or Non-Bargaining Employee as noted in the sub-section above.

Such Dependents may continue coverage as described under the Self-Payment Provisions for Surviving Spouse and Dependent Children or Domestic Partner or Domestic Partner Dependent Child Continuation Coverage.

Article III, Eligibility, Section 6 is amended to add the text in italics and delete the text in strike-through:

c. **Termination of Eligibility for a Dependent of a Retiree.** The eligibility with respect to a Dependent of a Retiree shall automatically terminate upon the occurrence of the first of the following events:

1. ~~the date~~ *the last day of the month in which* the Dependent ceases to be eligible as a Dependent as set forth under definition of Dependent;
2. ~~when~~ *the last day of the month in which* the Retiree's eligibility terminates;
3. ~~the date~~ ~~*the last day of the month in which*~~ the Retiree dies (See also the Self-Pay provisions of this Plan for continuation of coverage for a surviving Spouse and surviving Dependent Children or Domestic Partner or Domestic Partner Dependent Child);
4. failure to make the required self-payment within the specified time;
5. upon the Dependent Spouse's entrance into full-time active duty with the armed forces of the United States;
6. the date the Plan is terminated.

d. **Coverage for Surviving Spouse and Dependent Children or Domestic Partner or Domestic Partner Dependent Child of a Deceased Retired Employee.** If termination of a Retired Employee's coverage is due to the Retired Employee's death, coverage for the Dependents of that deceased Retiree (the surviving Spouse and Dependent Children or Domestic Partner or Domestic Partner Dependent Child) will remain in effect until the Surviving Spouse and Surviving Dependent Children or Domestic Partner or Domestic Partner Dependent Child meet the termination provisions outlined below.

1. **Termination of Eligibility for the Surviving Spouse and Dependent Children.** The coverage for a Surviving Spouse and Dependent Children of a Deceased Retiree coverage will terminate the first of the following events:
2. The **surviving Spouse's coverage will terminate** on the earlier of any of the following reasons:
   (a) the surviving Spouse remarries;
   (b) failure to make the required self-payment within the specified time;
   (c) the surviving Spouse becomes covered under any other group policy;
   (d) the date the Plan is terminated.
3. The **surviving Dependent Child's coverage will terminate** on the earlier of any of the following reasons:
   (a) ~~the date~~ *the last day of the month in which* the surviving Spouse's coverage terminates;
   (b) failure to pay the required self-pay premium;
   (c) ~~the date~~ *the last day of the month in which* the Dependent Child ceases to qualify under the definition of Dependent;
   ~~(d) the date of the expiration of the period of coverage for the Dependent Child as stated in the QMCSO;~~
   (e) the date the Plan is terminated.
4. **Termination of Eligibility of a Domestic Partner.** The eligibility with respect to a Domestic Partner, shall automatically terminate upon the occurrence of the first of the following events:
   (a) when the Domestic Partner ceases to be eligible as a Domestic Partner as set forth under the definition of Domestic Partner (such as the Domestic Partnership is terminated);
   (b) when the Domestic Partner enters full-time military service;
   (c) the date the Plan is discontinued;
   (d) ~~when~~ *the last day of the month in which* the Eligible Employee's eligibility terminates.
5. **Termination of Eligibility of a Domestic Partner's Dependent Child.** The eligibility with respect to a Dependent of Domestic Partner, shall automatically terminate upon the occurrence of the first of the following events:
   (a) ~~the date~~ *the last day of the month in which* the Dependent Child ceases to be eligible as a Dependent of a Domestic Partner, as set forth under the definition of Domestic Partner's Dependent Child;
   (b) the date of the expiration of the period of coverage for the Dependent Child of a Domestic Partner as stated in the QMCSO;
   (c) the date the Plan is terminated;
   (d) ~~the date~~ *the last day of the month in which* the Domestic Partnership is terminated;

(e) failure to pay the required self-pay premium.

~~(f) the date the surviving spouse's coverage terminates.~~

Throughout the document any reference to the Plan issuing a HIPAA Certificate of Creditable Coverage on or after January 1, 2015 is deleted.

In each place in the Eligibility Article III where this chart appears it is deleted and replaced with the new chart:

~~**COORDINATION OF BENEFITS WITH MEDICARE**~~

~~To comply with federal Medicare coordination of benefit regulations, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for which you have elected, or are electing, Plan coverage, and information on whether you or any of such Dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.~~

~~Failure to provide the SSN or complete the CMS model form http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf means that claims for eligible individuals will not be considered a payable claim for the affected individuals.~~

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNEorm081809.pdf) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

Article IV, Section 2 a is amended to add the text in italics:

Section 2: CONTINUATION OF COVERAGE UNDER COBRA

a. **Eligibility.**

A Qualified Beneficiary may temporarily continue health care coverage under COBRA for the maximum periods specified below, by making an election to do so with the Administrative Office and submitting the applicable COBRA self-payment contribution. The amount of the monthly self-payment contribution will be established by the Board of Trustees.

Other Health Coverage Alternatives to COBRA

*Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.*

Article VI, Section 13 is amended to add the text in italics and delete the text in strike-through:

Section 13. PAYMENT FOR CERTAIN OVER-THE-COUNTER (OTC) DRUGS.

Certain Over-the-Counter (OTC) Drugs are payable at no charge when prescribed by a Physician/Health Care Practitioner in compliance with Health Reform law.

The following chart outlines the OTC drugs that are payable by this non-grandfathered medical plan in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of OTC drugs, this Plan will comply with the new requirements on the date required.

OTC Drug Name	Who Is Covered for this Drug?	Cost-Sharing?	Payment Parameters in addition to a prescription:
Aspirin	For men 45-79 years to reduce chance of a heart attack and for women 55-79 years to reduce the chance of a stroke.	None, if payment parameters are met	Since dosage not established by USPSTF, plan covers up to one bottle of 100 tablets of generic medication per fill.
OTC Contraceptives for females, such as spermicidal products and sponges.	All females	None, if payment parameters are met	Up to a month's supply of prescription contraceptives per purchase are payable under the plan's Prescription Drug Program for females. Quantity Limit: 12 per 300 days for vaginal ring; 1 per 300 days for diaphragms, cervical cap, subdermal rod and IUD.
Folic acid supplements containing 0.4 - 0.8mg of folic acid	All females planning or capable of pregnancy should take a daily folic acid supplement.	None, if payment parameters are met	Covered for females less than or equal to age 55 years of age, excludes males.
Iron supplements	For children ages 6-12 months who are at increased risk for iron deficiency.	None, if payment parameters are met	Covered for individuals age 6 months to 12 months. OTC coverage excludes intravenous iron products and bulk iron products.
Vitamin D supplements	For adults age 65 and older who are at increased risk for falling.	None, if payment parameters are met	Since dosage not established by USPSTF, plan covers up to one bottle of 100 tablets every 3 months.
Tobacco cessation products	All ~~adults~~ *individuals* who use tobacco products.	~~None,~~ if payment parameters are met	Tobacco cessation drugs are payable with a Quantity limit: 168 day supply per year of generic nicotine replacement products like nicotine gum, patch and lozenge; 168 days of Zyban or Chantix.
Fluoride supplements	For preschool children older than age 6 months when recommended by provider because primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children up to and through age 6 years. Excludes products for individuals age 7 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.
Preparation "prep" Products for a Colon Cancer Screening Test	*For individuals receiving a preventive colon cancer screening test*	*None, if payment parameters are met*	*Plan covers the over-the-counter or prescription strength products prescribed by a physician as preparation for a payable preventive colon cancer screening test, such as a colonoscopy for individuals age 50-75 years. Two fills per 365 days are covered.*

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
Annual Out-of-Pocket Limit on In-Network Cost-Sharing • The Out-of-Pocket Limit is the most cost-sharing you pay for in-network medical and vision plan deductibles, coinsurance, and copayments each year. The annual Out-of-Pocket Limit includes the Coinsurance Maximum described in the row above. • The Out-of-Pocket Limit is accumulated on a calendar year basis. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit. • Expenses for mental health and substance use disorder benefits count toward the Out-of-Pocket Limit in the same manner as those for medical expenses.	• The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services. • Deductibles, copayments and coinsurance related to In-Network essential health benefits for Medical and Vision Plan expenses accumulate to the Out-of-Pocket Limit. • Covered out of area services along with covered emergency services performed in an Out-of-Network Emergency Room will apply to meet the in-network Out-of-Pocket Limit on cost-sharing. • **The Out-of-Pocket Limit does not include or accumulate:** 1. Premiums, 2. Expenses for medical services or supplies that are not covered by the Plan, 3. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers, 4. Penalties for non-compliance with Utilization Management programs, 5. Expenses for the use of non-network providers, except non-network emergency services performed in an Emergency Room, 6. Charges in excess of the Medical or Vision Plan's Maximum Benefits, 7. Expenses that are not considered to be essential health benefits, 8. Outpatient prescription drug cost-sharing expenses, ~~(starting January 1, 2015 outpatient prescription drug cost-sharing will accumulate to the Out-of-Pocket Limit~~). See also the separate Out-of-Pocket Limit for cost-sharing for outpatient drugs explained in the Drug row of this Schedule.	~~$6,350 per individual~~ ~~$12,700 per family~~ *$2,500 per individual* *$5,000 per family*	Not applicable	Accumulates to the In-Network Out-of-Pocket Limit

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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
Behavioral Health Services: (Mental Health and Substance Abuse Treatment) • Inpatient Admission including partial hospitalization. • Outpatient Visits. • *Behavioral Health residential treatment program is covered from in-network providers only for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates.* • **NOTE: The EAP Program offers free counseling visits.** See the Quick Reference Chart for the phone number to the EAP Program. The EAP benefits of this Plan may be used for smoking/tobacco cessation counseling.	• **All inpatient admissions *partial hospitalization and residential treatment program admissions* require precertification** by calling the Utilization Management Company, whose phone number is listed on the Quick Reference Chart. See Article IX for information on precertification requirements of the Plan. • Partial hospitalization means treatment of mental, nervous, or emotional disorders and substance abuse for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period. • See the specific exclusions related to Behavioral Health Services in the Exclusions Article. • Expenses for Applied Behavioral Analysis (ABA) Therapy (as defined in the Definitions Article of this document) and related services are not covered by the Plan. • Outpatient prescription drugs for Behavioral Health are payable under Drugs in this Schedule of Medical Benefits.	**EAP Counseling:** No charge **Actives and Retirees:** 75% after Deductible met	***Inpatient Admission, Partial Hospitalization and Outpatient services for* Actives and Retirees:** 50% after Deductible Met ***Residential Treatment Program Admission: Not covered.***	**Actives and Retirees:** 75% after Deductible met

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***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
Drugs (Outpatient Prescription Medicines) • Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them. • Coverage is provided for insulin, insulin syringes, diabetic supplies and contraceptives. • Contact the Prescription Drug Program (whose phone number is listed on the Quick Reference Chart in the front of this document) for **drug precertification, quantity limits, step therapy and information on Specialty drugs**. • **Specialty drugs** are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty drugs are products derived from living organisms used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, hepatitis, or rheumatoid arthritis. These drugs need precertification and are managed because they often require special handling, are date sensitive and are usually available only in a 30-day quantity. • Drugs not yet approved by the FDA are not covered. **New FDA-approved drugs** will be covered unless an amendment states otherwise or the class of drug is excluded. • The prescription drug benefits of this Plan are creditable with Medicare Part D prescription drug coverage. • **Certain over-the-counter (OTC) drugs are covered only under this Outpatient Prescription Drug Program at no charge** in compliance with Health Reform regulations. See Article VI for details.	Benefits for prescription drugs are provided through the Plan's **Prescription Drug Program** whose name is listed on the Quick Reference Chart in the front of this document. • **Retail Drugs**: To obtain up to a 30-day supply of medicine present your ID card to any in-network retail pharmacy. Contact the Prescription Drug Program (whose name is listed on the Quick Reference Chart) for the location of in-network retail pharmacies. • **Mail Order (Home Delivery) Drug Service:** The mail order service is the easiest and least expensive way to obtain many medications plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. Not all medicines are available via mail order. Check with the Prescription Drug Program for further information. To use the mail order service: a) Have your doctor write the prescription for a 90-day supply, with the appropriate refills. b) Mail your prescription, copay & mail order form to the Mail Order Services of the Prescription Drug Program whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the Prescription Drug Program. Allow up to 14 days to receive your order. • **No coverage for** erectile dysfunction drug treatment, fertility/infertility drugs, weight control drugs, etc. See also exclusions under Drugs (Medicines) in the Medical Plan Exclusions Article. • Copayments for drugs are not applied to meet the Plan's Coinsurance Maximum or Deductibles. • **Proton Pump Inhibitor (PPI) Step Therapy Program:** PPI drugs, such as Nexium, Prevacid and Prilosec, are used to block the production of stomach acid. The PPI Step Therapy Program ensures that these drugs are used in accordance with FDA guidelines. Unless otherwise medically indicated, PPI drugs will only be covered for one 90-day supply. You have the option of having your generic PPI drugs delivered through mail order without prior authorization. The step therapy program also includes cholesterol-lowering drugs (statins), sleep aids, SSRI antidepressants, COX-2 anti-inflammatory drugs and steroid nasal sprays. • The **Quantity Limitation Program** is designed to protect patients taking excessive amounts of narcotic pain relievers, migraine medications, respiratory and asthma medications, or sedative hypnotics. Any usage that exceeds FDA guidelines will require prior authorization from the Prescription Drug Program. • Coverage is extended for over-the-counter or prescription **tobacco cessation products** (such as nicotine gum or patches) intended to assist an individual to stop smoking or using tobacco products. You must present a written prescription from a physician for over-the-counter or prescription tobacco cessation products to the retail pharmacist. You may also submit a prescription order through the mail order program. See also the Behavioral Health benefit row of this schedule regarding payment for smoking/tobacco cessation counseling. • *No charge at an In-network Retail or Mail Order location for generic tamoxifen prescribed for women who are at increased risk of breast cancer and low risk for adverse medication effects.*	*The Out-of-Pocket Limit on outpatient drugs is the most you pay for covered generic, preferred brand, non-preferred brand & specialty drugs from in-network retail & mail order locations per calendar year is $4,100/person; $8,200/family (these amounts will be adjusted in accordance with law).* ACTIVES AND RETIREES: Note that if the cost of the drug is less than the copay you pay just the drug cost. **The Medical Plan deductible does not apply to these drugs.** In-Network Retail Pharmacy: (up to a 30-day supply) **Generic**: You pay 10% of the drug cost with a minimum copay of $10 and a maximum copay of $20 **Preferred Brand**: You pay 25% of the drug cost with a minimum copay of $25 and a maximum copay of $50 **Non-Preferred Brand**: You pay the greater of 50% of the drug cost or a $50 copay Specialty Drugs: (up to a 30-day supply) 100% after a $35.00 copay Mail Order Service: (up to a 90-day supply) **Generic:** 100% after a $20.00 copay **Preferred Brand**: 100% after a $50 copay **Non-Preferred Brand:** You pay 50% of the drug cost. FDA approved generic female Contraceptives: No charge. FDA approved brand name female contraceptives will be subject to the applicable coinsurance/copay. Certain CDC recommended vaccinations are payable at 100%, no cost sharing when obtained at an in-network retail pharmacy. Contact the Prescription Drug Program for more information on these vaccinations. Non-Network Retail Pharmacy: (up to a 30-day supply) If you fill a prescription at an Out-of-Network/Non-Network pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Drug Program at their address listed on the Quick Reference Chart. For Generic or Brand Drugs, the Plan reimburses 100% less any applicable copay/coinsurance. No reimbursement for specialty drugs, contraceptives or OTC drugs purchased from non-network retail pharmacy locations.			

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***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
Rehabilitation Services (Physical, Occupational & Speech Therapy) • Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.** • Outpatient physical therapy performed in conjunction with Spinal Manipulation services is subject to the Plan's limitations for Spinal Manipulation services.	• ***Inpatient rehabilitation admission and* all speech therapy services require precertification** by calling the Utilization Management Company, whose phone number is listed on the Quick Reference Chart. See Article IX for information on precertification. • Rehabilitation services are covered only when ordered by a Physician. • **Outpatient Rehabilitation Services (any combination of Physical, Occupational and Speech Therapy) are payable up to 50 visits per person per calendar year.** • Outpatient Physical Therapy or Occupational Therapy services prescribed by a Physician are payable up to two (2) consecutive months when in the judgment of the Physician, significant improvement can be obtained. Additional need for therapy must be certified by the attending Physician to be medically necessary. When prescribed or provided by a Physician, the following types of therapy are covered: 1. Physical Therapy performed by a Physician or a registered physical therapist. 2. Occupational Therapy performed by a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA). 3. Speech Therapy performed by a certified speech therapist. **Speech therapy requires precertification.** See Article IX for information on precertification. • Benefits are not payable for Physical, Occupational or Speech Therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected. • Physical Therapy and Occupational Therapy which are prescribed by a Physician in lieu of non-medical treatment (e.g., exercise) are not considered Medically Necessary and reasonable treatment and would not be payable by the Plan. • Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist: a) for children for childhood developmental speech delays and disorders, b) for adults/children to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure.	**Actives and Retirees:** 75% after Deductible met	***Outpatient Services for* Actives and Retirees:** 50% after Deductible Met ***Inpatient Rehabilitation Admission:*** *Not covered.*	**Actives and Retirees:** 75% after Deductible met

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***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
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility.	• ***Skilled nursing facility and subacute care facility admission requires precertification*** *by contacting the UM Company whose name and phone number are listed on the Quick Reference Chart in the front of this document.* ***No coverage for services not authorized by the Utilization Management Company.*** • Services must be ordered by a Physician. • To determine if a facility is a skilled nursing or subacute facility see the Definitions Article of this document. • **Skilled Nursing Facility confinement** or Subacute care facility confinement payable to a maximum of **70 days per calendar year.**	**Actives and Retirees:** 75% after Deductible met	**Actives and Retirees:** ~~50% after Deductible Met~~ *No Coverage*	**Actives and Retirees:** 75% after Deductible met

Article IX: Precertification and Medical Review, Section 5 is amended to delete the existing chart of services that must be precertified and add the new chart, as noted below. All reference to precertification in the document is to be amended to align with the requirements of the new chart below:

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.

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]

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. 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 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 NOT be paid for the related expenses.**

Article X, Medical Plan Exclusions, Section 2 B is amended to add the text in italics and delete the text in strike-through:

B. Behavioral Health Care Exclusions

1. ~~Expenses for residential care services for Behavioral Health Care~~.

Article XVII, Definitions, the definition of Behavioral Health Treatment Facility is amended to delete the text in strike-through:

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders and which is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Behavioral Health Treatment Facility that qualifies as a Hospital is covered by this Plan as a Hospital and not a Behavioral Health Treatment Facility. ~~A residential treatment facility, transitional facility, group home, halfway house or temporary shelter is not a Behavioral Health Treatment Facility under this Plan~~.

Article XVII, Definitions, the definition of Dependent is amended to add the text in italics and delete the text in strike-through:

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse or Domestic Partner or Domestic Partner Dependent Child as those terms are defined in this document. See also Eligible Dependent. "Dependent" means:

a. **Spouse:** The Eligible Employee's **lawful Spouse**, which shall include only:

1. a person to whom the Eligible Employee is legally married and to whom the Eligible Employee is not legally separated from; and

2. a person who is not legally married to the Eligible Employee, but who cohabits with the Eligible Employee (an employee that is not currently married) in the "good faith belief," such person is married to the Eligible Employee. Good faith belief shall require that the Eligible Employee and such person submit an affidavit and supporting documentation satisfactory to the Administrative Office establishing that the Eligible Employee and such person consented to be married and that the Eligible Employee, and only such person, mutually assumed a marital relationship, rights, duties and obligations for at least twelve (12) continuous months prior to the execution of the affidavit. Such affidavit and supporting documentation shall be filed with the Administrative Office prior to the time of accrual of any benefits under the Plan by such person.

b. **Dependent Child:**

1. For the purposes of this Plan, a Dependent Child is any of the employee's/retiree's children listed below who are under the age of 26 (whether married or unmarried):

a) **Son or daughter** (proof of relationship and age may be required)

b) **Stepson or stepdaughter** (proof of relationship and age may be required)

c) **Legally adopted child or child placed for adoption** with the employee/retiree (proof of adoption or placement for adoption and age may be required). **Placed for adoption means** the assumption and retention by the eligible employee/retiree of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation.

d) **Child under a permanent legal guardianship** (proof of court ordered guardianship may be required)

e) Dependent Child also includes a Dependent Child of an Eligible Employee, designated as an "Alternate Recipient" under the terms of a **Qualified Medical Child Support Order (QMCSO)**within the meaning of 609(a) of ERISA, 29 U.S.C. § 1169.

2. Except as provided below with respect to a disabled child, **coverage will terminate for a Dependent Child** at the earlier of the *end of the month in* ~~date on~~ which the child attains age 26, or when the guardianship ends.

3. **Disabled Adult Child:** The Eligible Employee's unmarried Dependent Children who are incapable of self-sustaining employment by reasons of mental or physical disability will continue to be covered for benefits provided such incapacity commenced while the child was an eligible Dependent prior to the end of the month in which the Dependent attains age 26 years of age, and provided the child is dependent upon the Eligible Employee for support and maintenance.

Notification and proof of such disability must be submitted to the Administrative Office within thirty-one (31) days of the date the Dependent Child's coverage would otherwise terminate.

Also, if the adult child you plan to add for coverage does not qualify as a tax dependent under applicable state law, benefits may need to be imputed as income to the employee for the purposes of state tax.

4. **When both husband and wife are Eligible Employees,** their children are eligible as Dependents of both. If a person has dual coverage, because they are the Dependent of two (2) covered Eligible Employees, the total amount of benefits payable on their account by reason of such dual coverage will in no event exceed 100% of allowable charges. Such dual coverage will be subject to all Plan provisions (i.e. benefit maximums).
5. It is the Employee/Retiree's obligation to **inform the Plan promptly if any of the requirements set out in this definition of a child are NOT met** with respect to any child for whom coverage is sought or is being provided.
6. **The following individuals are not eligible dependents under this Plan:** foster child, grandchild, son-in-law or daughter-in-law.

Article XIV, Definitions, a new definition is added as noted in italics:

Residential Treatment Program/Facility/Care: *is a non-acute hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for people with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a residential treatment facility under contract as an in-network facility.*

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 #2 to the 2014 Plan was duly adopted and executed at a meeting of the Board of Trustees called and held on December 11, 2014.

By: _____
Chairman

By: _____
Secretary

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