AMENDMENT NO. 25
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 as stated below, the Summary Plan Description/Plan Rules and Regulations is amended or clarified as follows:

Effective October 1, 2021, Article VII – Schedule of Medical Plan Benefits is amended at Emergency Room & Urgent Care Services to add the following 1st bullet to the Explanations and Limitations column as the new first bullet and moving the subsequent bullets down:

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
Emergency Room & Urgent Care Services (facility fees) • Hospital emergency room (ER) for "Emergency Services" (as that term is defined in the Plan). • Use of an Urgent Care facility. • Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit. • (See also the Ambulance section of this schedule.)	• Emergency Room Copayment will be waived if the Covered Individual is admitted to the hospital or provides documentation of a referral to the Emergency Room from a Physician or Health Care Practitioner, including a telehealth provider. • Expenses for Emergency Room services are covered only when those services are for **Emergency Services** as that term is defined in the Definitions Article of this document. • There is no requirement to recertify the use of a hospital based emergency room visit. • The plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with Health Reform regulations. See the definition of Allowed Charge or contact the Administrative Office for more details on what the Plan allows as payment to Out-of-Network emergency service providers.	**Urgent Care Services for Actives and Retirees:** 75% after Deductible met **Emergency Room Services for Actives and Retirees:** After a $500 copay per ER visit and after the Deductible is met, the Plan pays 75%. Copayment waived if admitted	**Urgent Care Services for Actives and Retirees:** 50% after Deductible met **Emergency Room Services for Actives and Retirees:** After a $500 copay per ER visit and after the Deductible is met, the Plan pays 75%. Copayment waived if admitted	**Urgent Care Services for Actives and Retirees:** 75% after Deductible met **Emergency Room Services for Actives and Retirees:** After a $500 copay per ER visit and after the Deductible is met, the Plan pays 75%. Copayment waived if admitted

Effective October 1, 2021, Article VII – Schedule of Medical Plan Benefits is amended at Physician and Other Health Care Practitioner Services to add "telemedicine (virtual)" to the 1st bullet in the Benefit Descriptions column as follows:

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

Physician and Other Health Care Practitioner Services
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility, retail medical clinic, telemedicine (virtual), or other covered health care facility location.
• Payable Physicians and Health Care Practitioner professional fees include:
  • Surgeon;
  • Assistant surgeon (if medically necessary);
  • Anesthesia by Physicians and Certified Registered Nurse Anesthetists;
  • Pathologist; Radiologist;
  • Physician Assistant; Nurse Practitioner; Nurse Midwife.
  • Breastfeeding/Lactation Educator.
• See also the Family Planning, Maternity and Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from in-network providers.
See also the Emergency Services row for payment of providers in an emergency room.
	• **Certain outpatient and all inpatient 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.
	• **Assistant Surgeon fees** will be reimbursed for medically necessary services to a **maximum** of 20% of the eligible expenses payable to the primary surgeon.
	  • If the assistant surgeon is a Certified Surgical Assistant, the reimbursement will be 10% of the eligible expenses allowed as payable to the primary surgeon.
	• See also the definition of Physician, Health Care Practitioner and Surgery in the Definitions Article.
	• The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery" in the Definitions Article.
	• The plan does not require the selection of a primary care physician (PCP) therefore you have the right to be seen by any primary care provider who participates in the Plan's medical PPO network and who is available to accept you or your eligible family members.
	You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the medical plan network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical plan PPO network at their website listed under PPO Networks on the Quick Reference Chart in this document.
		Actives and Retirees: 75% after Deductible met	**Actives and Retirees:** 50% after Deductible met	**Actives and Retirees:** 75% after Deductible met

Effective October 1, 2021, Article X – Medical Plan Exclusions, Section 1: General Exclusions is amended by deleting the current Exclusion 14 and renumbering the subsequent exclusions accordingly.

Effective January 1, 2014, Article X – Medical Plan Exclusions, Section 2: Exclusions Applicable to Specific Medical Services and Supplies is clarified by adding the following new Exclusion 2 and renumbering the subsequent exclusions accordingly:

B. Autism Treatment Exclusions

1. Expenses for and related to medical (including prescriptions), behavioral and educational treatment of autism.

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 #25 to the 2014 Plan was duly adopted and executed at a meeting of the Board of Trustees called and held on June 23, 2021.

By: _____
Chairperson

By: _____
Secretary