AMENDMENT NO. 6
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 September 16, 2015, the Summary Plan Description/Plan Rules and Regulations is amended as follows:

Article VIII, Medical Networks, Section 1 is amended to add a new subsection "d" as noted below:

d. **SPECIAL REIMBURSEMENT PROVISION.**

Claims incurred for surgery to correct a Chiari malformation (a structural defect in the cerebellum of the brain) will be treated as in-network regardless of whether the surgery is performed by an in-network provider or an out-of-network provider.

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. *For pregnant women who are at high risk for preeclampsia, (a pregnancy complication).*	None, if payment parameters are met	*For non-pregnant adults,* since dosage not established by USPSTF, plan covers up to one bottle of 100 tablets of generic medication per fill. *For pregnant women at high risk for preeclampsia: plan covers daily low dose aspirin (81mg) as preventive medication after 12 weeks gestation.*
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~~ *FDA-approved* 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.

Article VII, the Schedule of Medical Benefits, the Colonoscopy Screening Benefit row, the following bullet point is added to the Explanations and Limitations column:

- *For a screening colonoscopy, no charge for a specialist pre-procedure consultation, bowel prep medication used prior to a screening colonoscopy, anesthesia services or the lab charges for analysis of polyps removed during a screening colonoscopy.*

Throughout the document, any reference to coverage of a Breastfeeding/Lactation Educator is deleted, as the Plan will now cover lactation counseling, (in compliance with Health Reform), for any provider acting within the scope of their license, not just a Breastfeeding/Lactation Educator.

Article VII, the Schedule of Medical Benefits, the Drugs row, the following bullet point is amended to add the text in italics and delete the text in strike-through:

FDA-approved generic ~~female~~ Contraceptives *for females*: ~~No charge~~. *No cost-sharing for generic contraceptives submitted with a prescription purchased at an In-network Retail or Mail Order location.* FDA approved brand name female contraceptives will be subject to the applicable coinsurance/copay; *however, there is no charge for brand prescription contraceptives only if a generic contraceptive is unavailable or medically inappropriate. The attending provider determines medical necessity for FDA-approved female contraceptives.*

Article VII, the Schedule of Medical Benefits, the Durable Medical Equipment row, the following bullet point is amended to add the text in italics and delete the text in strike-through:

- ~~For the first 12 months following the birth of a child~~, *For females who are breastfeeding,* coverage is provided for a standard manual or standard electric breast pump, plus *supplies* necessary *to operate the* breast pump ~~supplies~~. ~~This includes comprehensive lactation support and counseling by a trained provider, during pregnancy and/or in the postpartum period~~. Rental versus purchase is at the option of the Plan. Repair is payable when medically necessary. *A hospital grade breast pump is payable if the Plan determines it to be medically necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child.* Coverage is available at no cost from in-network providers only.

Article VII, the Schedule of Medical Benefits, the Maternity row, the following bullet points are amended to add the text in italics and delete the text in strike-through:

- ~~For the first 12 months following the birth of a child,~~ *For females who are breastfeeding,* coverage is provided for a standard manual or standard electric breast pump, plus *supplies* necessary *to operate the* breast pump ~~supplies~~. ~~This includes comprehensive lactation support and counseling by a trained provider, during pregnancy and/or in the postpartum period.~~ Rental versus purchase is at the option of the Plan. Repair is payable when medically necessary. *A hospital grade breast pump is payable if the Plan determines it to be medically necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child.* Coverage is available at no cost from in-network providers only.
- ~~Breastfeeding supplies and rental of breast feeding equipment are payable. In conjunction with birth, the Plan pays for comprehensive lactation support and counseling by a trained Breastfeeding/lactation Educator (as defined in this Plan) during pregnancy and/or in the postpartum period~~. *For females who are breastfeeding, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no deductible, when provided by an in-network provider acting within the scope of his/her license. In-network providers are listed on the network directory described on the Quick Reference Chart.*
- Certain prenatal care/maternity related preventive care expenses are payable for all females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to screening for gestational diabetes, breastfeeding ~~supplies and rental of breastfeeding~~ equipment *and supplies to operate the equipment,* and ~~in conjunction with birth, coverage for~~ comprehensive lactation support and counseling ~~by a trained provider during pregnancy and/or in the postpartum period~~ while breastfeeding). These services are covered under the Wellness/Preventive Services category without cost sharing for a female when obtained from in-network providers. ~~See the definition of Breastfeeding/Lactation Educator~~.

Throughout the document any reference to the "Joint Commission on Accreditation of Healthcare Organizations (JCAHO)" is deleted and replaced with this organization's new name "The Joint Commission."

Article VII, the Schedule of Medical Benefits, the Wellness (Preventive): Well Child Examinations and Immunizations to age 26 years row, the following bullet points are added to the Explanations and Limitations column:

- *Coverage is provided in primary care clinician visits for fluoride varnish applied to the primary teeth of children through age 5 years.*
- *Preventive services are payable without regard to gender assigned at birth, or current gender status.*
- *For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician.*

Article VII, the Schedule of Medical Benefits, the Wellness (Preventive): Adult Health Maintenance Examinations and Immunizations, the following bullet points are added to the Explanations and Limitations column:

- *Preventive services are payable without regard to gender assigned at birth, or current gender status.*
- *Screening Colonoscopy: No charge for a specialist pre-procedure consultation, bowel prep medication used prior to a screening colonoscopy, anesthesia services or the lab charges for analysis of polyps removed during a screening colonoscopy.*
- *As a **preventive counseling benefit** in compliance with Health Reform, the Plan covers the following services: For adults (1) with a body mass index of 30 kg/m^2 or higher, OR (2) who are overweight (defined as a BMI of 25 to 29.9 kg/m^2) or obese (defined as a BMI of 30 kg/m^2 or higher) AND have additional cardiovascular disease (CVD) risk factors, the Plan covers Physician prescribed **intensive behavioral counseling interventions**. Intensive behavioral counseling interventions means the Plan will consider as medically necessary preventive services, up to a combined limit of 26 individual or group visits per 12-month period by an in-network provider.*

Article XV, Section 6, a new subsection "7" is added to describe Medicare Secondary Payer coordination of benefits rules:

7. **Summary Chart on Coordination of Benefits (COB) with Medicare:** If you are covered by Medicare and also have other group health plan coverage, the coordination of benefits (COB) rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below:

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	**Situation**	**Pays First**	**Pays Second**
Are covered by both Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage such as a group health plan has paid
Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working Spouse of any age	The employer has less than 20 employees*	Medicare	Group health plan
	The employer has 20 or more employees	Group health plan	Medicare
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Group health plan (*e.g.* a retiree plan coverage)
Are disabled and covered by a large group health plan from your work or from a family member who is working	The employer has less than 100 employees**	Medicare	Group health plan
	You are entitled to Medicare or the Employer has 100 or more employees	Group health plan	Medicare

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	**Situation**	**Pays First**	**Pays Second**
Have End-Stage Renal Disease (ESRD is permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Are covered under worker's compensation because of a job-related injury or illness	Entitled to Medicare	Workers' compensation for worker's compensation-related claims	Usually does not apply however Medicare may make a conditional payment.
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	Federal Black Lung Benefits Program for black lung-related claims	Medicare
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance, for the accident-related claims	Medicare
Are a veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Generally, Medicare and VA cannot pay for the same service.	Usually does not apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider.	TRICARE may pay second
Are age 65 or over OR, are disabled and covered by both Medicare and COBRA	Entitled to Medicare	Medicare	COBRA
Have End-Stage Renal Disease (ESRD) and COBRA	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA

- *or if it is part of a multiemployer plan where one employer has 20 or more employees, if the Plan has requested an exception that is approved by Medicare.
- ** and isn't part of a multiemployer plan where any employer has 100 or more employees.

See also : http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf or 1-800-Medicare for more information.

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 #6 to the 2014 Plan was duly adopted and executed at a meeting of the Board of Trustees called and held on March 16, 2016.

By: _____
Chairperson

By: _____
Secretary

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