Eighth District Electrical Benefit Fund

Summary Plan Description/Plan Rules and Regulations

describing the
Medical, Dental, and Vision Plans,
Personal Care Account, Weekly Disability Benefit,
Life and Accidental Death and Dismemberment,
and Dependent Life Insurance Benefits

for
Active Employees,
Early (non-Medicare-eligible) Retirees
and Medicare-eligible Retirees

Amended, restated and effective January 1, 2014

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Eighth District Electrical Benefit Fund

Dear Participant:

We are pleased to present you with this updated Summary Plan Description/Plan Rules and Regulations document describing the Medical, Dental, and Vision Plans, Weekly Disability benefit, Personal Care Account, Life and Accidental Death and Dismemberment and Dependent Life Insurance benefits of the Eighth District Electrical Benefit Fund. This booklet replaces all other Summary Plan Descriptions and Plan Rules previously provided to you.

The information in this booklet describes the benefits to which you and your eligible dependents are entitled, including the eligibility rules and the procedures you are required to follow in order to obtain benefits. This booklet provides you with comprehensive information about your benefits explained in a reader-friendly way.

The majority of benefits described in this booklet are self-funded and provided by the Fund, except for the Life and Accidental Death and Dismemberment Insurance benefits and the insured Dental Plan that are underwritten by Insurance Companies (whose names can be found on the Quick Reference Chart toward the front of this document).

The benefits in this document are important and valuable and we want to make sure you understand how they work. We request you read this booklet carefully so you may fully understand the extent of the benefits to which you are entitled. You are encouraged to keep this booklet for future reference. Important phone numbers are listed on the Quick Reference Chart in the front of this document. See the Table of Contents to help you locate information in here.

We would like to take this opportunity to remind you that the Fund participates with a network of Preferred Health Care Providers. The utilization of the Preferred (PPO) Providers could result in substantial savings to you and the Fund.

Included in this booklet is certain information as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Only the full Board of Trustees is authorized to interpret the Plan. No individual Trustees, employer, union representative, or employee of the Administrative Office has the authority to interpret the Plan on behalf of the Board or to act as an agent of the Board. If however, you have general questions about the information in this booklet or if you need assistance in filing a claim, the staff at the Administrative Office will be happy to assist you.

Sincerely,

The Board of Trustees

ARTICLE I: INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This Summary Plan Description/Plan Rules and Regulations document describes the Medical, Dental, and Vision Plans, Weekly Disability benefit, Personal Care Account, Life and Accidental Death and Dismemberment and Dependent Life Insurance benefits of the Eighth District Electrical Benefit Fund hereafter referred to as the "Plan" or "the Fund."

- Contributions provide coverage for applicable Medical and Dental plan benefits, Life insurance and AD&D insurance and Dependent Life insurance benefits.
- The Vision, Personal Care Account, and Weekly Disability benefits described in this document are available if your local union has negotiated a contribution for those benefits.

The Plan described in this document is **effective January 1, 2014**, except for those provisions that specifically indicate other effective dates, and replaces all other summary plan descriptions and plan rules and regulations previously provided to you.

This document will help you understand and use the benefits provided by the Fund. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Definitions Articles.

Remember, not every expense you incur for health care is covered by the Plan.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this Article.

IMPORTANT NOTE

The Fund is committed to maintaining health care coverage for employees and retirees and their families at an affordable cost, however, because future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

- The medical, personal care account, vision, weekly disability, and dependent life insurance benefits of the Plan are self-funded with contributions from participating employers and Eligible Employees and Retirees held in a Trust. An independent Claims Administrator pays benefits out of Trust assets.
- The Dental Plan and the Life Insurance and Accidental Death and Dismemberment benefits of the Plan are insured with an Insurance Company whose name is listed on the Quick Reference Chart in this document.

YOU MUST KEEP THE PLAN INFORMED

You or your Dependents must promptly furnish to the Plan Administrator information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Failure to do so may cause you or your Dependents to lose certain rights under the Plan or result in your liability to the Plan if any benefits are paid for an ineligible person.

QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Administrative Office at their phone number and address located on the Quick Reference Chart in this document. As a courtesy

to you, the staff of the Administrative Office may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits.

Your most reliable method is to **put your questions into writing and fax or mail** those questions to the Plan in care of the Administrative Office and **obtain a written response from the Plan**. In the event of any discrepancy between any information that you receive from the Administrative Office, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

SUGGESTIONS FOR USING THIS DOCUMENT

This document provides detail about your Plan. We suggest that you pay particular attention to the following:

- Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. If you do not understand a term, look it up in the **Definitions** Article. The **Table of Contents** provides you with an outline of all the articles. The **Definitions** Article explains many technical, medical and legal terms that appear in the text.
- This document contains a **Quick Reference Chart** following this introductory text**.** This is a handy resource for the names, addresses, and phone numbers of the key contacts for your benefits such as the Claims Administrator.
- The **Eligibility Article** outlines who is eligible for coverage and when coverage begins and ends. Then the article on **Self-Payment Provisions including COBRA** discusses your options if coverage ends for you or a covered Spouse or Dependent Child or Domestic Partner or Domestic Partner Dependent Child.
- Review the **Medical Plan, Schedule of Medical Benefits and Medical Plan Exclusions articles.** These describe your benefits in more detail. There are examples, charts, and tables to help clarify key provisions and more technical details of the coverages.
- Review the **Medical Networks and Precertification Articles**. They describe how you can maximize plan benefits by following the provisions explained in these Articles.
- Review the **Vision Plan, Schedule of Vision Benefits and Vision Exclusions** Articles for information on the benefits available to care for your eyes.
- Review the **Insured Dental Plan** Article for an explanation of the dental benefits of this Plan.
- Refer to the **General Provisions Article** for information regarding your rights and information about ERISA.
- The **Claim Filing and Appeal Information Article** tells you what you must do to file a claim and how to seek review (appeal) if you are dissatisfied with a claims decision.
- The Article on **Coordination of Benefits** discusses situations where you have coverage under more than one group health care plan, Medicare, another government plan, personal injury protection under mandatory no-fault automobile insurance coverage, workers' compensation, or where you can recover expenses from any other source.
- Review the **Life Insurance** Articles for information on how this benefit works for you and your family.

ENROLLMENT CARD, BENEFICIARY DESIGNATION AND CLAIM FORM

Enrollment Card: A completed enrollment card must be on file with the Plan in order to allow the processing of claims. Enrollment cards can be obtained from and returned to the Administrative Office whose address is listed on the Quick Reference Chart in the front of this document. The enrollment card also contains your beneficiary designation, described below:

Beneficiary Designation: You need to designate one or more beneficiaries for your life insurance benefits. Beneficiary Designation is part of the Enrollment card (noted above) that can be obtained from and returned to the Administrative Office whose address is listed on the Quick Reference Chart in the front of this document.

Claim Form: You must complete and sign a claim form at least once each year for certain situations, such as for a spouse and dependent child who have dual coverage, for children over age 26 years, and for accident related claims. Claim forms can be obtained from and returned to the Administrative Office whose address is listed on the Quick Reference Chart in the front of this document.

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
(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/RevisedHICNSSNForm081809.pdf)
means that claims for eligible individuals will not be considered a payable claim for the affected individuals.

QUICK REFERENCE CHART FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

ARTICLE II: QUICK REFERENCE CHART

Information Needed:	Please Contact:
Claims Administrator (Administrative Office) • Claims and appeals for: Medical, Vision, Weekly Disability, and Dependent Life Insurance • Claim Forms (Medical or Vision) • Weekly Disability Claims Administration and claim forms • Personal Care Account (PCA) Administration and Benny cards (the Prepaid Benefits cards) • Eligibility for Coverage • Plan Benefit Information • HIPAA Certificate of Creditable Coverage • Medicare Part D Notice of Creditable Coverage • ID cards	**CompuSys of Utah, Inc.** *Mailing Address*: P. O. Box 30101 Salt Lake City, UT 84130-0101 2156 West 2200 South Salt Lake City, Utah 84119-1376 **Phone: (801) 973-1001 or toll free (800) 628-6562** Fax: 801-973-1007
PPO Networks • Medical Network Provider Directory • Additions/Deletions of Providers	**For residents of Utah, the PPO Network in Utah is:** **WISE Provider Network** (aka *Imagine Health*) 1-801-649-6501 or toll-free at 866-485-5205 Website for providers: www.wiseprovidernetworks.com **For residents of Utah, the PPO Network if traveling outside of Utah is:** **First Health Network** 1-888-685-7774 Website for provider - www.myfirsthealth.com **For residents of Colorado, Idaho, Montana & Wyoming the PPO Network is:** **CIGNA** 1-800-244-6224 Website for providers - www.CIGNA.com
Utilization Management Program • Precertification of a variety of medical plan services (outlined in the Precertification and Medical Review Article IX of this document) • Case Management	**CIGNA CareAllies** Telephone: 1-800-768-4695
	OptumRx **Customer Service: 1-800-797-9791**

ARTICLE II: QUICK REFERENCE CHART

Information Needed:	Please Contact:
Prescription Drug Program for Outpatient Retail, Mail Order and Specialty Drugs • Retail Pharmacies for Discount Drug Purchases • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Prior authorization/Precertification (medical review) of Certain Drugs • Specialty Drug Program: Precertification and Ordering	Specialty Pharmacy: 1-866-218-5445 Prior Authorization: 1-800-711-4555 (option 2) **www.optumrx.com**
Member Assistance Program (MAP) Employee Assistance Program (EAP) • EAP **counseling at no cost** to the employee and retiree and their family members, along with referral services.	For residents of Utah, the EAP is: **Blomquist Hale at 1-800-926-9619** or **1-801-262-9619** For residents of Colorado, the EAP is: **Mines and Associates at 1-800-873-7138** For residents of Idaho, Montana and Wyoming the EAP is: **APS Healthcare at 1-800-999-1077**
Disease Management Program • Health education, self-care tips and guidance in the management of these chronic diseases: o heart disease (e.g. heart failure, chest pain, heart attack, coronary artery disease) o diabetes o respiratory disease (e.g. asthma, COPD, emphysema, chronic bronchitis)	**Nurtur** Phone: 1-800-293-0056 www.nurturhealth.com
Insured Dental Plan • Dental plan benefits information • Dental network providers • Dental claims and appeals	**Metropolitan Life Insurance Company** Customer Services: 1-800-942-0854 www.metlife.com/mybenefits
COBRA Administrator • Information About Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments	**CompuSys of Utah, Inc.** Mailing Address: P. O. Box 30101 Salt Lake City, UT 84130-0101 2156 West 2200 South Salt Lake City, Utah 84119-1376 **Phone: (801) 973-1001 or toll free (800) 628-6562** Fax: 801-973-1007
Board of Trustees (Plan Administrator) • Claim Appeals	**Board of Trustee of the Eighth District Electrical Benefit Fund** P. O. Box 30101 Salt Lake City, UT 84130-0101 Phone: (801) 973-1001 or toll free (800) 628-6562 www.8thdist.org
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**HIPAA Privacy/Security Officer for the Eighth District Electrical Benefit Fund** P. O. Box 30101 Salt Lake City, UT 84130-0101 Phone: (801) 973-1001 or toll free (800) 628-6562
Life and Accidental Death and Dismemberment Insurance Company	**Standard Insurance Company** 1100 SW Sixth Ave Portland, OR 97204-1093 To file a claim for benefits for life insurance benefits or for general questions contact the Administrative Office at their phone number in the first row of this chart.

ARTICLE III: ELIGIBILITY
WHO IS ELIGIBLE, HOW AND WHEN COVERAGE BEGINS AND ENDS

Section 1: ELIGIBILITY FOR BARGAINING EMPLOYEES

a. **General Provisions**. Bargaining Employees will become eligible for coverage in accordance with the following rules. Hours worked for a Contributing Employer will **not** be credited to a Bargaining Employee until the required contributions have been made by the Contributing Employer; however, see Section 1(g)(2) in this Article for information when a contributing employer is delinquent in making required contributions. No medical examination is required in order to become covered under this Plan.

b. **Eligibility.** Eligibility for benefits provided by the Plan will be established under an "hour bank" system.

c. **Presently Eligible Employees.** A Bargaining Employee eligible on January 1, 2014 will continue to remain eligible until that employee fails to meet the requirements as set forth under Termination of Eligibility in this Article.

d. **Initial Eligibility**.

1. A Bargaining Employee not eligible on January 1, 2014 will become eligible on the first day of the second calendar month next following the date on which sufficient contributions have been received from one (1) or more Contributing Employers to provide at least one (1) month of eligibility.

2. In order that there will be sufficient time for contributing Employer reports and contributions to be received and processed by the Administrative Office, a **lag month** will be used in determining a Bargaining Employee's monthly eligibility. The lag month is the month between the report period and the month of actual coverage.

3. Each Bargaining Employee must complete an enrollment card and submit it to the Administrative Office prior to payment of any claims under the Fund.

e. **Special Note on Effective Date.** The effective date of coverage for the Bargaining Employee will be the date on which the employee becomes eligible for benefits in accordance with the above rules and no benefits are payable for services rendered prior to that date.

f. **Continuation of Eligibility**.

1. Contributions received from Contributing Employers for hours worked by a Bargaining Employee will be credited to the Bargaining Employee's hour bank account. The monthly charge-off will be deducted from the Bargaining Employee's hour bank account for each month of coverage. A Bargaining Employee will continue to remain covered as long as their hour bank account contains at least one (1) month's charge-off amount required for coverage.

2. Whenever a Bargaining Employee is credited with more than one (1) month's charge-off amount (which is required to furnish one (1) month of coverage), the excess contributions will be added to the Bargaining Employee's hour bank accumulation not to exceed a maximum of three (3) months of coverage.

3. **Continuation of Eligibility While Disabled.** If a Bargaining Employee is continuously disabled for more than thirty (30) days, no deduction will be made from their hour bank account from the first day of the month in which their disability begins. In other words, the hour bank account will be "frozen" and the entire program of health benefits will remain in effect for the disabled employee and their Dependents. This extended coverage will continue until the earlier of the first day of the month after the month in which the disability ends, or the first day of the fourth (4^{th}) month. Protection will be extended for a maximum period of three (3) months under this rule.

4. It will be the responsibility of such employee to notify the Administrative Office of a disability that continues for more than thirty (30) days.

g. **Termination of Eligibility for a Bargaining Employee.**

A Bargaining Employee's coverage under the hour bank will terminate on the last day of the calendar month in which the credits in the account fall below the appropriate monthly charge-off amount. Notwithstanding any other provisions of this Plan Document to the contrary, an employee's coverage and eligibility under this section will terminate on the last day of the calendar month in which:

1. the latter of when the employee works in the electrical industry with an employer who does not make contributions to the Plan (non-union work) or when the Fund Office notifies the employee the employee's coverage shall be terminated due to the employee's work in the electrical industry with an employer who does not make contributions to the Plan (non-union work). However, the previous sentence shall not apply to individuals working under a duly executed salting agreement; or

2. a Contributing Employer is **delinquent** in making required contributions to the Fund, except the Fund will allow a maximum of three (3) months of hours to be posted retroactively to the employee's hour bank account when the delinquent Contributing Employer executes a payment agreement that is personally guaranteed; or

3. the contributions made by a Contributing Employer on behalf of such employee are less than the Minimum Contribution established by the Board of Trustees; or

4. the Bargaining Employee's hour bank account balance falls below one (1) month's charge-off amount; or

5. the date the Plan is discontinued.

A Bargaining Employee whose coverage terminates under this section shall not be entitled to continue coverage under the Self-Payment Provisions for Continuation Coverage unless such termination of coverage constitutes a Qualifying Event.

h. **Small Man Shop**.

1. Effective January 1, 2014, small man shop participants are able to contribute on hours worked. Hours reported over the required monthly minimum will be put into an hour bank. Hours reported less than the required monthly minimum will not be refunded. Small man shop participants will not be allowed to pay the difference between the number of hours reported and the required monthly minimum needed for coverage and will not be allowed to pay COBRA premiums at the reduced rate for three months.

2. In no event shall Minimum Contributions be accepted by the Benefit Fund or applied to give coverage under this Plan or credited to an hour bank on behalf of any individual who does not receive W-2 wages.

i. **Reinstatement of Eligibility**. An employee whose eligibility has terminated (under either the hour bank or self-payment provisions) shall again become eligible when employee contributions reach the monthly minimum within a six (6) consecutive calendar month period, subsequent to the termination of eligibility. Such reinstatement shall be effective on the first day of the second month that follows the month in which this requirement is met. If the employee is not reinstated within this six (6) calendar month period, any hours in the employee's hour bank will be forfeited; the employee will then become eligible for coverage upon completion of the eligibility requirements for Initial Eligibility.

j. **Transfer from Bargaining Employee Participation to Non-Bargaining Status**. A Bargaining Employee, who has at least one (1) month of minimum contributions in their current hour bank and transfers to a non-bargaining status for a Contributing Employer, may elect to freeze their hour bank effective on the first (1^{st}) day of the calendar month next following or coinciding with the effective date of such transfer. Such election shall be at the sole discretion of the Bargaining Employee and must be made within thirty (30) calendar days immediately following the date of transfer. Such request must be made in writing on a form as prescribed by the Board of Trustees. The hour bank may be frozen for a period not to exceed thirty (30) consecutive calendar months, after which time, the hour bank will be terminated.

k. **Reciprocity Agreements**. The Board of Trustees have entered into reciprocity agreements with other health funds, whereby eligibility may be continued for a Bargaining Employee working out of the jurisdiction of the local union, provided contributions are made to the Eighth District Electrical Benefit Fund in accordance with the provisions of the reciprocity agreements.

l. **Elected Public Officials.** In the event a Bargaining Employee becomes an elected public official, the employee shall have the right annually to elect to participate in this Plan or such other County, City, State, or Federal plan for which the employee may be eligible to become effective on the first of the month following enrollment in such plan. An elected public official may add to their hour bank account their contributions for hours worked in covered employment, up to the maximum hour bank. In the event the elected public official elects coverage under another plan for themselves and their Dependents, the employee's hour bank account will be frozen and accumulated credits will be reinstated effective immediately upon such Bargaining Employee's election to be covered under this Plan.

m. **Waiver of Initial Eligibility Requirements with Respect to Employees of a Newly Organized Contributing Employer.** The Board of Trustees may waive its Plans initial eligibility requirements to employees of a newly organized Contributing Employer who is currently providing their employees group medical coverage. The effect of this waiver shall be as follows:

1. The Fund will provide eligibility for the first month of coverage at the current monthly charge off for each Active Employee.

2. The newly organized Contributing Employer will make an initial contribution of one hundred seventy-three (173) hours at the Fund's current contribution rate, on all Bargaining Employees. This initial contribution will provide the second month of coverage. Excess contributions will be allocated to the employee's hour bank.

3. After the initial month, for all subsequent months, the newly organized Contributing Employer will make contributions based on the current contribution amount established by the Board of Trustees.

4. In addition, the newly organized Contributing Employer shall make contributions on behalf of all such Bargaining Employees based on the actual hours worked during the first month of participation. Such hours shall be used for the purpose of the third month's eligibility and so forth. Excess contributions will be credited to the Bargaining Employee's hour bank.

5. In the event the Bargaining Employee fails to receive the minimum monthly contribution in any subsequent month of their employment with a newly organized Contributing Employer, and there are not sufficient contributions to cover the current month's coverage, their eligibility will be terminated and the employee shall be eligible to continue coverage in accordance with the Self-Payment Provisions for COBRA Continuation of Coverage.

6. This provision shall apply only to those Bargaining Employees who were employed by the newly organized Contributing Employer on the employer's effective date of participation and for whom the employer had previously provided group medical coverage. Employees employed after the employer's initial effective date of participation shall be subject to the initial eligibility requirements described herein.

7. Bargaining Employees of a Contributing Employer will have their eligibility terminated at the end of the month following the date such Contributing Employer elects to withdraw from participation in the Fund and/or ceases to maintain with the local union a written agreement requiring contributions. Bargaining Employees who continue to work for the noncontributing employer are not eligible to continue coverage in accordance with the Self-Payment Provisions for COBRA Continuation Coverage.

Section 2: ELIGIBILITY FOR NON-BARGAINING EMPLOYEE PARTICIPATION.

a. **Contributing Employer Participation**. A Contributing Employer must make application to the Board of Trustees for non-bargaining participation. An application must be completed for each company requesting participation. The Board of Trustees reserves the right to accept or reject any non-bargaining application.

1. When a Contributing Employer's participation has been approved by the Board of Trustees, or their designee, the Contributing Employer will be notified in writing by the Administrative Office.

2. A Contributing Employer must contribute on all full-time* non-bargaining personnel who do not sign a waiver of benefit coverage card. To waive benefits, the Waiver of Benefits card must be completed with the name of the other coverage that must be group health insurance coverage (such as coverage through the Spouse/s employer), along with proof of this other coverage. The Waiver of Benefits card is available from and should be returned to the Administrative office.

* Must work at least thirty (30) hours per week for the participating Contributing Employer.

b. **Employee Application for Participation.** Each non-bargaining employee must complete an application form (available at the Administrative Office), which will be submitted by the Contributing Employer to the Board of Trustees, or their designee, for consideration. The non-bargaining employee application form must include the following information for each non-bargaining employee:

1. name and social security number (SSN) of non-bargaining employee and each Dependent;
2. marital status of non-bargaining employee;
3. date of birth of the non-bargaining employee and each Dependent;
4. sex of the non-bargaining employee and the relationship of each Dependent;
5. date of employment;
6. medical history form as provided by the Administrative Office; and
7. HIPAA Certificate of Creditable Coverage (or verify no prior coverage).

A waiver of benefit coverage card signed by the non-bargaining employee must be submitted for each non-bargaining employee not included in the Contributing Employer application. Those electing to sign a waiver card will be required to provide evidence to the Administrative Office of alternate group health insurance coverage.

Any non-bargaining employee who executes a waiver of coverage card must state in writing the reason coverage is being waived, to confirm entitlement to special enrollment, described hereafter, at a later date.

c. **Class of Non-Bargaining Employees Eligible.** Non-bargaining employees eligible to participate are as follows:

1. employees of the proprietorship (including the proprietor);
2. employees of a partnership (including the partners);
3. employees of corporations;
4. employees of the association; and
5. clerical employees of the Local Unions, Affiliated Electrical Joint and Apprenticeship Training Programs, Affiliated Credit Unions and Administrative Office employees.

d. **Benefits.** Non-bargaining employees will be entitled to all benefits provided by the Fund (i.e. Dependent Life, Medical Plan, Weekly Disability) along with Dental benefits and Life, Accidental Death and Dismemberment, which are underwritten by an insurance carrier.

e. **Contributing Employer Non-Bargaining Participation Effective Date.** The effective date of the Contributing Employer non-bargaining participation shall be the first of the month following the date the application has been approved by the Board of Trustees.

f. **Non-Bargaining Employee Effective Date of Coverage.**

1. All full-time non-bargaining employees and their Dependents, excluding those non-bargaining employees who have executed a waiver of coverage card, will become eligible for coverage on the initial effective date of Contributing Employer non-bargaining participation, subject to the Board of Trustees' approval.

2. Non-bargaining employees hired on or after the initial effective date of Contributing Employer non-bargaining participation must complete an application for participation or execute a waiver of coverage card within thirty (30) days from their original date of employment. The date of coverage, subject to the Board of Trustees' (or their designee's) approval, shall be the first day of the second month next following thirty (30) days of full-time employment with the Contributing Employer.

3. Any non-bargaining employee must complete an enrollment card and submit it to the Administrative Office prior to payment of any claims under the Fund.

g. **Special Enrollment**.

1. Special enrollment is allowed for non-bargaining employees or Dependents who originally declined coverage if they:

a. had other coverage, which they later lost because of separation/divorce, termination of employment or reduction in hours, death or the cessation of employer contributions for their coverage (unless it was for cause or failure to pay employee contributions on time); or

b. on account of Medicaid or a State Children's Health Insurance Program (CHIP); or

c. were on COBRA, but their COBRA eligibility has expired.

2. If a non-bargaining employee who did not initially enroll later marries or has or adopts a child, the non-bargaining employee is entitled to special enrollment along with the Dependent. A person eligible for special enrollment has thirty (30) days (or as applicable to Medicaid or CHIP, 60 days) from the date of the event within which to enroll, and shall become an eligible Participant on the first day of the month following receipt of the properly completed enrollment form. Failure to enroll means that claims cannot be considered for coverage until a completed enrollment form has been submitted.

3. You and your dependents may also enroll in this Plan if you (or your eligible dependents):

a. have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or

b. become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after you (or your dependents) are determined to be eligible for such premium assistance.

4. To obtain more information about Special Enrollment contact the Administrative Office.

h. **Monthly Premium Payment.** The amount of the monthly premium to be remitted by the Contributing Employer on each participating non-bargaining employee will be determined by the Board of Trustees. The Contributing Employer will be required to pre-pay two (2) months premium and each month thereafter the Contributing Employer must pre-pay the monthly premium on or before the fifteenth (15th) day of the month. In this regard, a lag month will be used in determining monthly eligibility. For example: September contributions will provide coverage for the month of November. The premiums must be remitted to the depository bank or the Administrative Office.

i. **Termination of Coverage for a Non-Bargaining Employee.**

1. If a non-bargaining employee's employment terminates, coverage will terminate on the last day of the second month following the month in which such termination occurs. Coverage for a non-bargaining employee will terminate on the earliest of the following events:

a. the date the Plan is discontinued;

b. termination of participation of the non-bargaining group, by the Board of Trustees at their discretion, for any reason;

c. the last day of the **second** month following the month of the non-bargaining employee's death (e.g. an employee who dies in January means the person has coverage through March);

d. in the event a Contributing Employer is delinquent in remitting contributions or submitting monthly reports for bargaining and/or non-bargaining employees, coverage will terminate for non-bargaining employees on the first (1st) day of the month for which the Contributing Employer is delinquent;

e. the end of the calendar month in which (a) the Contributing Employer is no longer a Contributing Employer subject to a written agreement calling for contributions to be made into the Fund on behalf of Bargaining Employees, or (b) the Contributing Employer's contributions made on behalf of Bargaining Employees are less than the Minimum Contribution established by the Board of Trustees.

2. Non-bargaining employees whose coverage terminates, as noted above, shall not be entitled to continue their coverage under the Self-Payment Provisions for Continuation Coverage unless such termination of coverage constitutes a Qualifying Event and the self-payment is for COBRA continuation coverage.

3. Non-bargaining employees may be eligible to participate under the Eighth District Electrical Benefit Fund as a Retiree provided they qualify as a Retiree under this Plan.

j. **Reinstatement Provision**. Once a non-bargaining group, and/or non-bargaining employee thereof, terminates their coverage, they must reapply, subject to the Board of Trustees' approval, before their coverage shall again become effective.

Section 3: MINIMUM CONTRIBUTION LEVELS

a. **Minimum Contribution means** the contribution determined, established and fixed by the Board of Trustees, from time to time, as the Board of Trustees, in their absolute discretion, deem appropriate and necessary to maintain a uniform Plan of benefits for Eligible Employees.

b. As established by the Board of Trustees, the **Minimum Contribution** required by an owner working with tools (also known as a small man shop) is **143 hours**. If more hours are worked those actual hours worked must be reported. See also Section 1(h) for more information on small man shop participation.

c. As established by the Board of Trustees, any contributions received under a Reciprocal Agreement that exceed the Minimum Contribution levels will be deposited in a Personal Care Account for the Active Employee as set forth in Article V.

Section 4: ELIGIBILITY FOR DEPENDENTS OF BARGAINING AND NON-BARGAINING EMPLOYEES

a. **Eligibility of Dependents of Active Employees:**

1. **Dependent Eligibility**: Employees must enroll their eligible Dependent (including a spouse, child, Domestic Partner, or child of a Domestic Partner) in order for that Dependent to be eligible for benefits under the Plan. There are three opportunities to enroll Dependents for coverage under this Plan: Initial Enrollment (becoming enrolled at the same time the employee is first eligible), New Dependent Enrollment, and Rolling Enrollment.

2. **Domestic Partner and Child of a Domestic Partner:** Individuals who qualify as a Domestic Partner, as that term is defined in this Plan, or as a child of a Domestic Partner may be eligible to enroll for coverage upon completion and approval of a Declaration of Same Sex Domestic Relationship and completion of the enrollment process. The coverage for the Domestic Partner will be the same as if covering a Spouse and coverage of a child of a Domestic Partner will be the same as if covering a child of an Employee; however, such coverage will generally result in imputed income for the Employee.

3. **Initial Eligibility Enrollment**: This is the first opportunity for the employee to enroll their eligible Dependent. A newly eligible participant has 90 days in which to enroll his or her dependents. If the Dependent is enrolled within 90 days of the employee's Initial Eligibility, the eligible Dependent's coverage will become effective on the date the employee's initial eligibility becomes effective. Failure to enroll during Initial Enrollment means the dependent will not receive coverage until the first day of the first month after the employee does enroll the dependent.

4. **New Dependent Enrollment**: This is the first opportunity for the employee to enroll a Dependent because of an event such as marriage, birth, adoption, placement for adoption or proof of Declaration of Same Sex Domestic Relationship. If an employee enrolls a new dependent child (newborn/adopted/placed for adoption/new stepchild, child of a Domestic Partner) or a new spouse or Domestic Partner within 90 days of the event (the child's birth, adoption, placement for adoption, or the employee marriage or date of the proof of Declaration of Same Sex Domestic Relationship), coverage is effective as of the date of the event. Failure to enroll during New Dependent Enrollment means the dependent will not receive coverage until the first day of the first month after the employee does enroll the dependent.

5. **Rolling Enrollment**: If any dependents are not enrolled within the first 90 days of the employee's initial eligibility or the date the person first became a new dependent, the employee may enroll them at any time, but coverage is not effective until the first day of the month after enrollment, not retroactively.

b. **How to Enroll a Dependent for Benefits**:

1. To request enrollment, generally an employee must contact the Administrative Office (by telephone, fax, postal service mail or hand delivery) and indicate their desire to enroll their Dependent in the Plan. (The address, phone number, and fax for the Administrative Office is listed on the Quick Reference Chart in the front of this document.) Once enrollment is requested, the employee will be provided with the steps to enroll that include all of the following:

   - submit a completed written enrollment form(s) (that may be obtained from and submitted to the Administrative Office), and
   - provide proof of Dependent status (proof includes but is not limited to a marriage certificate, birth certificate, paternity information, tax information, as requested), and
   - perform these steps above in a timely manner according to the timeframes noted under the Initial, New Dependent, or Rolling Enrollment provisions of this Plan.

   Proper enrollment is required for coverage under this Plan.

2. Note that if enrollment has been requested within the required time limit but proper enrollment including paperwork and Social Security Number has not been completed and submitted, claims will not be able to be considered for payment until such information has been completed and submitted to the Administrative Office.

3. **Coordination of Benefits with Medicare**:

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.

4. A person who has not properly enrolled by requesting enrollment in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.

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 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. 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. 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 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 date the Domestic Partnership is terminated;

5. 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 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.

Section 5: ELIGIBILITY FOR RETIREES: Early (non-Medicare Eligible) Retirees and Medicare-Eligible Retirees).

a. **Application to Participate.** The application to participate must be filed with the Administrative Office by the first day of the month coinciding with the effective date of the applicant's Pension from the Eighth District Electrical Pension Fund or by the fifteenth (15th) day of the month following the month in which the applicant lost eligibility under the eligibility rules of the Medical Plan for Active Employees, whichever occurs later. Coverage under the Plan as a Retiree (Early Retiree or Medicare-eligible Retiree) must be continuous immediately following the loss of eligibility as an Active Employee.

b. **Payment of Premium.** Premium rates are established by the Board of Trustees. Premium rates are based on years of participation in the Eighth District Electrical Pension or Benefit Fund. The first payment must accompany the application. Each subsequent payment must be received by the Administrative Office by the first (1st) day of the month for which the coverage is intended.

c. **Those Eligible for Participation as a Retiree <u>on or after</u> April 1, 2003.** Individuals who retire on or after April 1, 2003 must meet the following requirements in order to be eligible to participate under the Eighth District Electrical Benefit Fund Plan as a Retiree (either Non-Medicare Eligible or Medicare-Eligible):

1. If the Employee retires between the ages of fifty-five (55) and sixty (60), the employee must have participated in the Medical Plan as an Active Employee for:
   a. five (5) of the last seven (7) years immediately prior to retirement; **and**
   b. a minimum of twenty (20) years.
2. If the Employee retires at age sixty (60) or older, the employee must have participated in the Medical Plan as an Active Employee for:
   a. five (5) of the last seven (7) years immediately prior to retirement; **and**
   b. a minimum of ten (10) years.

d. **An Employee may participate as an Early Retiree, if the Employee becomes totally disabled as a result of work for a Contributing Employer**, in accordance with these provisions:

1. The total disability commenced (or the Social Security Disability award was issued) after July 1, 2011.
2. The Active Employee has participated in the Medical plan for at least twenty (20) years and is at least 50 years of age on the date of total disability.
3. This Plan requires that the disabled Employee make application to the Social Security Administration for permanent disability (website: www.ssa.gov or http://www.ssa.gov/applyfordisability/).
4. If a permanent disability award <u>is received</u> from the Social Security Administration within 29 months of the date the Employee is accepted as an Early Retiree under this Plan, then the disabled individual can continue coverage under this Plan until the "Termination of Retiree Eligibility" provisions of the Plan (section 5 (i) below) are met.
5. If a permanent disability award <u>is **not** received</u> from the Social Security Administration within 29 months of the date the Employee is accepted as an Early Retiree under this Plan, then the disabled individual can continue coverage under this Plan as an Early Retiree (in lieu of electing COBRA continuation coverage) only for the total of 29 months.

e. **Working for a Non-Contributing Employer.** If a Retired Employee starts to work in covered employment for an employer not subject to a written agreement requiring a contribution to the Medical Plan for Active Employees, his/her eligibility under the Plan and benefits will terminate on the earliest of the following dates:

1. the last day of the month in which the Retired Employee has exhausted the eighteen (18) month minimum; or
2. the last day of the month following commencement of such employment.

Such former Retired Employee shall not be permitted to participate in the Plan after the date such eligibility terminated.

Such former Retired Employee, who loses eligibility under this provision shall again become eligible for coverage only upon completion of the Reinstatement of Eligibility or Initial Eligibility rules of the Medical Plan for Active Employees.

f. **Classifications.** Premium rates have been established by the Board of Trustees in the following classifications:

1. Early (non-Medicare eligible) Retirees and Dependents,
2. Medicare-eligible Retirees and Spouse or Domestic Partner or Domestic Partner Dependent Child,
3. Surviving (Medicare-eligible) Spouse of a deceased Retired Employee or Medicare-eligible Retiree with no dependents or Domestic Partner or Domestic Partner Dependent Child,
4. Retired Employee and Spouse or Domestic Partner or Domestic Partner Dependent Child, one of which is covered by Medicare.

g. **Effective Date of Coverage.** A Retired Employee will become eligible under the Plan as a Retiree on the first day of the month during which application for a pension or disability application has been approved from the Eighth District Electrical Pension Fund or the date eligibility under the Medical Plan for Active Employees for the Eighth District Electrical Benefit Fund terminates whichever is later, provided application to participate and the required self-payment premium has been made.

Coverage under the Plan as a Retiree must be continuous upon loss of eligibility under the Medical Plan for Active Employees.

h. **Type of Coverage.** The benefits otherwise covered and payable under this Plan shall be reduced by the charges for services and supplies for which the Participant is eligible to be reimbursed by the Medicare Program Parts A and B. If ineligibility for reimbursement is a result of a Participant's failure to enroll in or apply for benefits under Medicare Parts A and B, then his/her benefits hereunder shall be reduced by amounts equal to the Medicare benefits which would have otherwise been available. This provision shall be applied in any benefit determination prior to the application of the Coordination of Benefits provision.

Retirees are eligible to enroll in the following Benefit Options:

Type of Benefits *(* denotes an insured benefit)*	**Early Retiree (not Medicare-eligible)**	**Medicare-eligible Retiree**
Option A: Medical Plan including Prescription Drugs benefits **BUT NOT** the Dental Plan, Life Insurance*, AD&D*, and Dependent Life Insurance*.	Yes	Yes
Option B: Medical Plan including Prescription Drugs benefits **PLUS** Life Insurance*, AD&D*, and Dependent Life Insurance* **BUT NOT** the Dental Plan.	Yes	No
Personal Care Account: Is only available if an individual had this benefit as an active participant. Amounts remaining in the PCA are available for use by a self-pay participant however, no additional contributions will be allowed to be deposited into the PCA.	See comments to the left.	See comments to the left.

Newly eligible Early (non-Medicare eligible) Retirees will have a one time option for life and accidental death and dismemberment benefits. This one time option is only available at retirement. Note however, that the life and accidental death and dismemberment benefit is not available to Medicare Retirees.

Once a selection is made, it cannot be changed at a later date, except when a non-Medicare Retired Employee becomes eligible for Medicare he/she will automatically be transferred to the applicable Plans on the first day of the month he/she becomes eligible for Medicare.

i. **Termination of Retiree Eligibility.** An Early Retiree's or Medicare-eligible Retiree's eligibility shall terminate for the following reasons, whichever should occur first:

1. failure to make the required self-payment within the specified time;
2. the date a Bargained Retired Employee is no longer receiving a pension benefit;
3. the date the Plan is discontinued;

4. the last day of the month in which the minimum of eighteen (18) months is exhausted or the last day of the month following the date the Retired Employee starts to work in covered employment for an employer not subject to a written agreement requiring a contribution to the Medical Plan;
5. the date 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).
6. for a disabled Early Retiree who has not received a permanent disability award from the Social Security Administration, the last day of the month in which 29 months of Early Retiree coverage under this Plan is exhausted.

j. A Retiree who returns to work for a Contributing Employer may be eligible for a waiver of the monthly self-payment requirements if sufficient hours are reported, but will remain on the Retiree benefits level.

k. **Self-Payment Grace Period**. Each self-payment is due by the first of the month for which coverage is intended, and shall be considered timely if received within thirty (30) days of the date due. If self-payments are not received in a timely manner coverage will terminate.

Section 6: ELIGIBILITY FOR DEPENDENTS OF A RETIREE

a. **Eligibility of Dependents of a Retired Employee (Retiree):**

1. **Dependent Eligibility**: Retirees must enroll their eligible Dependent (including a spouse, child, Domestic Partner, or child of a Domestic Partner) in order for that Dependent to be eligible for benefits under the Plan. There are three opportunities to enroll Dependents for coverage under this Plan: Initial Enrollment (becoming enrolled at the same time the retiree is first eligible), New Dependent Enrollment, and Rolling Enrollment.
2. **Domestic Partner and Child of a Domestic Partner:** Individuals who qualify as a Domestic Partner, as that term is defined in this Plan, or as a child of a Domestic Partner may be eligible to enroll for coverage upon completion and approval of a Declaration of Same Sex Domestic Relationship and completion of the enrollment process. The coverage for the Domestic Partner will be the same as if covering a Spouse and coverage of a child of a Domestic Partner will be the same as if covering a child of a Retiree; however, such coverage will generally result in imputed income for the Retiree.
3. **Initial Eligibility Enrollment**: This is the first opportunity for the retiree to enroll their eligible Dependent. A newly eligible participant has 90 days in which to enroll his or her dependents. If the Dependent is enrolled within 90 days of the retiree's Initial Eligibility, the eligible Dependent's coverage will become effective on the date the retiree's initial eligibility becomes effective. Failure to enroll during Initial Enrollment means the dependent will not receive coverage until the first day of the first month after the retiree does enroll the dependent.
4. **New Dependent Enrollment**: This is the first opportunity for the retiree to enroll a Dependent because of an event such as marriage, birth, adoption, placement for adoption or proof of Declaration of Same Sex Domestic Relationship. If a retiree enrolls a new dependent child (newborn/adopted/placed for adoption/new stepchild, child of a Domestic Partner) or a new spouse or Domestic Partner within 90 days of the event (the child's birth, adoption, placement for adoption, or the retiree's marriage or date of the proof of Declaration of Same Sex Domestic Relationship), coverage is effective as of the date of the event. Failure to enroll during New Dependent Enrollment means the dependent will not receive coverage until the first day of the first month after the retiree does enroll the dependent.
5. **Rolling Enrollment**: If any dependents are not enrolled within the first 90 days of the retiree's initial eligibility or the date the person first became a new dependent, the retiree may enroll them at any time, but coverage is not effective until the first day of the month after enrollment, not retroactively.

b. **How to Enroll a Dependent for Benefits**:

1. To request enrollment, generally a retiree must contact the Administrative Office (by telephone, fax, postal service mail or hand delivery) and indicate their desire to enroll their Dependent in the Plan. (The address, phone number, and fax for the Administrative Office is listed on the Quick Reference Chart in the front of this document.) Once enrollment is requested, the retiree will be provided with the steps to enroll that include all of the following:
   - submit a completed written enrollment form(s) (that may be obtained from and submitted to the Administrative Office), and
   - provide proof of Dependent status (proof includes but is not limited to a marriage certificate, birth certificate, divorce decree, paternity information, tax information, as requested), and
   - perform these steps above in a timely manner according to the timeframes noted under the Initial, New Dependent, or Rolling Enrollment provisions of this Plan.

   Proper enrollment is required for coverage under this Plan.

2. Note that if enrollment has been requested within the required time limit but proper enrollment including paperwork and Social Security Number has not been completed and submitted, claims will not be able to be considered for payment until such information has been completed and submitted to the Administrative Office.

3. **Coordination of Benefits with Medicare**:

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
(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/RevisedHICNSSNForm081809.pdf)
means that claims for eligible individuals will not be considered a payable claim for the affected individuals.

4. A person who has not properly enrolled by requesting enrollment in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.

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 Dependent ceases to be eligible as a Dependent as set forth under definition of Dependent;
2. when the Retiree's eligibility terminates;
3. the date 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 surviving Spouse's coverage terminates;
   (b) failure to pay the required self-pay premium;
   (c) the date 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 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 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 Domestic Partnership is terminated;
   (e) failure to pay the required self-pay premium;
   (f) the date the surviving spouse's coverage terminates.

Section 7: PROOF OF DEPENDENT STATUS

See also the definition of Dependent in the Definitions Article of this document. Specific documentation to substantiate Dependent status will be required by the Plan and may include a birth certificate, marriage certificate, proof of the dependent's age, and the dependent's social security number and any of the following:

a. **Marriage:** copy of the certified marriage certificate.

b. **Birth:** copy of the certified birth certificate.

c. **Adoption or placement for adoption**: court order signed by the judge.

d. **Stepchild**: the certified birth certificate, divorce decree and marriage certificate.

e. **Legal Guardianship:** a copy of your court-appointed permanent legal guardianship documents and a copy of the certified birth certificate.

f. **Disabled Dependent Child:** Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled (as that term is defined in this document) and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your Spouse for support and maintenance. The plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.

g. **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document or National Medical Support Notice.

h. **Domestic Partners**: Signed Declaration by the employee and domestic partner that they meet the requirements of this Plan's domestic partner eligibility using the Plan's "Declaration of Same Sex Domestic Relationship" form and meet the following requirements:
   - have had an intimate, committed relationship of mutual caring for a period of at least twelve (12) months immediately prior to the date of this Affidavit, and intend to remain sole Domestic Partners indefinitely, and
   - have shared a common residence for at least twelve (12) months (proof required, such as rental agreement, mortgage, state or federal tax returns, etc.); and
   - both are 18 years of age or older and neither is legally married. Both are the same sex. Neither is related by blood in a way that would prevent them from being married to each other; and
   - neither has a different Domestic Partner now or has had a different Domestic Partner in the last twelve (12) months.

i. **Child of a Domestic Partner**: copy of certified birth certificate.

Section 8: DEPENDENTS MAY DECLINE/WAIVE HEALTH COVERAGE

Effective January 1, 2014, a Dependent Spouse and/or Dependent Child may decline/waive health coverage under the Plan if they provide written proof of other group health coverage to the Administrative Office. In order to reenroll in the Plan, the dependent must provide written proof of loss of the other health coverage. There is no compensation, monetary payment or other incentive provided to a dependent to decline/waive coverage under the Fund nor to return to coverage under the Fund.

Section 9: SPECIAL ENROLLMENT

a. This Plan complies with the Federal law regarding Special Enrollment by virtue of the fact that all eligible employees, and their eligible Dependents are automatically enrolled in this Plan as soon as the Eligibility requirements of the Plan are met.

b. There is no option to decline coverage, except non-bargaining employees and a spouse and/or dependent child may decline/waive coverage if they provide proof of other group coverage.

c. Refer to the section on Eligibility for Non-Bargaining Employee Participation earlier in this Article.

d. Special Enrollment provision applies to Retirees and their eligible Dependents only if the Retiree is covered under this Plan at the time of the event giving rise to the Special Enrollment opportunity.

Section 10: QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) (Special Rule for Enrollment)

a. This Plan will provide benefits in accordance with a National Medical Support Notice. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice.

b. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

c. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

d. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the employee, the Administrative Office will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. The Administrative Office will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

e. No coverage will be provided for any Dependent Child under a QMCSO unless the applicable employee contributions for that Dependent Child's coverage are paid, and all of the Plan's requirements for coverage of that Dependent Child have been satisfied.

f. Coverage of a Dependent Child under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions, subject to the Dependent Child's right to elect COBRA Continuation Coverage if that right applies.

For additional information regarding the **procedures for administration of QMCSOs**, contact the Administrative Office and see also the Claim Filing and Appeal Information Article of this document for payment of claims under QMCSOs.

Section 11: FAMILY AND MEDICAL LEAVE ACT (FMLA)

a. Coverage under the Fund will continue while an Active Employee is on an approved leave of absence under the Family and Medical Leave Act of 1993.

b. It is the responsibility of the employee's last employer to make any required contributions to the Fund during a period of leave taken under FMLA.

Section 12: LEAVE FOR MILITARY SERVICE
Under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994

a. If an Active Employee enters service in the Uniformed Services (as defined by USERRA) **for up to thirty (30) days**, the Employee's coverage will continue and the employee will only be required to pay the same share, if any, they would pay as an Active Employee for that period.

b. If an Active Employee enters service in the uniformed services (as defined by USERRA) **for more than thirty (30) days**, the Employee's eligibility will terminate at the end of the month in which they enter active duty. The former Active Employee's hour bank will be frozen effective the end of the month the Active Employee enters service in the uniformed services and he/she will be entitled to elect coverage under the Self-Payment provisions of the plan.

In the case of a former Bargaining Employee the hour bank will be frozen effective the end of the month the Employee enters service in the uniformed services.

If the employee elects USERRA continuation coverage the maximum period for this coverage is **up to 24 months**.

When an employee's coverage under this Plan terminates because of the reduction in hours due to their military service, the Employee and their eligible dependents may choose to continue coverage under COBRA or USERRA. See also the self-payment provisions for COBRA described earlier in this Article. Questions regarding entitlement to USERRA leave and to the continuation of health care coverage should be referred the Administrative Office.

c. If a former Active Employee is discharged (not less than honorably from Uniformed Services) the employee will be reinstated on the day they return to work with a Contributing Employer provided such former Active Employee notifies a Contributing Employer of the intent to return to employment within:

1) fourteen (14) days from the date of discharge, if the period of service was more than thirty (30) but less than one hundred eighty-one (181) days; or

2) ninety (90) days from the date of discharge, if the period of service was more than one hundred eighty (180) days.

If the former Active Employee is hospitalized or convalescing from an illness or injury caused by active duty, these time limits are extended up to two (2) years.

Any amounts remaining in a Bargaining Employee's hour bank when such Bargaining Employee enters "service in the uniformed services" (as defined by USERRA) will be preserved until such time as the employee is discharged from "service in the uniformed services." If such individual returns to work for a Contributing Employer within the time frames identified above, the employee's hour bank will be reinstated as soon as their eligibility is reestablished.

If the individual does not return to work for a Contributing Employer within the time frames identified above, the hour bank will be forfeited to the Plan.

d. Coverage under USERRA will end when the covered person on leave for service in the Uniformed Services again becomes covered under this Plan. In the event of conflict between this Plan and the provisions of USERRA, the provisions of USERRA will control.

Section 13: NOTICE TO THE PLAN

NOTICE YOU NEED TO GIVE TO THE PLAN

You, your Spouse, or any of your Dependent Children or Domestic Partner or a child of a Domestic Partner **must notify the Plan preferably within 31 days but no later than 60 days** after the date that a:

- Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce, legal separation); and
- Dependent Child ceases to meet the Plan's definition of Dependent (such as the Dependent Child reaches the Plan's limiting age or the Dependent Child ceases to have any physical or mental disability);
- Domestic Partner ceases to meet the Plan's definition of Domestic Partner (such as a termination of a domestic partnership);
- A Domestic Partner's child ceases to meet the Plan's definition of Domestic Partner Dependent Child (such as the child reaches the Plan's limiting age or the child ceases to have any physical or mental disability).

Failure to give this Plan a timely notice will cause your Spouse and/or Dependent Child(ren) or Domestic Partner and Domestic Partner Dependent Children to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a Dependent Child to end when it otherwise might continue because of a physical or mental disability.

Section 14: HIPAA CERTIFICATION OF CREDITABLE COVERAGE WHEN COVERAGE ENDS

a. When your coverage ends, you and/or your covered Dependents are entitled by law to and will automatically be provided (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. You can present this certificate to your new employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

b. The requirement on the Plan to provide a HIPAA certificate of creditable coverage will be eliminated effective December 31, 2014 because Health Reform prohibits medical plans from applying a pre-existing condition limitation starting with a plan year beginning on or after January 1, 2014.

c. **Procedure for Requesting and Receiving a HIPAA Certificate of Creditable Coverage**: A certificate will be provided upon receipt of a written request for such a certificate that is received by the Administrative Office within two years after the date coverage ended under this Plan. The written request must be mailed or faxed to the Administrative Office and

should include the names of the individuals for whom a certificate is requested (including Spouse and Dependent Children or Domestic Partner and Domestic Partner Dependent Children) and the address where the certificate should be mailed. The address and fax of the Administrative Office is on the Quick Reference Chart in the front of this document. A copy of the certificate will be mailed by the Plan to the address indicated. See the COBRA Article IV for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

ARTICLE IV: SELF-PAYMENT PROVISIONS FOR CONTINUATION OF COVERAGE INCLUDING COBRA

Section 1: OVERVIEW

a. This article discusses several options for self-payment of continuation of coverage.

b. **For Active Employees and their eligible Dependents**, if you were covered by the medical, dental or vision benefits under the Medical Plan as an Active Employee and then lose your eligibility for those coverages (for example, because you do not have at least one (1) month's charge-off amount in your hour bank), the Medical, Dental and Vision Plan benefits can be continued temporarily under COBRA continuation coverage.

c. **For Early Retirees who are not yet Medicare-eligible and their eligible Dependents**, the Medical Plan benefits can be continued under COBRA continuation coverage for up to 18 months, or, as an alternative to COBRA for those Early Retirees who meet the Early Retiree requirements of this Plan (discussed in Article III), the Medical Plan as a Retiree.

d. **For Medicare-eligible Retirees and their eligible Dependents**, the Medical Plan benefits can be continued under COBRA continuation coverage for up to 18 months, or, as an alternative to COBRA the Retiree Medical Plan.

e. Note that a Retiree will not be entitled to continuation coverage under COBRA and then later be entitled to participate under the Medical Plan as a Retiree.

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.

b. **Compliance with COBRA**.

Active Employees whose hour bank is forfeited and termination of non-bargaining participation due to a Contributing Employer's termination of participation in the Fund are not entitled to the health care continuation coverage under this section unless they incur a Qualifying Event prior to the date of withdrawal of the Contributing Employer.

Furthermore, continuation of coverage under this section shall be terminated under this Fund for Qualified Beneficiaries of a Contributing Employer on the date of termination of participation in the Fund by the Contributing Employer.

c. **Entitlement to COBRA Continuation Coverage**.

In compliance with a federal law commonly called COBRA, this Plan, offers its eligible employees and retirees and their covered Dependents (called "Qualified Beneficiaries") the opportunity to elect a temporary continuation of the group medical plan coverage ("COBRA Continuation Coverage") sponsored by the Fund, including medical only or medical, dental, and vision coverage (the "Plan"), when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense under the self-pay provisions of this Plan.

This Plan provides no greater COBRA rights than what is required by law and nothing in this Article is intended to expand a person's COBRA rights.

IMPORTANT:

This Article serves as a notice to summarize your rights and obligations under the COBRA continuation coverage law. It is provided to all covered employees, retirees, and their covered Spouses and is intended to inform them (and their covered dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this notice carefully and be familiar with its contents.

Section 3: COBRA ADMINISTRATOR

a. The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart in the front of this document.

Section 4: WHO IS ENTITLED TO COBRA CONTINUATION COVERAGE, WHEN AND FOR HOW LONG

a. Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

b. **NOTE: Domestic Partners and children of Domestic Partners** are offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends (in accordance with how COBRA is offered as described in this Article); however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary. This Article describes in general how the Domestic Partner COBRA-like benefit will work. Contact the Administrative Office for questions.

c. 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.

d. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Employee or Retiree or the Spouse or Dependent Child of an Employee or Retiree who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption, or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- A child of the covered employee or retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's or retiree's period of employment, is entitled to the same rights under COBRA as an eligible Dependent Child.
- A person who becomes the new Spouse or Domestic Partner of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse or Domestic Partner is not entitled to elect COBRA for him/herself.

e. **"Qualifying Event"**: Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but does not lose their health care coverage under this Plan, (*e. g.* employee continues working even though entitled to Medicare) then COBRA is not yet offered.

Section 5: FAILURE TO ELECT COBRA CONTINUATION COVERAGE

In considering whether to elect COBRA, you should take into account that failure to continue your group health coverage will affect your future rights under federal law. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; and electing COBRA may help you not have such a gap.

Section 6: SPECIAL ENROLLMENT RIGHTS

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's or Domestic Partner's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this Article. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Section 7: MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this Article on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this Article.

Section 8: MEDICARE ENTITLEMENT

A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law. Generally a person becomes entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

Section 9: COBRA QUALIFYING EVENTS

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	**Duration of COBRA for Qualified Beneficiaries[1] and individuals entitled to COBRA-like benefits**		
	Employee	**Spouse or Domestic Partner**	**Dependent Child(ren) or children of Domestic Partners**
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

1: When a covered employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse, and Dependent Children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

Section 10: PROCEDURE ON WHEN THE PLAN MUST BE NOTIFIED OF A QUALIFYING EVENT (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "Dependent Child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

That written notice should be sent to the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE:

If such a notice is not received by the COBRA Administrator within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage. In addition, the Trustees will pursue the employee or retiree and ineligible dependents for any benefits paid on their behalf.

Officials of the employee's own employer should notify the COBRA Administrator of an employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the**

COBRA Administrator in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Section 11: NOTICES RELATED TO COBRA CONTINUATION COVERAGE

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or

b. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE:

If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

Section 12: THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage below for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees or retirees and their families, that same change will apply to your COBRA Continuation Coverage.

Section 13: PAYING FOR COBRA CONTINUATION COVERAGE (THE COST OF COBRA)

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated active employees or retirees and families (including both the Fund's and employee's/retiree's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Section 14: GRACE PERIODS

The initial payment for the COBRA Continuation Coverage is due to the COBRA Administrator 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the 30-day time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Section 15: CONFIRMATION OF COVERAGE BEFORE ELECTION OR PAYMENT OF COBRA COVERAGE

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) or Domestic Partner or Domestic Partner Dependent Child have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) or Domestic Partner or Domestic Partner Dependent Child are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Section 16: ADDITION OF NEWLY ACQUIRED DEPENDENTS

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, have a child placed with you for adoption, or, have a Domestic Partner or child of a Domestic Partner that now qualifies for benefits, you may enroll that Spouse or child or Domestic Partner or child of a Domestic Partner for coverage for

the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child or Domestic Partner or child of a Domestic Partner may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

Section 17: LOSS OF OTHER GROUP HEALTH PLAN COVERAGE

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage your Spouse or dependent or Domestic Partner or child of a Domestic Partner loses coverage under another group health plan, you may enroll the Spouse or dependent or Domestic Partner or child of a Domestic Partner for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or dependent or Domestic Partner or child of a Domestic Partner must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the Spouse or dependent or Domestic Partner or child of a Domestic Partner must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child or Domestic Partner or child of a Domestic Partner may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Section 18: NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the COBRA Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Section 19: EXTENDED COBRA COVERAGE WHEN A SECOND QUALIFYING EVENT OCCURS DURING AN 18-MONTH COBRA CONTINUATION PERIOD

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to 36 months measured from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and dependents who are Qualified Beneficiaries.

Notifying the Plan:
To extend COBRA when a second Qualifying Event occurs, you must notify the COBRA Administrator in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse or Domestic Partner or child of a Domestic Partner after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee/retiree) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Section 20: EXTENDED COBRA COVERAGE IN CERTAIN CASES OF DISABILITY DURING AN 18-MONTH COBRA CONTINUATION PERIOD

If, at any time before or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any

covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

1. This extension is available only if:
   a. the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; **and**
   b. the disability lasts until at least the end of the 18-month period of COBRA continuation coverage.

   Notifying the Plan: you or another family member need to follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.
2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be higher than the cost for that coverage during the 18-month period. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.
3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Section 21: EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date on which the employee's Contributing employer no longer provides group health coverage to any of its employees;
2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid in full on time;
3. The date, after the date of the COBRA election, on which the covered person first becomes entitled to Medicare;
4. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a Pre-Existing Condition that the covered person may have. . Such pre-existing condition exclusions will become prohibited beginning with the plan year in 2014;
5. The date the Plan has determined that the covered person must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan);
6. The date the Plan is terminated;
7. During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled.

Section 22: NOTICE OF EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated, and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

Section 23: NO ENTITLEMENT TO CONVERT TO AN INDIVIDUAL HEALTH PLAN AFTER COBRA ENDS

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

Section 24: COBRA QUESTIONS OR TO GIVE NOTICE OF CHANGES IN YOUR CIRCUMSTANCES

If you have any questions about your COBRA rights, please contact the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document.

For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of

Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the COBRA Administrator:

1. within 31 days of a **change in marital status (e.g. marry, divorce, legal separation)**; or change in Domestic Partner status, or have **a new Dependent Child**; or
2. within 60 days of the date you or a covered dependent Spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. within 60 days if a covered child **ceases to be a "Dependent Child"** as that term is defined by the Plan; or
4. promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

Section 25: HIPAA CERTIFICATION OF CREDITABLE COVERAGE WHEN COVERAGE ENDS

When COBRA coverage ends, the Administrative Office will automatically provide you and/or your covered Dependents (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Administrative Office within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended.

The requirement on the Plan to provide a HIPAA certificate of creditable coverage will be eliminated effective December 31, 2014 because Health Reform prohibits medical plans from applying a pre-existing condition limitation starting with a plan year beginning on or after January 1, 2014.

Section 26: CONTINUATION OF BENEFITS UNDER NON-COBRA SELF-PAYMENT PROVISIONS

a. SELF-PAYMENT WHEN WORKING FOR A DELINQUENT CONTRIBUTING EMPLOYER

1. In the event a Contributing Employer becomes delinquent in making the required contributions, a Bargaining Employee may make self-payments under COBRA continuation coverage for **six (6) consecutive calendar months**, provided the individual does not have hour bank coverage.
2. If the Contributing Employer does not become current with the required contributions, the eligibility for such Bargaining Employees employed by the delinquent Contributing Employer will be terminated on the first day of the seventh month; however, the Bargaining Employee and Dependents may elect to temporarily continue the remainder of the COBRA coverage period.

b. SELF-PAYMENT FOR DEPENDENTS OF A DECEASED ACTIVE EMPLOYEE (SURVIVING SPOUSE AND DEPENDENT CHILDREN)

1. The surviving Spouse or Domestic Partner of a deceased Active Employee may continue coverage under the Medical Plan for Active Employees including coverage for their Dependent Children, until terminated from this Plan.
2. See also the Termination of Eligibility for the Surviving Spouse and Dependent Children provisions in Article III.

c. DISABLED EMPLOYEE AND SURVIVING SPOUSE OF A DECEASED DISABLED EMPLOYEE

1. An Active Employee who becomes totally and permanently disabled may continue coverage under COBRA for him/herself, including continuation of coverage for Dependents, under the Medical Plan for Active Employees.
2. **Coverage for a Disabled Employee will terminate** on the first of the following events:
   (a) the disabled individual exhausts COBRA,
   (b) the disabled individual is no longer disabled,
   (c) the disabled individual who received a Social Security disability award is no longer receiving Social Security disability benefits,

(d) the Plan is discontinued,

(e) failure to pay the required premium within the specified time.

3. When such disabled employee becomes entitled to Medicare, COBRA coverage will terminate. See the provisions for Early Termination of COBRA described earlier in this Article. Note however that certain Qualified Beneficiaries (certain disabled employees and their eligible dependents, Domestic Partner or child of a Domestic Partner and dependents of a deceased active employee) have negotiated a benefit to allow for the continuation of self-payment beyond the COBRA period with coverage under the Medical Plan at Retiree rates with the Medicare Coordination of Benefits provisions.

4. The **surviving Spouse or Domestic Partner of a deceased disabled employee** may continue coverage under the Medical Plan including coverage for Dependent Children.

5. **Coverage for a surviving Spouse or Domestic Partner of a deceased disabled employee will terminate** on the first of the following events:

   (a) the surviving Spouse remarries;

   (b) failure to pay the required premium within the specified time;

   (c) the surviving Spouse becomes covered under any other group policy;

   (d) the surviving Spouse becomes entitled to Medicare (at which time the surviving Spouse will be covered under the Medical Plan as a Retiree);

   (e) the date the Dependent or Domestic Partner or child of a Domestic Partner ceases to qualify under the definition of Dependent;

   (f) the date the Plan is terminated.

6. **The surviving Dependent Child's coverage shall terminate** on the first of any of the following events:

   (a) the date the surviving Spouse's coverage terminates;

   (b) failure to pay the required premium within the specified time;

   (c) the date the Dependent Child ceases to qualify under the definition of Dependent;

   (d) the date the Plan is terminated.

d. BENEFIT OPTIONS FOR SELF-PAY PARTICIPANTS

A self-pay participant can choose to continue benefits under the applicable Benefit Options noted below. **Once an option is elected that benefit option may not be changed to a different option**.

Benefit Options *(* denotes an insured benefit)*	**COBRA Self-Pay Participants**	**Non-Medicare-eligible Retirees and Medicare-eligible Retirees**
Option A: Medical Plan including Prescription Drugs benefits **BUT NOT** the Dental Plan, Life Insurance*, AD&D*, and Dependent Life Insurance*.	X	X
Option B: Medical Plan including Prescription Drugs benefits **PLUS** Life Insurance*, AD&D*, and Dependent Life Insurance* **BUT NOT** the Dental Plan.	X	Yes, for Non-Medicare eligible Retirees No, for Medicare-eligible Retirees
Option D: Medical Plan including Prescription Drugs benefits and the Dental Plan, **BUT NOT** Life Insurance*, AD&D*, and Dependent Life Insurance*.	X	Option not available
Option E: Medical Plan including Prescription Drugs benefits, and the Dental Plan **PLUS** Life Insurance*, AD&D*, and Dependent Life Insurance*.	X	Option not available

Benefit Options *(* denotes an insured benefit)*	COBRA Self-Pay Participants	Non-Medicare-eligible Retirees and Medicare-eligible Retirees
Personal Care Account (PCA)	Only available if an individual had this benefit as an active participant. Amounts remaining in the PCA are available for use by a self-pay participant however no additional contributions will be allowed to be deposited into the PCA.	Only available if an individual had this benefit as an active participant. Amounts remaining in the PCA are available for use by a self-pay participant however no additional contributions will be allowed to be deposited into the PCA.
Vision Plan	Yes, for Active Employee and their dependents who were covered under the negotiated Vision Plan when coverage terminated. No, for Early Retirees and Medicare-eligible Retirees	Option not available

ARTICLE V: PERSONAL CARE ACCOUNTS (PCA)

Section 1: ESTABLISHMENT OF PERSONAL CARE ACCOUNT(S)

This portion of the plan is designed to permit an Active Employee to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the Personal Care Account (PCA).

a. The Personal Care Account benefits described in this document are available **if** your local union has negotiated a contribution for those benefits. However, in the case of an Active Employee working under a Reciprocal Agreement, when the required contributions exceed the Minimum Contribution levels required by this Plan, the overage will establish a PCA for such individual, regardless whether the contribution has been negotiated.

   1. In addition, an Active Employee may establish a Personal Care Account in instances where the Active Employee is working under the geographic jurisdiction of the Eighth District Electrical Benefit Fund as a traveler and the contribution rate of the home local health and welfare fund for which health and welfare contributions are directed to be reciprocated is an hourly rate less than the contribution rate established under the collective bargaining agreement in which the Active Employee is working. In such event, the excess contribution not subject to reciprocity will be used to establish a Personal Care Account for the Active Employee.

   2. Finally, an Active Employee who is working as a traveler in a geographic jurisdiction outside of the Eighth District Electrical Benefit Fund may establish a Personal Care Account with regard to any excess funds received by the Eighth District Electrical Benefit Fund through reciprocity if the hourly contribution rate remitted to the Eighth District Electrical Benefit Fund exceeds the hourly contribution rate for health and welfare contributions established by the Active Employee's home local collective bargaining agreement. In such event, the excess contribution received by the Benefit Fund via reciprocity will be used to establish a Personal Care Account for the Active Employee.

b. The PCA is not a benefit for any Medicare-eligible or non-Medicare-eligible Retiree; however, if you had the PCA benefit as an active employee and then you retired, you may use the balance of your PCA for payment of your self-pay premiums or other eligible expenses.

c. **Legal Status**

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses, COBRA premiums and Retiree self-payments reimbursed under the Plan are intended to be eligible for exclusion from participating employees' gross income under Code §105(b). The Plan is intended to comply with the requirements of IRS Notice 2013-54 and shall be interpreted to accomplish that objective.

d. **Definitions**

1. **"Code"** means the Internal Revenue Code of 1986, as amended.

2. **"Health FSA"** means a health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125-2, Q/A-7(a).

3. **"Highly Compensated Individual"** means an individual defined under Code §105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

4. **"PCA"** means a health reimbursement arrangement as defined in IRS Notice 2002-45.

5. **"PCA Account"** means the personal care (health reimbursement arrangement) account described later in this Article under "Establishment of Account."

6. **"Medical Care Expenses"** has the meaning described later in this Article under "Eligible Medical Care Expenses."

7. **"PCA Participant"** means a person who is an Active Employee for whom the required contributions have been negotiated and paid, and who is participating in the PCA portion of this Plan. A Domestic Partner or child of a Domestic Partner is not a PCA Participant and medical care expenses for these individuals cannot be reimbursed from the Active Employee's PCA account.

8. **"Period of Coverage"** means the Plan Year, with the following exceptions:
   (a) for Active Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences; and
   (b) for Active Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, unless there is an account balance in which case claims can be reimbursed from the PCA account after the date of termination until the account balance is depleted. The Period of Coverage also includes any COBRA extension period, in which PCA funds can be used to pay COBRA premiums.

e. **Eligibility**.

1. **Coverage under a Group Health Plan**. An Active Employee may not participate in the PCA account unless the Active Employee is actually enrolled in a group health plan that provides minimum value. Pursuant to Internal Revenue Code §36B(c)(2)(C)(ii), regardless of whether the group health plan is sponsored by this health and welfare fund. A group health plan provides minimum value if the coverage is at least 60 percent of the actuarial value of a standard plan as determined by the IRS.

2. **Proof of Coverage**. Proof of other group health plan coverage in a manner to be determined by the Trustees. If proof is not required, benefits will be restricted, as defined below.

3. **Opt-Out**. An Active Employee or Retiree is permitted to permanently opt-out of and waive future reimbursements from the PCA at least annually, in a time and manner determined by the Trustees. An Active Employee or Retiree also has the ability to opt-out upon termination of coverage under the Plan. This means that the Active Employee or Retiree waives future reimbursements from the PCA upon termination of coverage under the Plan.

f. **Benefits Offered and Method of Funding.**

1. **Benefits Offered.** When an Active Employee becomes a PCA Participant, an account will be established for such PCA Participant to receive benefits in the form of reimbursements for Medical Care Expenses, COBRA premiums and Retiree self-payments, as described later in the section titled "Health Reimbursement Benefits." In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses. In no event are premiums for individual health insurance payable, whether purchased in the individual insurance market or in a Health Insurance Marketplace.

2. **Plan and PCA Participant Contributions.**
   a) Plan Contributions. When the required contributions have been negotiated the Contributing Employer will submit the contributions in the appropriate manner. In addition, Plan Contributions will be received and a PCA established for each Active Employee described in Section 1(a)(1) and 1(a)(2) above.
   b) PCA Participant Contributions. There are no PCA Participant contributions for benefits under the Plan.

3. **No Funding Under Cafeteria Plan**. Under no circumstances will the benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

Section 2: HEALTH REIMBURSEMENT BENEFITS

a. **Benefits.** The Plan will reimburse PCA Participants for Medical Care Expenses, COBRA premiums and Retiree self-payments up to the unused amount in the PCA Participant's account, as described later in the section titled "Health Reimbursement Benefits," provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees. In addition, the Plan will reimburse Qualified Beneficiaries, in the event of the Employee's death, for COBRA premiums and a surviving spouse of a deceased Retiree.

1. **Lack of Proof of Other Group Health Plan Coverage**. If a PCA Participant does not provide proof of enrollment in other group health plan coverage that provides minimum value, in a manner determined by the Trustees, benefits will be reduced as required by Notice 2013-54.

2. Specifically, if a PCA Participant is enrolled in other group health plan coverage, but the coverage does not provide minimum value, then the PCA is limited to reimbursement of copayments, coinsurance, deductibles and premiums under the other group health plan coverage, as well as medical care as defined under IRC Section 213(d) that does not constitute essential health benefits.

b. **Prepaid Benefits Card**. PCA Participants are provided with an easy way to access their PCA using a prepaid benefits card, called a "Benny" card. Once a PCA Participant has accumulated the **required balance of $50** in their PCA account, they will receive two Prepaid Benefits Cards at their home address for their use and the use by their family members. The Prepaid Benefits card will be loaded with the value of the Participant's PCA as it becomes available. The PCA contribution amount varies by agreement and depends on hours worked. Unspent funds in the PCA will roll over automatically to the next month, and from year to year.

To use the Prepaid Benefits card, simply swipe the card each time you incur a qualified health care expense and the amount of the purchase will automatically be deducted from the PCA. It is also possible to fill in the Card number on bills received from providers to pay the amount owed. Using the Prepaid Benefits card means that there are generally no claim forms to complete and no wait to get a PCA reimbursement check in the mail. PCA account balances and account details can be checked online or questions can be directed to the Administrative Office.

The IRS requires the Card be used only for eligible medical care expenses (discussed below), so the Card will not work at gas stations or restaurants – only at health care related providers. Most of the time, the swipe of the card automatically allows the verification of the eligibility of the expense being purchased. However, in certain situations, you may receive a letter/notification asking you to furnish an itemized receipt to verify the expense. When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your Card suspended until receipts have been submitted and approved.

c. **Eligible Medical Care Expenses.** Under the PCA, a PCA Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage, provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees.

d. **Incurred**. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a PCA Participant first becomes covered by the Plan are not eligible. See also the section on Carryover of Accounts, below.

e. **Medical Care Expenses Generally**. "Medical Care Expenses" means expenses incurred by a PCA Participant or his/her Dependents for medical care, as defined in Code §105 and 213(d) (including, for example, amounts for certain bills for hospital care, doctors, dental care, vision care and prescription drugs), but shall not include expenses that are described in the section of this Article titled "Exclusions to the PCA Account." Reimbursements due for Medical Care Expenses incurred by the PCA Participant or the PCA Participant's Dependents shall be charged against the PCA Participant's account.

f. **Medical Care Expenses Exclusions**. "Medical Care Expenses" shall not include:

1. health insurance premiums for individual policies, whether purchased in the individual insurance market or on a state or federal Health Insurance Marketplace;

2. health insurance premiums for any other group health plan (including a plan sponsored by a Contributing Employer); and

3. the expenses listed as exclusions under the section of this Article titled "Exclusions to the PCA Account." Notwithstanding the foregoing, a PCA may reimburse COBRA premiums or self-payment premiums for coverage under this Plan.

g. **Cannot Be Reimbursed or Reimbursable from Another Source**. Medical Care Expenses can only be reimbursed to the extent that the PCA Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Plan, other insurance, or any other accident or health plan (if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Plan imposes copayment or Deductible limitations), the PCA can reimburse the remaining portion of such expense if it otherwise meets the requirements herein.

h. **Maximum Benefits.** There will not be a maximum dollar amount that may be credited to a PCA Account for an Active Employee. Unused amounts may be carried over to the next Period of Coverage, as provided hereafter.

i. **Nondiscrimination**. Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Board of Trustees in its sole discretion.

j. **Establishment of Account.** The Administrative Office will establish and maintain a PCA Account with respect to each PCA Participant but will not create a separate fund or otherwise segregate assets for this purpose. The PCA Account so established will merely be a recordkeeping account with the purpose of keeping of contributions and available reimbursement amounts.

k. **Crediting of Accounts**. A PCA Participant's account will be credited at the beginning of each month with an amount equal to the contributions received based on the hours worked, increased by any carryover of unused account balance from prior Periods of Coverage.

l. **Debiting of Accounts**. A PCA Participant's account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses, COBRA premiums or Retiree self-payments incurred during the Period of Coverage.

m. **Available Amount**. The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's PCA as described above reduced by prior reimbursements debited as described above.

n. **Carryover of Accounts**. If any balance remains in the PCA Participant's account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the PCA Participant for Medical Care Expenses incurred during a subsequent Period of Coverage.

o. **Inactivation of the PCA Account:** The PCA account will be terminated/inactivated at the time a COBRA notice is sent to a participant. If the participant pays COBRA premiums for the month, the PCA account will be reinstated. If a participant has terminated coverage (PCA account inactivated) but has eligible expenses for reimbursement in a month the participant had eligibility, a manual claim can be filed for reimbursement with the Administrative Office, but the participant cannot use the Benny card in a month in which coverage is terminated. Reciprocity participants who have not gained eligibility under the 8th District plan may qualify for PCA claim reimbursement if they have coverage in their home plan or their spouse's plan. An opt out and waiver of future reimbursements is allowed annually as determined by the Trustees.

Section 3: REIMBURSEMENT PROCEDURE (if the Prepaid Benefits Card is not used)

a. **Timing**. Within thirty (30) days after receipt by the Administrative Office of a reimbursement claim from a PCA Participant, the Administrative Office will reimburse the PCA Participant for appropriate Medical Care Expenses, or the Administrative Office will notify the PCA Participant that his/her claim has been denied.

1. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Administrative Office, including in cases where a reimbursement claim is incomplete.

2. The Administrative Office will provide written notice of any extension, including the reasons for the extension, and will allow the PCA Participant forty-five (45) days in which to complete an incomplete reimbursement claim.

b. **Claims Substantiation.** A PCA Participant who seeks benefits may apply for reimbursement of claims that were incurred during a Period of Coverage by submitting an application in writing to the Administrative Office in such form as the Board of Trustees may prescribe, setting forth:

1. the person or persons on whose behalf Medical Care Expenses have been incurred;
2. the nature and date of the Medical Care Expenses so incurred;
3. the amount of the requested reimbursement; and
4. a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted. The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Administrative Office may request. Except for the final reimbursement claim for a Period of Coverage, **no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $25 (manual claim) or $50 for the Prepaid Benefits card.**

c. **Claims Denied.** For reimbursement PCA claims that are denied, see the post-service appeals procedure in the Claim Filing and Appeals Information Article in this document.

Section 4: REIMBURSEMENTS AFTER TERMINATION AND COBRA/SELF-PAYMENT

a. When a PCA Participant ceases to be a PCA Participant hereunder, the PCA Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his/her participation terminates, unless there is an account balance in which case claims can be reimbursed from the PCA account after the date of termination until the account balance is depleted.

b. Notwithstanding any other provisions herein to the contrary, an employee's coverage and eligibility will terminate on the last day of the calendar month in which:

1) such employee commences work in covered employment in the electrical industry within the Eighth District with an employer who does not make contributions to the Plan; or

2) the contributions made by a Contributing Employer on behalf of such employee are less than the Minimum Contribution established by the Board of Trustees; or

3) the Participant exercises an annual or post-termination opt-out right, as described above.

c. An Active Employee whose coverage terminates under this PCA provision shall not be entitled to continue coverage under the Self-Payment Provisions for Continuation Coverage unless such termination of coverage constitutes a COBRA Qualifying Event.

d. PCA Participant claims are reimbursable after PCA participation terminates as long as there is an account balance.

Section 5: RECORDKEEPING AND ADMINISTRATION

a. **Inability to Locate Payee**. If the Administrative Office is unable to make payment to any PCA Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such PCA Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such PCA Participant or other person shall be subject to the provisions set forth in the "Account Forfeiture" section described later in this Article.

b. **Effect of Mistake**. In the event of a mistake as to the eligibility or participation of an Active Employee, or the allocations made to the account of any PCA Participant, or the amount of benefits paid or to be paid to a PCA Participant or other person, the Administrative Office shall, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such PCA Participant or other person the credits to the PCA or distributions to which he/she is properly entitled under the Plan. Such action by the Administrative Office may include withholding of any amounts due to the Plan from any future benefits.

c. **Termination and Rehire**.

1) If a PCA Participant terminates his/her employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then is rehired within thirty (30) days or less of the date of a termination of employment, the individual will be reinstated with the same PCA Account balance that such individual had before termination.

2) If an Active Employee (whether or not a PCA Participant) terminates employment and is not rehired within thirty (30) days or ceases to be an Active Employee for any other reason, including (but not limited to) a reduction in hours, and then becomes an Active Employee again, the Active Employee will again become eligible to participate in the Plan in accordance with the Eligibility provisions of the Plan.

d. **Account Forfeiture**.

1) Any account that remains inactive (no money coming in or money going out) for twelve (12) consecutive months, **will have a $25 per month administrative fee assessed beginning on the first day of the thirteenth month until the account balance is exhausted.**

2) **In the event an account balance is $25 or less, the money will be forfeited and the account will be closed.**

3) Note however that an account balance will be forfeited if the PCA Participant works in **non-covered employment**.

e. **No Guarantee of Tax Consequences.**

1) Neither the Administrative Office nor the Board of Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of a PCA Participant under this portion of the Plan will be excludable from the PCA Participant's gross income for federal, state or local income tax purposes.

2) It shall be the obligation of each PCA Participant to determine whether each payment under this portion of the Plan is excludable from the PCA Participant's gross income for federal, state and local income tax purposes, and to notify the Administrative Office if the PCA Participant has any reason to believe that such payment is not so excludable.

Section 6: EXCLUSIONS TO THE PCA ACCOUNT - MEDICAL EXPENSES NOT REIMBURSABLE FROM A PCA ACCOUNT

a. The Plan document contains the general rules governing what expenses are reimbursable. To be reimbursed for eligible over-the counter drugs from your Personal Care Account, you must obtain a prescription from your doctor and submit that prescription with your request for reimbursement.

b. This section specifies certain expenses that **are not reimbursable by this Plan**, even if they meet the definition of "medical care" under Code §213 and may otherwise be reimbursable under IRS guidance pertaining to PCAs.

1) Health insurance premiums for any other plan (including a plan sponsored by a Contributing Employer). (Notwithstanding the foregoing, the PCA Account may reimburse COBRA premiums that a PCA Participant pays on an after-tax basis under any other group health plan sponsored by the Employer.)

2) Long-term care services.

3) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

4) Cosmetic dental services.

5) The salary expense of a nurse to care for a healthy newborn at home.

6) Funeral and burial expenses.

7) Household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).

8) Massage therapy.

9) Home or automobile improvements.

10) Custodial care.

11) Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.

12) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.

13) Social activities, such as dance lessons (even though recommended by a physician for general health improvement).

14) Bottled water.

15) Diaper service or diapers.

16) Cosmetics, toiletries, toothpaste, etc.

17) Vitamins and food supplements, even if prescribed by a physician.

18) Uniforms or special clothing, such as maternity clothing.

19) Automobile insurance premiums.

20) Transportation expenses of any sort, including transportation expenses to receive medical care.

21) Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

22) Any item that does not constitute "medical care" as defined under Code §213.

ARTICLE VI: MEDICAL PLAN

Section 1: ELIGIBLE MEDICAL EXPENSES (Covered Charges)

a. You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expenses" or "covered charges" and they are limited to those that are:

1) determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that the charges are **"Allowed Charges"** (as those terms are defined in the Definitions Article of this document); and

2) not services or supplies that are **excluded from coverage** (as provided in the Medical Plan Exclusions Article of this document); and

3) not services or supplies **in excess of Maximum Plan Benefits** shown in the Schedule of Medical Benefits, and

4) for the **diagnosis or treatment of an injury or illness** (except where certain wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document).

b. Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have incurred a maximum out-of-pocket cost each calendar year, for providers used In-network and Out of Area, no further cost-sharing will be applied for that calendar year.

Section 2: NON-ELIGIBLE MEDICAL EXPENSES

a. The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are determined to be medically unnecessary, determined to be in excess of the Allowed Charges, not covered by the Plan, in excess of Maximum Plan Benefits or not payable on account of failure to comply with the Plan's Precertification requirements as described in Article IX in this document.

Section 3: NETWORK AND NON-NETWORK HEALTH CARE PROVIDER SERVICES

a. **In-Network** (also called Participating, Contracted, Network and PPO):

In-Network refers to health care providers who are contracted with the PPO Network and who are located within the service area of the PPO Network. If you receive medical services or supplies from a Health Care Provider that is contracted with the Plan's PPO you will be responsible for paying less money out of your pocket. Health Care Providers who are under a contract with the PPO have agreed to accept the discounted amount the Plan pays for covered services, plus any additional Deductible, copayments or coinsurance you are responsible for paying, as payment in full, except with respect to certain claims involving a third party payer. See Article VIII, the Medical Network Article for more details.

b. **Out-of-Network** (also called Non-Network, Non-PPO, Non-Contracted or Non-Participating):

Out-of-Network refers to providers who are not contracted with the PPO Network but who are located within the service **area** of the PPO network. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount for any balance that may be due in addition to** the allowed amount payable by the Plan, also called balance billing. See Article VIII, the Medical Network Article for more details.

c. **Out of Area:**

Out of Area refers to Out-of-Network providers who are not contracted with the PPO Network and who are located outside the **service area** of the PPO Network. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount for any balance that may be due in addition to** the allowed amount payable by the Plan, also called balance billing. See Article VIII, the Medical Network Article for more details.

Section 4: PRECERTIFICATION

a. Precertification is required for a variety of medical plan services as described in the Precertification Article of this document, and for certain classes of drugs under the Prescription Drug Program. See the Precertification Article of this document.

Section 5: DEDUCTIBLES

a. The Deductible is the amount of expenses incurred for covered charges each calendar year before medical benefits are payable by the Plan. Each calendar year, you (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits.

b. Deductibles are applied to the Eligible Medical Expenses in the order in which claims are received by the Plan. The amount applied to the Deductible is the "Allowed Charge" amount as defined in this document.

c. Deductibles under this Plan are accumulated on a Calendar Year basis.

d. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles.

e. Copayments are also not applied to meet the Deductible.

f. There are two types of Deductibles: Individual and Family.

- The **Individual Deductible** is the maximum amount one covered person has to pay toward Eligible Medical Expenses before Plan benefits begin. The Plan's Individual Deductible varies depending on the Plan design.
- The **Family Deductible** is the maximum amount that a family of three or more persons is responsible for paying toward Eligible Medical Expenses before Plan benefits begin. The Plan's Family Deductible varies depending on the Plan design.

g. **Expenses Not Subject to Deductibles**: Certain Eligible Medical Expenses are not subject to Deductibles. These expenses may be covered 100% by the Plan, or they may be subject to Copayments (explained below).

h. See the Schedule of Medical Benefits to determine when Eligible Medical Expenses are not subject to Deductibles.

Section 6: COINSURANCE

a. Once you've met your annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. If you use the services of a Health Care Provider who is a member of the Plan's PPO, you will be responsible for paying less money out of your pocket. This feature is described in more detail in the Medical Network Article of this document.

b. **Coinsurance When You Don't Comply with Precertification Requirements of this Plan**: If you fail to follow certain requirements of the Plan's Precertification Requirements (as described in the Precertification Article of this document) the Plan may pay a smaller percentage of the cost of those services, and you will have to pay a greater percentage of those costs, and the additional amount you'll have to pay will not accumulate to the Plan's Deductibles, Coinsurance Maximum or Out-of-Pocket Limit described below.

Section 7: COPAYMENT

a. A copayment (or copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur an Eligible Medical Expense. The Plan's copayments are indicated in the Schedule of Medical Benefits. Copayments are not used to satisfy (and do not apply to meet) the Deductible or Coinsurance Maximum. Copayments will continue to be your responsibility even after you reach your annual Coinsurance Maximum.

Section 8: COINSURANCE MAXIMUM

a. **Individual Coinsurance Maximum**: Each Calendar Year, after an individual has incurred a maximum Out-of-Pocket cost for Coinsurance (the amount varies whether you use providers who are considered to be In-Network, or Out of Area), no further Coinsurance will apply to covered Eligible Medical Expenses for an individual.

b. **Family Coinsurance Maximum**: Note that three individuals in the same family who each satisfy their individual coinsurance maximum will be considered to have met the family coinsurance maximum for that calendar year.

c. As a result of satisfying the coinsurance maximum, the Plan will pay 100% of all covered Eligible Medical Expenses, except for the Out-of-Pocket expenses you pay, listed below, that are incurred during the remainder of the Calendar Year after the Coinsurance Maximum has been reached.

d. **Expenses You Pay That Do Not Accumulate to the Coinsurance Maximum**: This Plan never pays benefits equal to **all** the medical expenses you may incur. You may be responsible for paying for certain expenses for medical services and supplies yourself. Under the Plan, each year, you will be responsible for paying the following expenses out of your own pocket **and** these expenses do not accumulate to meet the Coinsurance Maximum:

1. Any plan Deductible or Copayment.
2. The coinsurance that is paid by a plan participant up to the point that the Coinsurance Maximum is met.
3. All expenses for medical services or supplies that are not covered by the Plan.
4. All charges in excess of the Allowed Charge determined by the Plan. (See the definitions of Allowed Charge and Balance Billing in the Definitions Article of this document.)
5. All charges in excess of the Plan's Maximum Benefits, or in excess of any other limitation of the Plan. (These maximums are discussed below.)
6. All expenses for medical services or supplies in excess of Plan benefits or that are incurred with respect to Outpatient Prescription Mail Order Drugs.
7. All expenses for Out-of-Network providers.
8. Premiums.

e. Note that expenses incurred from providers who are considered to be In-network, and Out of Area are combined to meet your annual coinsurance maximum.

Section 9: OUT-OF-POCKET LIMIT (ANNUAL LIMIT ON IN-NETWORK COST SHARING)

a. This Plan has an Out-of-Pocket Limit (also referred to as an Out-of-Pocket Maximum) which limits your annual cost-sharing for covered essential health benefits received from in-network providers related to Medical and Vision Plan deductibles, coinsurance, and copayments. The annual Coinsurance Maximum for in-network services, as described earlier in this Article, accumulates to the Out-of-Pocket Limit.

1) The Out-of-Pocket Limit is accumulated on a calendar year basis.
2) Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
3) 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.
4) 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.

5) 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.

6) 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.

b. **Out-of-Pocket Limit Amount**.

Annual Limit on Cost Sharing is:	*Out-of-Pocket Limit Applies to:
$6,350 per individual $12,700 per family	Deductibles, copayments and coinsurance related to In-Network essential health benefits for Medical and Vision Plan expenses accumulate to the Out-of-Pocket Limit.

c. *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).

Section 10: MAXIMUM PLAN BENEFITS

a. **Types of Maximum Plan Benefits**: There are various types of maximum amounts of benefits payable by the Plan on account of medical expenses incurred by any covered Plan Participant under this Plan. They are described in detail in the following sections and they include the Limited Overall Maximum Plan Benefit and Annual Maximum Plan Benefit.

b. **Limited Overall Maximum Plan Benefits:** Certain Plan benefits are subject to limitations that are not considered Lifetime maximums or Annual maximums. These other types of maximums are referred to under this Plan as Limited Overall Maximums. Examples include: Morbid Obesity and Respite care services.

The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of these maximums are identified in the Schedule of Medical Benefits. Once the Plan has paid the Limited Overall Maximum Plan benefit for any of those services or supplies on behalf of any Covered Individual, it will not pay any further Plan benefits for those services or supplies on account of that Covered Individual.

c. **Annual Maximum Plan Benefits:** Plan benefits for certain Eligible Medical Expenses are subject to Annual Maximums per Covered Individual or family during each Calendar Year. Once the Plan has paid the Annual Maximum Plan Benefit for any of those services or supplies on behalf of any Covered Individual or family, it will not pay any further Plan benefits for those services or supplies on account of that Individual or family for the balance of the Calendar Year. The services or supplies that are subject to Annual Maximum Plan Benefit are identified in the Schedule of Medical Benefits.

Section 11: INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR PEOPLE WITH MEDICARE

a. If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage outlined in this document is "creditable." "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

b. Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (generally October 15th through December 7th of each year).

c. You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If however you keep this Plan coverage and also enroll in a Medicare Part D prescription drug plan you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefit Article for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.

d. Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:
- when they first become eligible for Medicare; or
- during Medicare's annual election period (generally from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare prescription drug plan

e. If you do not have creditable prescription drug coverage and you do not enroll in a Medicare prescription drug plan you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

f. For more information about creditable coverage or Medicare Part D coverage see the Plan's Notice of Creditable Coverage (a copy is available from the Administrative Office. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

g. The Medicare program has arranged to let Plans who have filed for a subsidy, like this Plan, know if their participants have tried to enroll in a Medicare Prescription Drug Plan. This is because many people with Medicare may not understand that they are able to keep their current prescription drug coverage and do not need the Medicare Part D prescription drug coverage.

If we find out that you have tried to enroll in a Medicare Prescription Drug Plan, we will contact you to see if that is your final decision or just an error.

Section 12. NONDISCRIMINATION IN HEALTH CARE.

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.

The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

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.

OTC Drug Name	Who Is Covered for this Drug?	Cost-Sharing?	Payment Parameters in addition to a prescription:
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 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.

Section 14. PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The medical plan in this document does not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or Non-Network health care provider; however, payment by the Plan may be less for the use of a Non-Network provider.

You also 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 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, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Medical Plan PPO network at their website listed on the Quick Reference Chart.

Section 15: SCHEDULE OF MEDICAL BENEFITS

A schedule of the Plan's Medical Benefits appears on the following pages in a chart format. The Plan's Medical benefits are described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided In-Network (when you use PPO Network Providers) and Out-of-Network (when you use Non-PPO, Non-Network Providers) are shown in the subsequent columns.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check the Medical Plan Exclusions Article of this document to see if they are excluded.

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

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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
Deductibles • The amount you must pay each calendar year before the Plan pays benefits. • Note that expenses incurred in-network, Out-of-Network and out of area are combined to meet your annual Deductible amount.	• See also the information on Deductible in Article VI.	**Active Employees and their Dependents, Early (non-Medicare-eligible) Retirees and their Dependents:** $400/person $1,200/family **Medicare-eligible Retirees and their Dependents:** $400/person $1,200/family		
Annual Coinsurance Maximum • The maximum amount of coinsurance each person is responsible for paying each calendar year, in addition to the Deductible, before the Plan pays 100% of covered Eligible Medical Expenses. Some out-of-pocket expenses do not apply to this maximum, including Out-of-Network provider expenses. • Note that expenses incurred from providers who are considered to be In-network and Out of Area are combined to meet your annual coinsurance maximum.	• Certain expenses do not accumulate to the Coinsurance Maximum . See also the information on Coinsurance Maximum in Article VI. • **Family Coinsurance Maximum**: Note that once three individuals in the same family each satisfy their individual coinsurance maximum the family coinsurance maximum will be considered to have been met for that calendar year.	**Actives and Retirees**: **In-Network:** 75% of $8,000 ($2,000/person/year) **Out-of-Network:** 50% of an **Unlimited** amount. **Out of Area:** 75% of $8,000 ($2,000/person/year)		

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

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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
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).	$6,350 per individual $12,700 per family	Not applicable	Accumulates to the In-Network Out-of-Pocket Limit
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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
Ambulance Services • **Ground vehicle transportation** to the nearest appropriate facility as medically necessary for treatment of a medical Emergency, acute illness or inter-health care facility transfer. • **Air/sea transportation** only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.	• Expenses for ambulance services are covered only when those services are for an **Emergency** as that term is defined in the Definitions Article of this document or for medically necessary inter-facility transport.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 75% after Deductible met
Ambulatory Surgery	• See Outpatient Surgery in this schedule.			
Behavioral Health Services: (Mental Health and Substance Abuse Treatment) • Inpatient Admission including partial hospitalization. • Outpatient Visits. • **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 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	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met
Blood Transfusions • Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a Physician. • Expenses related to autologous blood donation (patient's own blood) are covered.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met
Cardiac Rehabilitation	• See "Rehabilitation Services: Cardiac" in this schedule.			
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.		**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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
Chiropractic Services	• See the Spinal Manipulation section of this Schedule of Medical Benefits.			
Colonoscopy, Screening Benefit	• A screening colonoscopy is payable once every five years for individuals age 50 and older, and more frequently than every five years or starting earlier than age 50 if the individual is at high risk of colon cancer, such as having a family history of colon cancer. • See also the Wellness rows of this Schedule.	**Actives and Retirees**: 100%, no deductible applies	**Actives and Retirees**: No coverage	**Actives and Retirees**: 100%, no deductible applies

Corrective Appliances: (Prosthetic & Orthotic Devices, other than Dental)
• Corrective appliances includes prosthetics devices and Orthotics devices such as casts, splints, braces and crutches as follows:
  • rental for the first 90 days will be used as an offset against the purchase price (but only up to the allowed purchase price of the device).
  • purchase of standard model.
  • adjustment or servicing of the device
  • repair or replacement of the device is limited to once in any five calendar year period or if the device cannot be satisfactorily repaired.
• Colostomy or ostomy (orthotic) supplies.
	• **Orthotic devices over $500 per item and Prosthetic devices 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.
	• See the exclusions related to Corrective Appliances in the Medical Plan Exclusions Article. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions Article.
	• Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner.
	• **Prosthetic Devices** are payable including the temporary and definitive (permanent) appliance, and necessary supplies.
	• **Foot Orthotics** (including orthopedic or corrective shoes and other supportive devices for the feet), when prescribed by a Physician, are payable **for one pair of foot orthotics per person per calendar year**.
	• **Post-mastectomy bras** are payable to a maximum of two bras per calendar year.
		Actives and Retirees: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

Dialysis • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • **It is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. • See also the Coordination of Benefits Article that discusses what this Plan pays when you are also Medicare eligible.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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
Diabetes Education • Educational services for a Plan Participant diagnosed with diabetes mellitus.		**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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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
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.	**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.		

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
	• 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.			

Durable Medical Equipment (DME)
• Coverage is provided for:
  • rental for the first 90 days will be used as an offset against the purchase price (but only up to the allowed purchase price of the device).
  • purchase of standard model;
  • adjustment or servicing;
  • repair or replacement is limited to once in any 5 calendar year period unless due to pathological changes or normal growth or if the equipment cannot be satisfactorily repaired.
• Coverage is provided for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration.
	• **Durable Medical Equipment over $1,000 per item requires precertification** by calling the Utilization Management Company, whose phone number is listed on the Quick Reference Chart. See Article IX for information on precertification.
	• See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Medical Plan Exclusions Article.
	• To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions Article.
	• Durable Medical Equipment is covered only when its use is medically necessary and it is ordered by a Physician or Health Care Practitioner.
	• A Continuous Positive Airway Pressure (CPAP) humidifier is payable once every 5 years, based on allowed charges.
	• For the first 12 months following the birth of a child, coverage is provided for a standard manual or standard electric breast pump, plus necessary 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. Coverage is available at no cost from in-network providers only.
		Actives and Retirees: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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.)	• 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 precertify 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 $200 copay per ER visit and after the Deductible is met, the Plan pays 75%.	**Urgent Care Services for Actives and Retirees**: 50% after Deductible met **Emergency Room Services for Actives and Retirees:** After a $200 copay per ER visit and after the Deductible is met, the Plan pays 75%.	**Urgent Care Services for Actives and Retirees**: 75% after Deductible met **Emergency Room Services for Actives and Retirees:** After a $200 copay per ER visit and after the Deductible is met, the Plan pays 75%.
Endoscopy Facility (Outpatient) • Endoscopy is a procedure to evaluate the interior surfaces of an organ by inserting a device such as an endoscope into the body, including but not limited to the lungs, intestines, bladder, sinus, etc.	• See also the Colonoscopy (screening) benefit in the Colonoscopy row or in the Wellness row of this Schedule.	**Facility Fees for Actives and Retirees**: 75% after Deductible met	**Facility Fees for Actives and Retirees**: 50% after Deductible met	**Facility Fees for Actives and Retirees**: 75% after Deductible met

Enteral Therapy Services
• Enteral nutritional therapy provides nourishment directly (e.g. feeding tube) to the digestive tract of a person who cannot ingest an appropriate amount of calories and nutrients to maintain an acceptable nutritional status. Enteral nutritional formula is payable when medically necessary and meets all the following criteria:
  • When the formula is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and ALL of the following criteria are met:
  • Without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate weight by dietary adjustment and/or oral supplements, and
		Actives and Retirees: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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
• The individual has one of the following conditions that is expected to be permanent or of indefinite duration: • an anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel; • disease of the small bowel that impairs absorption of an oral diet; • a central nervous; or system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.	• Enteral therapy services are covered only when ordered by a Physician.			

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

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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
	• Coverage for a home enteral infusion pump (and associated necessary supplies) is considered payable when the use of the pump is medically necessary because the individual cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion of the enteral formula.			

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

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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

	• Enteral nutritional formula that is not payable by the Plan includes:
	  • standardized or specialized infant formula (e.g., Alimentum, Elecare, Neocate, and Nutramigen), or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems.
	  • food thickeners, dietary and food supplements including but not limited to puddings, powders, mixes, vitamins and minerals; lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like.
	  • weight-loss or weight-gain foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and mineral.			

Family Planning and Contraceptive Services • Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure). There is no cost-sharing for female sterilization procedures and these benefits will be paid at 100% no Deductible. • FDA approved female contraceptives and counseling such as oral birth control pills/patch, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD), cervical cap, contraceptive ring, diaphragm, implantable birth control device/service.	• Certain FDA approved prescription drug contraceptives are to be obtained from the Prescription Drug Program and are payable under the Drugs (Medicines) row in this Schedule. There is no cost-sharing for generic FDA approved female contraceptives and these benefits will be paid at 100% no Deductible for services received from In-Network providers. • See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Medical Plan Exclusions Article. • No coverage for the treatment of Fertility and Infertility. • No coverage for the treatment of erectile dysfunction (impotency) including medical (e.g., prescription drugs such as Viagra, Cialis) or surgical services.	**FDA approved contraceptive services and female sterilization:** 100% no deductible. **Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**FDA approved contraceptive services and female sterilization:** 100% no deductible. **Actives and Retirees**: 75% after Deductible met

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

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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
Genetic Testing and Counseling The genetic testing payable under this Plan is for: • state-mandated newborn screening tests for genetic disorders (referred to as surrogate biochemical markers); • fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee; • tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; • the genetic testing is recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis; • genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Health Reform regulations (see the Wellness row in this Schedule). • the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants who have all the following: a. the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and b. the covered individual displays clinical features/symptoms, or is at direct risk of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and c. the results of the test will directly impact the clinical decision-making, clinical outcome or treatment being	• Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided in conjunction with a genetic test that is payable by this Plan. • See the definitions of Genetic Counseling and Genetic Testing in the Definitions Article. • See the Medical Plan Exclusions Article for exclusions relating to Genetic Testing and Counseling, other than those indicated here as covered. • No coverage for Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents. No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**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
delivered to the covered individual.				
Hearing Services • Hearing Testing (audiology examination).	• Hearing aides are not payable. See the hearing exclusions in the Medical Plan Exclusions Article of this document.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met
Home Health Care and Home Infusion Services • Part-time, intermittent **Skilled Nursing Care** services and medically necessary supplies to provide Home Health Care or home infusion services. • Certified nurse aide services under the supervision of a registered nurse.	• **Home Health Care and Home Infusion 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. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner and provided by a licensed home health care agency. • Home Hospice coverage is payable under Hospice benefits. • Home Physical Therapy services coverage is payable under the Rehabilitation Services benefits. • See the exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Medical Plan Exclusions Article of this document.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met
Hospice • Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the definition of Hospice in the Definitions Article of this document.	• Bereavement counseling beyond that included as part of the Hospice provider's normal services is payable under the Behavioral Health benefits of this Plan. • Inpatient Respite Care is payable to a maximum of 8 days per person per lifetime.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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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
Hospital Services (Inpatient) (including licensed birthing center) • Daily average room & board facility fees in a semiprivate room with general nursing services. • Specialty care units (e.g., intensive care unit, cardiac/coronary care unit). • Lab/x-ray/diagnostic services. • Related medically necessary ancillary services (e.g., prescriptions, anesthesia, blood, supplies). • Routine nursery care of a newborn child and newborn circumcision.	• **All inpatient 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. • Private room is covered only if medically necessary or if the facility does not provide semi-private rooms. • A stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service. • For a hospital admission, in addition to the Deductible and Coinsurance, there is a **$200 copay per admission**.	**Actives and Retirees**: $200 copay/admit then 75% after Deductible met.	**Actives and Retirees**: $200 copay/admit then 50% after Deductible met.	**Actives and Retirees**: $200 copay/admit then 75% after Deductible met.
Laboratory Services (Outpatient) • Technical and professional fees. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some laboratory services are payable under the Wellness benefits in this Schedule.	• Covered only when ordered by a Physician or Health Care Practitioner. • **Transplantation-related laboratory services (pre-transplant work-up) require precertification** by contacting the Utilization Management Company (at their phone number on the Quick Reference Chart in the front of this document). See Article IX for information on precertification.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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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
Maternity Services • Hospital and Birth (Birthing) Center charges and Physician and Licensed Nurse Midwife fees for medically necessary maternity services. • Plan benefits are payable for charges incurred by a Participant as a result of pregnancy, childbirth or a related medical condition. • See the Eligibility Article on **how to enroll a Newborn Dependent Child(ren).** • Elective induced abortion. • See Genetic Testing for additional information. • 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. • Under this Plan, there is no requirement to select a Primary Care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.	• See the exclusions related to Maternity Services in the Medical Plan Exclusions Article. • Pregnancy-related care is covered for a female Participant. No coverage is provided for the baby of a Dependent Child. • For all females, prenatal and postnatal visits obtained from an in-network provider are payable at no cost to you. Normal plan cost-sharing still applies to all other maternity related services including ultrasounds and delivery fees. When a provider submits a bill to the plan with a global CPT code for the combination of prenatal/postnatal visits and delivery expenses, the Plan's claims administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal/postnatal visit expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses. • 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 in conjunction with birth, coverage for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period). 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. • For the first 12 months following the birth of a child, coverage is provided for a standard manual or standard electric breast pump, plus necessary 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. Coverage is available at no cost from in-network providers only. • **Hospital Length of Stay for Childbirth:** This Plan complies with federal law that prohibits restricting 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 cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan for prescribing a length of stay not	**Prenatal Visits and breast pumps, supplies and counseling:** No charge. **All Other Maternity Services for Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Prenatal Visits and breast pumps, supplies and counseling:** No charge. **All Other Maternity Services for Actives and Retirees**: 75% after Deductible met

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

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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
	in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). • **Inpatient admissions require precertification ONLY IF the length of stay for delivery exceeds 48 hours for vaginal birth or 96 hours for C-section,** by calling the Utilization Management Company whose phone number is listed on the Quick Reference Chart. See Article IX for information on precertification.			

Nondurable Supplies
• Coverage is provided for up to a 31-day supply of:
  • Sterile surgical supplies used immediately after surgery.
  • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances.
  • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
  • Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under this benefit or under the Prescription Drug Program.
	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions Article.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

Obesity Services	• See the Weight Management row of this Schedule.			

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Oral, Craniofacial, and TMJ Services
• Accidental Injury to Teeth/Jaw
• Temporomandibular Joint (TMJ) dysfunction or syndrome.
• Oral and/or Craniofacial Surgery.
	• **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.
	• See the exclusions related to Dental Services in the Medical Plan Exclusions Article.
	• Treatment of Accidental Injuries to the Teeth/Jaw: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met:
	  • The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and
	  • The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and
	  • The dental treatment will return the person's teeth to their pre-injury level of health and function. See also the definition of Injury to Teeth in the Definitions Article of this document.
	• Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess, acute injury and for reconstructive but not cosmetic purposes.
	• No coverage for dental services such as removal of wisdom teeth, root canal, gingivectomy, or dental abscess treatment.
		Actives and Retirees: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

Outpatient (Ambulatory) Surgery Facility • Ambulatory (Outpatient) Surgical Facility (e.g. surgicenter, same day surgery). • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	• **Certain outpatient 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. • A stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**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

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 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

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
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• **Certain outpatient and all diagnostic radiology services (such as MRI, CT scan, PET scan, nuclear radiology 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. • Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered under the Wellness Programs described in this Schedule. • **Transplantation-related services require precertification** by contacting the Utilization Management Company (at their phone number on the Quick Reference Chart in the front of this document). See Article IX for information on precertification.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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

Reconstructive Services and Breast Reconstruction After Mastectomy
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any Covered Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • reconstruction of the breast on which the mastectomy was performed;
  • surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • prostheses and physical complications for all stages of mastectomy, including lymphedemas.
• Reconstructive Surgery only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital anomaly that causes a functional defect.
	• **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.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Medical Plan Exclusions Article. Cosmetic and Dental (including Orthognathic) services are excluded from coverage.
	• Breast reduction guidelines: A female employee/retiree or dependent seeking coverage for breast reduction surgery must submit, to the Administrative Office, information and medical documentation which supports the medical necessity of the recommended procedure, prior to the expenses being incurred. Medical necessity would require that at least 450 grams of tissue must be removed from each breast. This must be certified by a medical doctor who performs such surgical procedures.
	• Reconstructive services are payable if medically necessary because of congenital disease or anomaly of a Dependent Child that has resulted in a functional defect. Non-functional defects resulting from congenital malformations of a Dependent Child will be covered after review by the Board of Trustees or its designee, on a case by case basis.
		Actives and Retirees: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

Rehabilitation Services: Cardiac • **Cardiac Rehabilitation** is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.).	• Cardiac Rehabilitation programs must be ordered by a Physician. • See also the Definition of Cardiac Rehabilitation in the Definitions Article of this document.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

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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.	• **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	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met

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
Respite Care	• See Hospice in this Schedule.			
Routine Costs • Routine costs associated with an individual's participation in an "approved clinical trial" related to cancer or other life-threatening illnesses.	• **Routine costs 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. • See the definition of "Experimental" for information on what routine costs are payable by the plan.			
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility.	• 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	**Actives and Retirees**: 75% after Deductible met
Smoking/Tobacco Cessation • Coverage is provided for free counseling sessions through the EAP, and over-the-counter or retail prescription drug tobacco cessation products.	• Counseling sessions are covered under the Plan's EAP, up to the number of visits available from a particular EAP vendor. (Refer to Article II Quick Reference Chart for the EAP in your area and their phone number.) • Over-the-counter or retail prescription drug products used for smoking/tobacco cessation are payable by the Plan. (Refer to the Drug row in this Schedule of Medical Plan Benefits for a complete description of the outpatient drug benefits.) • Physician office visit for smoking/tobacco cessation is also covered at no charge if an in-network provider is used.	**Counseling:** Plan pays 100% via the EAP or for an office visit with an in-network physician.	No coverage	**Counseling:** Plan pays 100% via the EAP or for an office visit with an in-network physician.
Spinal Manipulation Services • Spinal Manipulation Services (from a Physician or Chiropractor) including related ancillary services (e.g., office visit, x-rays). No other benefits are payable for services rendered by a chiropractor. • Chiropractic care means only manipulations and/or mobilizations performed by a Physician or Chiropractor.	• Services are payable to **a maximum of 20 visits** per person per year In-Network or Out-of-Network.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met
Surgeon, Assistant Surgeon	• See the Physician row in this Schedule.	-	-	-

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

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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
Transplants, Organ and Tissue • Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue (specifically cornea, bone marrow, peripheral stem cells, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin) along with the facility and professional services, FDA approved drugs, and medically necessary equipment and supplies. • Organ or tissue testing, procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor. • Reasonable and necessary expenses incurred by a donor who **is covered** by this Plan, without any Deductibles and Coinsurance applicable to those expenses. • Reasonable and necessary expenses incurred by a donor who **is not covered** by this Plan, without any Deductibles and Coinsurance applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan**.	• **Transplantation-related outpatient services and admission to a hospital for a transplant requires precertification** by contacting the Utilization Management Company (at their phone number on the Quick Reference Chart in the front of this document). See Article IX for information on precertification. • For precertified Transplant services, coverage is permitted for certain travel benefits when the transplant must occur in a location where the participant does not reside: The following transportation, lodging, and meal expenses will be reimbursed up to the maximum benefits for each covered transplant procedure completed. If the recipient of the covered transplant procedure is an adult, costs of transportation to and from the site of the covered transplant procedure for the recipient and one other individual will be reimbursed. If the recipient of the covered transplant procedure is a minor, costs of transportation to and from the site of the covered transplant procedure for the recipient and two other individuals will be reimbursed. All reasonable and necessary lodging expenses incurred, up to a daily maximum of $200.00, by said individual(s) accompanying the recipient will be reimbursed. The aggregate sum of all costs of transportation, and lodging is payable at 100% no deductible to a maximum of $10,000 per transplant, thereafter the Plan pays 10%. • Donor expenses are payable at 100%, no Deductible. Donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan. • See the specific exclusions related to Experimental and Investigational Services and Transplants in the Medical Plan Exclusions Article.	**Actives and Retirees**: 75% after Deductible met	**Actives and Retirees**: 50% after Deductible met	**Actives and Retirees**: 75% after Deductible met
	• One annual vision exam (with eye refraction) for Active Employees and their covered Dependents under 19 years of age is payable. For individuals age 19 years and older the plan pays 100% for an annual vision exam up to $100 per year, thereafter the Plan pays 10% coinsurance. • Benefits are payable when the vision exam is performed by any licensed vision provider, such as an optometrist or ophthalmologist.	**Actives:** No charge. **Retires:** Not covered.	**Actives:** No charge. **Retires:** Not covered.	**Actives:** No charge. **Retires:** Not 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
Vision Exam Services	• See Article XI for Vision Plan benefits covering eyeglasses. • Retirees are not eligible for this Vision Exam benefit.			
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. • **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 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
Wellness (Preventive): Well Child Examinations and Immunizations to age 26 years • The wellness/preventive services payable by this plan are designed to comply with Health Reform regulations as outlined to the right. • Routine immunizations are payable, in accordance with the Centers for Disease Control (CDC) recommendations, when they are obtained from an in-network provider or from an in-network retail pharmacy location.	Coverage is provided for preventive services that are required to be covered under the federal law "Affordable Care Act," in accordance with the US Preventive Services Task Force and Health Resources and Services Administration (HRSA) and immunizations approved by the Centers for Disease Control (CDC). For a list of payable services, visit this website: https://www.healthcare.gov/what-are-my-preventive-care-benefits. • In addition to the wellness services listed on the website above, the Plan will pay for well child office visits. • Certain additional preventive care expenses are payable for all covered 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, HPV testing starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, plus annual screening and counseling for interpersonal and domestic violence). These services are covered as a Wellness benefit without cost sharing for a female when obtained from in-network providers. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). • The Plan will use reasonable medical management techniques - such as age, location for service and test frequency - for consideration of payable preventive services. Services not covered under the wellness benefit may be covered under another portion of the medical plan. • 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. See Article VI for more information.	**Actives and Retirees**: No charge.	**Actives and Retirees**: No coverage.	**Actives and Retirees**: No charge.

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
Wellness (Preventive): Adult Health Maintenance Examinations and Immunizations • The wellness/preventive services payable by this plan are designed to comply with Health Reform regulations as outlined to the right. • Routine immunizations are payable, in accordance with the Centers for Disease Control (CDC) recommendations, when they are obtained from an in-network provider or from an in-network retail pharmacy location. • See also the separate row on "Colonoscopy" in this Schedule.	Coverage is provided for preventive services that are required to be covered under the federal law "Affordable Care Act," in accordance with the US Preventive Services Task Force and Health Resources and Services Administration (HRSA) and immunizations approved by the Centers for Disease Control (CDC). For a list of payable services (including immunizations, mammogram, pap smear, colonoscopy) visit this website: https://www.healthcare.gov/what-are-my-preventive-care-benefits • In addition to the wellness services listed on the website above, the Plan will pay for these wellness services: an annual wellness/physical exam for adults and annual prostatic specific antigen (PSA) lab test for men, an annual EKG, annual complete blood count, and annual urinalysis. • Certain additional preventive care expenses are payable for all covered 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 well woman visits, screening for gestational diabetes, HPV testing starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, plus annual screening and counseling for interpersonal and domestic violence). These services are covered as a Wellness benefit without cost sharing for a female when obtained from in-network providers. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). • The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency. Services not covered under the wellness benefit may be covered under another portion of the medical plan.	**Actives and Retirees**: No charge.	**Actives and Retirees**: No coverage.	**Actives and Retirees**: No charge.

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
	• 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. See Article VI for more information.			

ARTICLE VIII: MEDICAL NETWORKS

Section 1: IN-NETWORK AND OUT-OF-NETWORK SERVICES

Plan Participants may obtain health care services from In-Network or Out-of-Network Health Care Providers.

a. IN-NETWORK SERVICES:

In-network health care providers have agreements with the Plan's Preferred Provider Organization (PPO) under which they provide health care services and supplies for a favorable negotiated discount fee for plan participants. When a plan participant uses the services of an in-network health care provider, except with respect to any applicable Deductible, the plan participant is responsible for paying the applicable coinsurance on the discounted fees and/or copayment for any medically necessary services or supplies, subject to the Plan's limitations and exclusions.

Because providers are added to and dropped from the PPO network periodically throughout the year it is best if you ask your health care provider IF they are still participating with the PPO each time BEFORE you seek services.

You may also verify if your health care provider is an in-network provider by contacting the PPO at their phone number and website listed on the Quick Reference Chart in the front of this document.

b. OUT-OF-NETWORK SERVICES:

Out-of-Network (also called Non-Network, Non-Contracted or Non-PPO) health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan participant for the Allowed Charge (as defined in this document) for any medically necessary services or supplies, subject to the Plan's Deductibles, coinsurance (on non-discounted services), copayments, limitations and exclusions. Plan participants must submit proof of claim before any such reimbursement will be made.

Out-of-Network Health Care Providers may bill the Plan participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing.

You can avoid balance billing by using in-network providers. (See the definitions of Allowed Charge and Balance Billing in the Definitions Article of this document.)

c. OUT OF AREA:

Out of Area refers to Out-of-Network providers who are not contracted with a PPO Network and who are located outside the **service area** of the PPO Network. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount for any balance that may be due in addition to** the allowed amount payable by the Plan, also called balance billing. (See the definitions of Allowed Charge and Balance Billing in the Definitions Article of this document.)

Section 2: PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan's Preferred Provider Organizations (PPOs) are networks of Hospitals, Physicians, laboratories and other Health Care Providers who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to Plan participants. **If you receive medically necessary services or supplies from a PPO Provider you will pay less than if you received those medically necessary services or supplies from a Health Care Provider who is not a PPO Provider;**

and the PPO Provider has agreed to accept the Plan's payment plus any applicable Deductible, Coinsurance or Copayment that you are responsible for paying as payment in full.

Before you obtain services or supplies from an Out-of-Network Health Care Provider, you can find out whether the Plan will provide In-Network or Out-of-Network Benefits for those services or supplies by contacting the Claims Administrator at their phone number and website shown on the Quick Reference Chart in the front of this document.

Section 3: DIRECTORIES OF NETWORK PROVIDERS

Physicians and Health Care Providers who participate in the Plan's Network are added and deleted during the year. At any time, you can find out if any Health Care Provider is a member of the Network by contacting the PPO at their telephone number or website shown on the Quick Reference Chart in the front of this document.

Updated Provider Directories are available from the PPO at their telephone number or website noted on the Quick Reference Chart in the front of this document and sent to you at no cost, on request.

ARTICLE IX: PRECERTIFICATION AND MEDICAL REVIEW

Section 1: PURPOSE OF THE PRECERTIFICATION PROGRAM

To enable your plan to provide coverage in a cost-effective way, your plan has adopted a medical review program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the plan and all its benefits.

If you follow the procedures of the plan's precertification procedures, you may avoid some out-of-pocket costs. However, if you do not follow these procedures, your plan provides reduced benefits, and you will be responsible for paying more out of your own pocket.

Section 2: MEDICAL REVIEW PROGRAM

The Plan's Medical Review Program is administered by independent professional medical review firms (including the Utilization Management Company and Prescription Drug Program) operating under a contract with the Plan. The name, address and telephone number of the Utilization Management firm and Prescription Drug Program appears in the Quick Reference Chart in the front of this document. The health care professionals of the medical review firms focus their review on the necessity and appropriateness of certain proposed health care services.

In carrying out their responsibilities under the Plan, the Medical Review firms have been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of this Plan.

Section 3: ELEMENTS OF THE MEDICAL REVIEW PROGRAM

The Plan's Medical Review Program consists of:

a. **Precertification (preservice) review**: review of proposed health care services (including certain prescription drugs) before the services are provided;

b. **Concurrent (continued stay) review**: ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility or continued duration of healthcare services;

c. **Retrospective (post-service) review**: review of health care services after they have been provided.

d. **Case Management**: a process whereby the patient, the patient's family, physician and/or other health care providers, and the Fund work together under the guidance of the plan's independent Medical Review firm to coordinate a quality, timely and cost-effective treatment plan.

Section 4: RESTRICTIONS AND LIMITATIONS OF THE MEDICAL REVIEW PROGRAM (Very Important Information)

a. The fact that your Physician recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered medically necessary for determining coverage under the Medical Plan.

b. The Medical Review Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The Medical Review firm's certification that a service is medically necessary does not mean that a benefit payment is guaranteed.

c. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.

d. All treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if the Medical Review firm does not certify proposed surgery/treatment/service or admission as medically necessary or as an eligible expense. However, the benefits payable by the Plan may be affected by the determination of the Medical Review firm.

e. With respect to the administration of this Plan, the Fund, the Administrative Office and the Medical Review firms are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the Medical Review firm as medically necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the Medical Review firm as medically necessary.

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. 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. An upcoming transplant as soon as the participant is identified as a potential transplant candidate. 3. The following procedures: surgical treatment of morbid obesity, 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. 4. All Home Health Care services 5. Home Infusion services including outpatient injectable drugs administered in an outpatient facility. 6. All diagnostic radiology type services (such as MRI, CT scan, PET scan, nuclear radiology service, etc.). 7. Speech therapy. 8. Orthotic devices over $500 per item. 9. Prosthetic devices. 10. Durable Medical Equipment over $1000 per item. 11. 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.	**Utilization Management 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.**

WHAT SERVICES MUST BE PRECERTIFIED:	MEDICAL REVIEW FIRM TO BE CONTACTED	PENALTY FOR FAILURE TO PRECERTIFY
Certain outpatient prescription drugs and specialty prescription drugs including specialty injectable 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.**

b. **How to Request Precertification (Pre-service Review):**

It is your responsibility to assure that precertification occurs when it is required by this Plan. Any penalty for failure to precertify is the responsibility of the plan participant, not the health care provider.

You or your Physician must call the appropriate Medical Review firm (as noted in the chart above) at their telephone number shown in the Quick Reference Chart in the front of this document.

1. **Calls for Elective services should be made at least 7 days before the expected date of service.**
2. The caller should be prepared to provide all of the following information: the Fund's name, employee's/retiree's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the name of the Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. When calling to precertify, if the preservice review process was not properly followed the caller will be notified as soon as possible but not later than 5 calendar days after your request.
4. If additional information is needed, the Medical Review firm will advise the caller. The Medical Review firm will review the information provided, and will let you and your Health Care Provider, and the Administrative Office know whether or not the proposed health care services have been certified as medically necessary. The Medical Review firm will usually respond to your Health Care Provider **by telephone within 3 working days (but not later than 15 calendar days) after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.
5. If your health care service is determined not to be medically necessary or an eligible expense, you and your health care provider will be given recommendations for alternative treatment. You may also pursue an appeal. See the Claim Filing and Appeal Information Article regarding appealing a Medical Review determination.

Section 6: CASE MANAGEMENT

How Case Management Works:

Case Management is a process administered by the Utilization Management (UM) Company. Its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrator and the Fund to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers. See the section titled Restrictions and Limitations of the Utilization Management Program in this Article.

Working with the Case Manager:

Any Plan Participant, Physician, or other Health Care Provider can request Case Management services by calling the UM Company at the telephone number shown on the Quick Reference Chart in the front of this document. However, in most cases, the UM Company will be actively searching for those cases where the patient could benefit from Case Management services, and will initiate Case Management services automatically.

The Case Manager of the UM Company will work directly with your Physician, Hospital, and/or other Health Care Facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Non-Network Health Care Providers as needed. From time to time, the Case Manager may confer with your Physician or other Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

Contacting a Case Manager:

You, your family, or your Physician may call the Case Manager of the Utilization Management Company at any time at the telephone number shown on the Quick Reference Chart in the front of this document to ask questions, make suggestions, or offer information.

Section 7: DISEASE MANAGEMENT (DM)

Disease Management (DM) refers to a health education and self-care promotion program offered at no cost to Plan Participants diagnosed with certain chronic health conditions. The program is managed by an independent Disease Management Program whose name and phone number are listed on the Quick Reference Chart in the front of this document.

- This disease management program is available for Plan Participants who have been diagnosed with the following chronic conditions: **heart disease (e.g. heart failure, chest pain, heart attack, coronary artery disease), diabetes, and respiratory disease (e.g. asthma, COPD, emphysema, chronic bronchitis).**

While any Plan Participant with these diseases can request Disease Management services by calling the Disease Management Program, the Disease Management Program will automatically be screening claims data to identify those patients who could benefit from disease management services.

Disease Management Programs support the patient/physician relationship and the plan of care, emphasize techniques for prevention of disease progression and disease complications, and help the patient with strategies to improve self-care. Individuals who properly manage their chronic conditions have fewer complications, shorter and fewer hospital stays and emergency room visits, are more productive and improve the quality of their life.

The Disease Management Program may find that some individuals with chronic diseases are low risk and their condition is fairly well managed so that they may only need some occasional written educational material. Other higher risk individuals may be struggling to control their chronic condition and need, in addition to written educational material, more support from the Disease Management Program, such as telephone calls by the company's professional medical staff with customized education tips and self-care support.

This is a voluntary Disease Management Program so a person can decline the educational and support services of the Disease Management Program.

ARTICLE X: MEDICAL PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by the Medical Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related plan exclusions.

Section 1: GENERAL EXCLUSIONS (applicable to all medical services and supplies)

1. **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
2. **Complications of a Non-covered Service**: Any services, supplies or accommodations related to complications of non-covered services/treatment.
3. **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, interest charges, late fees, mileage costs, provider administration fees and/or photocopying fees. disabled person license plates/automotive forms, concierge/retainer agreement/membership/surcharge fees or provider's special plan charging fees to access added benefits.
4. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: expenses for learning deficiencies, behavioral problems or Special Education, educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, vision therapy, auditory aides, speech aids, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices. Certain educational services may be listed as a covered benefit in the Schedule of Medical Benefits in this document.

5. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by the Fund or a participating employer of the Fund, or if benefits are otherwise provided under this Plan or any other plan that the employer contributes to or otherwise sponsors.

6. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation or Maximum Plan Benefit as described in the Medical Plan Article of this document.

7. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions Article of this document.

8. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party may be required to pay are not covered, except as provided for in the provisions relating to Third Party Liability in the Article on Coordination of Benefits. See the provisions relating to Third Party Liability in the Article on Coordination of Benefits in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.

9. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical program; or after the date the patient's coverage ends, except under those conditions described in the COBRA Article of this document.

10. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions Article of this document.

11. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.

12. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

13. **Illegal Act:** Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence, or the commission or attempted commission of an assault or felony, is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.

14. **Internet/Virtual Office/Telemedicine Services:** Expenses related to an online internet consultation with a Physician or other Health Care Practitioner, also called a virtual office visit/consultation, physician-patient web service or physician-patient e-mail service, or telemedicine (realtime or store and forward types) telehealth, e-health, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.

15. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission.

16. **Medical Students, Interns or Residents:** Expenses for the services of a medical student, intern or resident.

17. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be medically necessary as defined in the Definitions Article of this document, except for certain wellness benefits as outlined in the Schedule of Medical Benefits.

18. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.

19. **No-Cost Services:** Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

20. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if you or your covered Dependent were not covered by workers' compensation insurance, or if the

Covered Individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified.

21. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, DVD/CD or similar device, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

22. **Physical Examinations, Tests for Employment, School, etc.:** Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party.

23. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

24. **Relatives Providing Services:** Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, Spouse, sibling (by birth or marriage) or child of the patient or covered Employee/Retiree.

25. **Services Not Prescribed by a Physician**: Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician, except for covered services provided by a Behavioral Health Practitioner, Audiologist, Chiropractor, Dentist, Midwife or Nurse Midwife, Nurse Practitioner, Physician Assistant or Podiatrist.

26. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in the Definitions Article of this document.

27. **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.

28. **Telephone Calls:** Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Medical Review firm, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan or its Medical Review firm, for any purpose related to the care or treatment of a Covered Individual, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.

29. **Travel and Related Expenses:** Expenses for and related to travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual, unless those expenses have been pre-approved by the Plan Administrator or its designee.

30. **Travel Contrary to Medical Advice:** Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.

31. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, invasion, or release of nuclear energy, except as required by law.

32. **Failure to Provide Required Information:** If the Plan requests information from a Plan Participant in order to process a claim for benefits and that requested information is not provided within the timeframe allowed under the Plan, no payment will be extended for the questionable services. If the requested information is later received by the Plan in a timely manner according to the claim filing article of this document, the claim will be reviewed.

33. **Non-Routine Services**: Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

Section 2: EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

A. Alternative/Complementary Health Care Services Exclusions

1. Expenses for acupuncture and/or acupressure.
2. Expenses for chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
3. Expenses for prayer, religious healing, or spiritual healing including services provided by a Christian Science Practitioner.
4. Expenses for naturopathic, naprapathic and/or homeopathic services or treatments/supplies.

B. Behavioral Health Care Exclusions

1. Expenses for residential care services for Behavioral Health Care.
2. Expenses for hypnosis, hypnotherapy and/or biofeedback.
3. Expenses related to enuresis (bedwetting).
4. Expenses for **Applied Behavioral Analysis (ABA) Therapy** (as defined in the Definitions Article of this document) and related services.
5. Expenses for Behavioral Health Care services related to:
   - dyslexia, learning disorders, educational delays, including tests and related expenses to determine the presence of or degree of a person's dyslexia or learning/reading disorder.
   - vocational disabilities;
   - court-ordered Behavioral Health Care services or custody counseling;
   - family planning/pregnancy/adoption counseling, transsexual/gender reassignment/sex counseling;
   - Marital or family counseling (except that such counseling is available from the Plan's Employee Assistance Program (EAP)).

C. Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

1. Expenses for any items that are **not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions Article of this document, including but not limited to air purifiers, air conditioners, swimming pools, spa/whirlpools, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, and water beds.
2. Expenses for **replacement of lost, missing, or stolen**, **duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.
3. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.
4. Expenses for **occupational therapy adaptive supplies and devices** used to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.
5. Expenses for **nondurable supplies,** except as payable under Nondurable Supplies in the Schedule of Medical Benefits.

D. Cosmetic Services Exclusions

1. No coverage for surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast augmentation/breast reduction, elimination of redundant skin of the abdomen or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.
2. The Medical Program **does** cover medically necessary Reconstructive Services following a surgery-related to a malignancy and reconstruction after a mastectomy. To determine the extent of this coverage, see Reconstructive Services in the Schedule of Medical Benefits. Reconstructive surgery is payable for surgery that is necessary for the repair or alleviation of damage predominately caused by accidental bodily injuries precipitated by external means. Expenses are also considered payable for surgery that is necessary because of congenital disease or anomaly of a Dependent Child that has resulted in a functional defect. Non-functional defects resulting from congenital malformations of a Dependent Child will be considered on a case by case basis when determined by the Board of Trustees or their designated agent that such surgery is medically indicated based upon the recommendation of a Physician designated by the Board of Trustees.

E. Custodial Care Exclusions

1. Expenses for Custodial Care as defined in the Definitions Article of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, residential care, services of a homemaker, or personal care, sitter/companion service, except when Custodial Care is provided as part of a covered Hospice program or is provided during a covered hospitalization, or when the services of Certified nurse aides are payable under Home Health Care Services in the Schedule of Medical Benefits.
2. Any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are medically necessary.

F. Dental Services Exclusions

1. Expenses for Dental services or supplies of any kind, (even if they are necessary because of symptoms, congenital anomaly or illness affecting the mouth or another part of the body) including but not limited to dental prosthetics and dental services for the care, filling, removal or replacement of teeth, or disease of the teeth, gums or structures directly supporting or attached to the teeth.
2. Expenses for Dental services may be covered under the Medical Plan if they are incurred for the repair or replacement of Accidental Injury to Teeth or restoration of the jaw if damaged by an external object in an accident. For the

purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing. See Oral, Craniofacial and TMJ Services in the Schedule of Medical Benefits to determine if those services are covered.

3. Expenses for Orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with Prognathism, Retrognathism, or other cosmetic reasons. See Oral, Craniofacial and TMJ Services in the Schedule of Medical Benefits for additional information.

G. Drugs, Medicines and Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (*i.e.* are used "off-label"). Off-label use of an FDA approved drug will only be considered for payment (as not being experimental or investigational), on a case by case basis considering the facts and circumstances of the clinical situation, if approved by the Board of Trustees with medical evidence to support the fact that the benefits of the use of the drug outweigh the risks, or the off label use of an FDA drug relates to treatment of cancer. The Board of Trustees reserves the right to seek independent medical review regarding the request for off label drug use.
2. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin, drugs mandated for coverage in accordance with Health Reform regulations and tobacco cessation products.
3. Foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, diets, dietary supplements, vitamins, herbs and minerals, enzymes (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered hospitalization or as mandated for coverage in accordance with Health Reform regulations . Nutritional support may be payable when it is determined by the Plan Administrator or its designee to be Medically Necessary, and is the sole means of adequate nutritional intake and is administered enterally (i.e., by feeding tube) or parenterally (i.e., by intravenous administration) and is not considered a food thickener, infant formula, donor breast milk, baby food, or other non-prescription product that can be mixed in a blender.
4. Naturopathic, naprapathic or homeopathic services and substances.
5. Drugs, medicines or devices for:
   - non-prescription contraceptives drugs and devices for males;
   - fertility and/or infertility drug products or agents;
   - hair removal or hair growth products (*e.g.,* Propecia, Rogaine, Minoxidil, Vaniqa);
   - growth hormone;
   - erectile dysfunction (*e.g.,* Viagra, Cialis, Muse, Caverject);
   - vitamin A derivatives (retinoids) for dermatologic use (*e.g.* Retin A, Renova) are excluded after age 26;
   - weight control, appetite suppressants or anorexiants (*e.g.,* Xenical) except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy.
6. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
7. Self-help devices such as a scale, pill crusher, magnifying glass/device, etc.

H. Durable Medical Equipment Exclusions

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

I. Fertility and Infertility Services Exclusions

1. Expenses for the treatment of infertility along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting or surrogate related expenses (surrogate refers to an arrangement for a woman to carry and give birth to a child who will be raised, and usually legally adopted, by others and often includes invitro fertilization, the implantation of a fertilized egg for the purpose of carrying the fetus to term for another woman) including expenses for and related to the pregnancy, delivery fees and complications for the woman who is the surrogate; donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization procedures.

J. Foot/Hand Care Exclusions

1. Expenses for routine foot care, (including but not limited to trimming of toenails, removal or reduction of corns and callouses, removal thick/cracked skin on heels, foot massage, preventive care with assessment of pulses, skin condition and sensation) or hand care including manicure and skin conditioning, unless the Plan Administrator or its designee determines such care to be medically necessary. Medical treatment of the foot, by a podiatrist, is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
2. Expenses for weak or fallen arches, flat or pronated foot metatarsalgia or foot strain, orthopedic shoes, foot orthotics and supportive devices for the feet such as arch supports, heel lifts, strapping or similar items unless listed as payable under the Corrective Appliances row of the Schedule of Medical Benefits in this document.

K. Genetic Testing and Counseling Exclusions

1. **Genetic Testing:** Expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, except as listed as payable in the Genetic Testing row in the Schedule of Medical Benefits and as required under Health Reform. Non-covered genetic services includes:
   a. **Pre-parental genetic testing (also called carrier testing)** intended to determine if an individual is at risk of passing on a particular genetic mutation, such as a family member who is unaffected but at risk for producing affected children. No coverage for pre-parental/carrier genetic testing intended to determine if a prospective parent or parents or in vitro embryo have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents;
   b. Expenses for **Pre-implantation Genetic Diagnosis (PGD)** where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
   c. **Prenatal genetic testing** intended to determine if a developing fetus is a risk for inheriting identifiable genetic diseases or traits **except** as described in the Genetic Testing row of the Schedule of Medical Benefits that covers tests using fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis in pregnant women;
   d. **Genetic testing and non-covered individuals:** No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the treatment of a plan participant.
   e. **Home genetic testing kits/services** are not covered.

   See the Genetic Services row of the Schedule of Medical Benefits for a description of the genetic services that are covered by the Plan.

   Plan Participants should contact the Utilization Management program for assistance in determining if a proposed Genetic Test will be covered or excluded.
2. **Genetic Counseling:** Expenses for genetic counseling are not covered, unless these three conditions are met: is ordered by a Physician, performed by a qualified genetic counselor and performed in conjunction with a genetic test that is payable by this Plan.

L. Hair Exclusions

1. Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis.

M. Hearing Care Exclusions

1. Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices.

N. Home Health Care Exclusions

1. Expenses for any Home Health Care services other than part-time, intermittent **skilled nursing** services and supplies, except when the services of Home Health aides are payable under Home Health Care Services in the schedule of Medical Benefits.
2. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, Spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, custodial care, child care, adult care or personal care attendant, except as provided under the Plan's Hospice coverage, and when custodial care is provided by Home Health aides that are payable under Home Health Care Services in the Schedule of Medical Benefits.

O. Maternity/Family Planning/Contraceptive Exclusions

1. **Contraception:** Expenses related to non-prescription contraceptive drugs and devices for males, such as condoms.
2. Expenses for **childbirth education, and Lamaze classes**.
3. Expenses related to the **maternity care and delivery expenses associated with a surrogate mother's pregnancy.**
4. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**
5. No coverage is provided for the **baby of a Dependent Child**. Pregnancy-related care is covered for a female Participant.

For Nondurable supplies (see Corrective Appliances).

P. Nursing Care Exclusions

1. Expenses for services of private duty nurses.

Q. Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

1. Expenses for educational, job training, vocational rehabilitation.
2. Expenses for massage therapy, rolfing (deep muscle manipulation and massage), craniosacral therapy (noninvasive rhythmic manipulation of the craniosacral areas) and related services.
3. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to coma stimulation programs and services.
4. Expenses for Maintenance Rehabilitation as defined under Rehabilitation in the Definitions Article of this document.
5. Expenses for speech therapy for functional purposes including, but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering and conditions of psychoneurotic origin.
6. Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired) unless it is speech therapy for children for the treatment of delays in childhood speech development.

R. Sexual/Erectile Dysfunction Services Exclusions

1. **Treatment of Erectile Dysfunction (Impotency)**: Expenses for prescription drugs (*e.g.* Viagra) and/or medical or surgical treatment of erectile dysfunction or inadequacy.
2. **Sex Change Counseling, Therapy and Surgery:** Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.

S. Transplant (Organ and Tissue) Exclusions

1. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs/medicines and all complications thereof, except those Transplant Services and their complications that are listed as payable under Transplantation in the Schedule of Medical Benefits.
2. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.
3. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except heart valves, kidney dialysis, and a ventricular assist device (VAD) (that is a mechanical pump used to assist a damaged or weakened heart in pumping blood) only when used as a bridge to a heart transplant or for support of blood circulation post-cardiotomy (following open-heart surgery, or for destination therapy (permanent mechanical cardiac support only if there is approval from the FDA for that purpose, and the device is used according to the FDA-approved instructions).
4. Donor expenses unless the person who receives the donated organ/tissue is a person covered by this Plan.

T. Vision Care Exclusions

1. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK).
2. Expenses for diagnosis and treatment of refractive errors, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except as provided by the vision exam benefit in the Medical Plan, and the negotiated Vision Plan.
3. Vision therapy (orthoptics) and supplies.

U. Weight Management and Physical Fitness Exclusions

1. Expenses for weight loss drugs and surgical treatment of obesity that does not meet the Weight Management benefit of the Plan as described in the Schedule of Medical Benefits.
2. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, work hardening and/or weight training services, expenses for a masseur, physical culturist, physical education instructor, swimming program/sessions.

ARTICLE XI: VISION PLAN

Section 1: OVERVIEW OF THE VISION PLAN

a. Active employees and their eligible Dependents may participate in this Vision Plan **if your local union has negotiated a contribution for those benefits**.

Vision plan benefits are not treated as a standalone (or excepted) benefit under HIPAA and the PPACA. The Plan will provide pediatric vision care to the extent required for compliance with the PPACA Essential Health Benefits rules for pediatric care.

b. Retirees are not eligible for Vision Plan benefits.

c. The Vision Plan is designed to provide for regular vision examinations and benefits toward eyeglasses or contact lenses.

d. There is **no vision network** so you are free to seek care from any vision provider. You pay for the service and later send your claims to the Administrative Office for reimbursement. Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; and this Plan will reimburse as noted in the Schedule of Vision Benefits. The itemized bill reflecting the provider's fees must be submitted to the Administrative Office for reimbursement. You will be reimbursed according to the Allowed Charge up to the amount allowed by the Plan.

e. Covered expenses are noted in the Schedule of Vision Benefits in this Article. You are covered for expenses you incur for many, but not all, routine vision services and supplies that are determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that:

1) **services or supplies are not excluded** from coverage (as provided in the Vision Plan Exclusions section of this Article); and

2) **services or supplies are not in excess** of a Maximum Plan Benefit as shown in this Vision Plan Article; and

3) the charges for services are **"Allowed Charges."** See the Definitions Article under "Allowed Charge."

Section 2: DEFINITION OF TERMS USED IN THIS VISION PLAN

a. A **vision exam** includes a professional examination and an eye refraction including case history, exam for pathological abnormalities of the eyes and lids, ranges of clear single vision and balance and coordination of muscles for far-seeing and near-seeing and special working distances.

b. **Dispensing optician** means a person qualified to manufacture and sell eyeglasses and/or contact lenses.

c. **Optometrist** is a person licensed to practice optometry.

d. **Ophthalmologist** is a physician licensed to practice ophthalmology.

Section 3: SCHEDULE OF VISION BENEFITS

SCHEDULE OF VISION BENEFITS

This chart shows what the Plan pays.
You pay the difference between the amount that is payable by this Plan and the provider's bill.

Covered Vision Benefits	Explanations and Limitations *See also the Vision Plan Exclusions section.*	Vision Benefits Payable by this Plan
Vision Examination	• One vision exam is payable each calendar year.	100% after a $10 copay per exam. For individuals under age 19 years an annual vision exam is payable at 100% no copay.
Frames for Eyeglasses	• One frame is payable every 24 months.	100% to a maximum of $50, thereafter the Plan pay 10% coinsurance.
	• Lenses are payable every 24 months.	• Single Vision (Standard): 100% to a maximum of $30, thereafter the Plan pay 10% coinsurance. • Bifocal: 100% to a maximum of $40, thereafter the Plan pay 10% coinsurance. • Trifocals: 100% to a maximum of $55, thereafter the Plan pay 10% coinsurance. • Lenticular: 100% to a maximum of $80, thereafter the Plan pay 10% coinsurance.

SCHEDULE OF VISION BENEFITS This chart shows what the Plan pays. You pay the difference between the amount that is payable by this Plan and the provider's bill.		
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision Plan Exclusions section.*	**Vision Benefits Payable by this Plan**
Lenses for Eyeglasses		
Contact Lenses	• One set of contact lenses are payable every 24 months.	100% to a maximum of $150, thereafter the Plan pay 10% coinsurance.

Section 4: FILING A VISION CLAIM OR APPEALING A DENIED CLAIM

a. If you use the services of a vision provider, you will need to pay the provider for all services and then, at a later date, submit the bill to the Administrative Office (whose name and address are listed on the Quick Reference Chart in the front of this section of this document). You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits.

b. **Vision claims must be submitted by July 1 of the year following the year in which services were provided, or else the service may not be considered for reimbursement**.

c. Your appeal of a denied vision claim should be submitted to the Plan according to the Claim Appeal procedures in the Claim Filing and Appeals Information Article of this document.

Section 5: VISION PLAN EXCLUSIONS

a. The Vision Plan is designed to cover visual needs rather than cosmetic materials. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Vision Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

b. In addition to the Exclusions and Limitations in Article X, the following is a list of services and supplies or expenses **not covered (excluded) by the Vision Plan**.

1. Oversized lenses (larger than 61mm), coated lenses, tinted lenses (addition of substance to produce a color such as pink or green, etc.), photochromic lenses (changes color with intensity of sunlight), sunglasses (plain or prescription), laminated lenses, plano (non-prescription/no refractive power) lenses or orthokeratology lenses for reshaping the cornea of the eye to improve vision.
2. Vision services and supplies that cost more than the Plan's allowance as noted in the Schedule of Vision Benefits.
3. Orthoptics (vision training to improve the visual perception and coordination of the two eyes), subnormal vision aids and any associated supplemental testing.
4. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
5. Glasses secured when there is no prescription charge, such as reading glasses obtained from a drugstore.
6. Two pair of lenses or eyeglasses in lieu of bifocals.
7. Medical or surgical treatment of the eyes, including, but not limited to, refractive keratoplasty (RK) or laser assisted in situ keratoplasty (LASIK).
8. Vision check-ups or screenings requested by the participant's employer, school or government.
9. Experimental and/or investigational treatment or procedure.
10. Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.
11. Eye examinations or eyewear required as a condition of employment.

ARTICLE XII: DENTAL PLAN

Section 1: ELIGIBILITY FOR THE INSURED DENTAL PLAN

This section outlines the fully insured Dental Plan coverage; however, where this Article deviates from the certificate of coverage and summary of benefits produced by the Dental Plan insurance company, the insurance company documents will prevail. Contact the insured Dental Plan (whose name is listed on the Quick Reference Chart in the front of this document) for a copy of Dental plan insurance benefit information.

- Active employees and their eligible Dependents may participate in the Insured Dental Plan.
- Early (non-Medicare eligible) Retirees and Medicare-eligible Retirees are not eligible for insured Dental Plan benefits.

Section 2: DENTAL PLAN GENERAL PROVISIONS

The insured Dental Plan is designed to provide preventive and comprehensive dental services. This insured Dental Plan is treated as a stand alone (or excepted) benefit under HIPAA and the PPACA.

The insured Dental Plan includes a network of dental providers (e.g. dentists and dental hygienists) who extend a discount (negotiated fees) to you for covered dental services. To locate a network dental provider contact the Insured Dental Plan on the Quick Reference Chart in the front of this document.

Section 3: DENTAL PLAN OVERVIEW OF BENEFITS

OVERVIEW OF THE INSURED DENTAL PLAN BENEFITS

This chart only provides a brief overview. Not all dental services are covered by the insured Dental Plan. For full details, including restrictions, limitations and dental plan exclusions refer to the certificate of coverage and summary of benefits produced by the Dental Plan insurance company.

	IN-NETWORK DENTAL PROVIDERS	OUT-OF-NETWORK DENTAL PROVIDERS
Annual Maximum Dental Plan Benefit	$1,000 per person	
Annual Dental Plan Deductible	$50 per person $150 per family	
TYPE A DENTAL SERVICES • Two cleanings per 12 months. • Two oral examinations per 12 months. • Two fluoride treatments per 12 months for children up to their 19th birthday. • Full mouth x-rays: one per 36 months. • Bitewing x-rays: two sets per 12 months. • Space Maintainer: one is covered per lifetime for dependent children up to their 14th birthday. • Periodontal maintenance treatments and prophylaxis is payable up to two in 12 months.	No charge, no deductible.	No charge, no deductible up to the Dental Plan's R&C charge**
TYPE B DENTAL SERVICES • Fillings, extractions, endodontics, oral surgery, sealants (1 application for certain teeth every 36 months up to child's 15th birthday)	80% of the negotiated fee*	80% of the Dental Plan's R&C charge**
TYPE C DENTAL SERVICES • Bridge, crowns, implant (1 tooth position every 60 months) and dentures	50% of the negotiated fee*	50% of the Dental Plan's R&C charge**

***Negotiated fee** refers to the fees that participating dentists have agreed to accept as payment in full, subject to any copayments, deductibles cost-sharing and benefits maximums. Negotiated fees are subject to change.*

***R&C refers to the Reasonable and Customary (R&C)** charge which is based on the lowest of : (1) the dentist's actual charge, (2) the dentists usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by the insured Dental Plan.*

ARTICLE XIII: WEEKLY DISABILITY BENEFITS

Section 1: ELIGIBILITY

a. Active employees are eligible for weekly disability benefits only when required contributions are negotiated and paid.

Section 2: BENEFITS

a. **Overview of Weekly Disability Benefits**.

OVERVIEW OF WEEKLY DISABILITY BENEFITS	
Waiting Period (Elimination Period)	• No waiting period if disability caused by an accident or, if otherwise hospital confined (benefits begin on the 1st day) • 7 days if disability caused by a sickness (benefits begin on the 8th day)
Maximum Weekly Benefit	• $30 (minus FICA taxes) per week for an occupational disability • $250 (minus FICA taxes) per week for a non-occupational disability
Maximum Possible Disability Benefit Period (Benefit Duration)	• 39 calendar weeks

b. **Weekly Benefit.**

If an Active Employee becomes totally disabled because of either an accident or sickness (whether due to an occupational or non-occupational cause), the Plan shall, subject to the provisions hereafter stated and upon receipt of claim, which includes a Physician's (M.D. or D.O.) certification of total disability satisfactory to the Board of Trustees, pay to the employee a benefit during the period of disability as follows:

- **$30 (minus FICA taxes) per week for an occupational disability;**
- **$250 (minus FICA taxes) per week for a non-occupational disability;**

not to exceed thirty-nine (39) weeks of payments for any one (1) period of disability.

c. **Commencement of Benefits**.

Weekly disability benefits begin on:

- the **first (1st) day of disability caused by an accident or, if otherwise hospital confined**, or
- on the **eighth (8th) consecutive day of disability caused by a sickness**,

provided the Active Employee is eligible under the Plan on the date of the accident or on the first day of sickness causing the disability. Disabilities occurring in the lag month do not qualify for coverage.

d. **Successive Periods of Disability**.

Successive periods of disability separated by less than thirty (30) days of full-time active employment will be considered one (1) period of disability unless the subsequent disability is due to a cause or causes entirely unrelated to the previous disability and commences after the employee has returned to full-time active employment.

e. **Totally Disabled/Total Disability Defined**.

An Active Employee is totally disabled when he/she is prevented by reason of bodily injury or sickness from engaging in his or her own occupation for wages or profit.

f. **Cessation of Weekly Benefit**.

Benefits herein described shall cease when the disabled employee attains age sixty-five (65) or begins receiving any of the following, whichever occurs first:

- Social Security Disability Benefits or Social Security Benefits.
- Disability Pension Benefits from the Eighth District Electrical Pension Plan or other pension plan(s) to which the participant may be entitled.
- Upon exhaustion of the **thirty-nine (39) week period**.

g. **Hour Bank Freeze for Continuation of Eligibility While Disabled.** See Article III for information.

Section 3: EXCLUSIONS RELATED TO WEEKLY DISABILITY BENEFITS

a. Benefits are not payable for a disability resulting from acts of war.

b. Disabilities occurring in the lag month.

c. Retired employees.

ARTICLE XIV: CLAIM FILING AND APPEAL INFORMATION

Section 1: OVERVIEW

This Article describes the procedures for filing claims for certain benefits under this Plan and for appealing adverse benefit determinations in connection with those claims in compliance with 29 CFR §2560.503-1. Claims covered by these procedures

include those claims filed under the Medical Plan (including prescription drugs), Vision Plan, Weekly Disability Plan, and Dependent Life Insurance.

The Plan takes steps to assure that Plan provisions are applied consistently with respect to you and other similarly situated Plan participants. The claims procedures outlined in this Article are designed to afford you a full, fair and fast review of the claim to which it applies.

This Article also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not medically necessary, is experimental or investigational).

Section 2: QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. For additional information regarding QMCSOs, see the Eligibility provisions in Article III of this document.

Section 3: WHEN YOU MUST REPAY PLAN BENEFITS

If it is found that the Plan benefits paid by the Plan are too much because:

1. some or all of the health care expenses were not payable by you or your covered Dependent; or
2. you or your covered Dependent received money to pay some or all of those health care expenses from a source other than the Plan; or
3. you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan benefits were paid (see also the Subrogation section of Article XV, the COB Article);or
4. the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan; or
5. the Plan erroneously paid benefits because of false information entered on your enrollment form, claim form or required documentation;

then, the Plan will be entitled to

a. a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;

b. offset future benefits (that would otherwise be payable on behalf of you or your dependents) if necessary in order to recover such expenses; and/or

c. its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

Section 4: TIME LIMIT FOR INITIAL FILING OF HEALTH AND DISABILITY CLAIMS

TIME LIMIT FOR INITIAL FILING OF HEALTH AND DISABILITY CLAIMS
All post-service claims should be submitted to the Plan's Claims Administrator by July 1st of the year following the year in which the claims were incurred or in which the disability occurred.

Section 5: ADDITIONAL INFORMATION NEEDED

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

Section 6: WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the definition of pre-service claims in this Article. See also Article IX Precertification for which services require precertification. You are not required to obtain approval in advance for emergency care or hospital admission for delivery of a baby.

Section 7: KEY DEFINITIONS

a. **Days:** For the purpose of the claim and appeal procedures outlined in this Article, "days" refers to calendar days, not business days.

b. **Adverse Benefit Determination**: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit including any such denial, reduction, termination or failure to provide or make a payment that is based on:

- a determination of an individual's eligibility to participate in this Plan; or
- a determination that a benefit is not a covered benefit; or
- a reduction in a benefit resulting from the application of any utilization review (medical review) decision, source of injury exclusion, network exclusion or other limitation on otherwise covered benefits, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
- any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

c. **Claim:** For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this Article) in accordance with the Plan's claims procedures, described in this Article.

There are **five types of claims** covered by the procedures in this Article: **Pre-service, Urgent, Concurrent, and Post-service and Disability**, described later in this Article. The type of claim is determined as of the time the claim or review of denial of the claim is being processed. For the insured benefits of the Plan, such as Life insurance and the Dental Plan, follow the claims and appeal procedures outlined in the documents produced by those insurers.

A claim must include the following elements to trigger the Plan's claims processing procedures:

1. be **written or electronically** submitted (oral communication is acceptable only for urgent care claims),
2. be **received by the Appropriate Claims Administrator** as that term is defined in this Article;
3. **name a specific individual**,
4. **name a specific medical condition or symptom**,
5. **name a specific treatment, service or product** for which approval or payment is requested, and
6. **made in accordance with the Plan's benefit claims filing procedures** described in this Article.

A claim is NOT:

1. a request made by **someone other than** the individual or his/her authorized representative;
2. a request made by a **person who will not identify him/herself** (anonymous);
3. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
4. a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
5. an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
6. a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim. A request is also not a claim if you or your covered Dependent were not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law have been declined/waived, not purchased or qualified.
7. a **submission of a prescription** with a subsequent adverse benefit determination at the point of sale at a retail pharmacy or from a mail order service.

d. **Appropriate Claims Administrator:** means the companies and types of claims outlined in the chart below. (See the Quick Reference chart in the front of this document for the name and address of these Appropriate Claims Administrators)

Appropriate Claims Administrator	Types of Claims Processed
Administrative Office	• Medical including behavioral health and Vision plan post-service claims. • Weekly disability claims and PCA claims
Utilization Management Company	• Pre-service, urgent, and concurrent claims

Appropriate Claims Administrator	Types of Claims Processed
MAP and EAP Program	• Preservice claims for MAP and/or EAP visits
Prescription Drug Program	• Drugs needing pre-service review • Post-service drug claims
Dental Plan Insurance Company	• Dental pre-service and post-service claims
Life Insurance and Accidental Death and Dismemberment Insurance Company	• Life Insurance post-service claims • Accidental Death and Dismemberment post-service claims

e. **Pre-Service Claim:** A pre-service claim is a request for benefits under this group health plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. For example, some of the services that require precertification (also called prior authorization) include but are not limited to inpatient admissions, transplants, surgery for morbid obesity and certain prescription drug services. See Article IX of this document for more details on precertification requirements.

The Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing precertification (that were obtained without prior approval) if you were unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (precertification) procedure could have seriously jeopardized the patient's life or health.

f. **Urgent Care Claim**: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification, as determined by your Health Care Professional:

- could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function, or
- in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

The services that require precertification (also called prior authorization) are listed in Article IX, the Precertification Article of this document.

g. **Concurrent Care Claim:** A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short. The services that may receive concurrent care review are listed in the Precertification Article in this document.

h. **Post-Service Claim:** A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage or a claim regarding the Personal Care Account benefit will be treated as a post-service claim.

i. **Life Insurance/Accidental Death and Dismemberment Claim:** A life insurance/AD&D claim is a claim for benefits under the Plan to which the Plan conditions availability of the benefit on proof of a claimant's death or proof of accidental dismemberment. See the Life insurance documents for details on their claim filing and appeals.

j. **Disability Claim:** A disability claim is a claim for benefits under the Plan (also called Weekly disability) to which the Plan conditions the availability of the benefit on proof of a claimant's disability.

k. **Health Care Professional:** Means a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

l. **Tolled:** Means stopped or suspended, particularly as it refers to time periods during the claims process.

m. **Rescission:** Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan. (See also Article XVI).

n. **Independent Review Organization or IRO:** Means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan's external review provisions and current federal external review regulations.

Section 8: REVIEW OF ISSUES THAT ARE NOT A CLAIM AS DEFINED IN THIS ARTICLE

A Plan participant may request review of an issue (that is not a claim as defined in this Article) by writing to the Board of Trustees whose address is listed on the Quick Reference chart in the front of this document. The request will be reviewed and the participant will be advised of the decision within 90 days of the receipt of the request.

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 claim for a plan participant.) 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.

Section 10: HOW TO FILE A CLAIM FOR WEEKLY DISABILITY BENEFITS (DISABILITY CLAIM PROCESS)

A claim for disability benefits is a request for weekly disability plan benefits made by you (an individual covered under the Weekly Disability Benefits) or your authorized representative (as defined in this Article) in accordance with the Plan's disability claims procedures, described below in this Article. See also the "Key Definitions" subheading of this Article for a definition of a "claim" and the information on what is and is not considered a claim.

Eligible employees who become totally disabled from an occupational or non-occupational illness or injury should apply (file a claim) for disability benefits within 30 calendar days after the date on which the illness or injury began, according to the following steps:

1. Obtain a disability claim form from the Administrative Office. Complete the patient portion of the form. Then give the form to your physician to complete the health care provider section of the form. Return the completed disability claim form to the Administrative Office at their address listed on the Quick Reference chart in the front of this document. **Disability claims will be determined no later than 45 calendar days after receipt of the claim for disability benefits by the Appropriate Claims Administrator.** (See below for information on extension of this time period.)
2. You will be notified if you did not follow the disability claim process or if you need to submit additional medical information or records to prove a disability claim and provided 45 calendar days in which to obtain this additional information.
    - Proof of disability must be provided to the Plan no later than 90 calendar days after the end of the period for which disability benefits are payable. If you do not provide proof of disability within the time specified, you can still claim full benefits if you can show that proof was furnished as soon as reasonably possible.
    - The Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefit is pending or payable.
3. The Board of Trustees or its designee determines if employees are eligible to receive disability benefits under this Plan. The Plan will review your disability claim and notify you or your authorized representative in writing (or electronically, as applicable) no later than 45 calendar days from the date the Appropriate Claims Administrator receives the claim.
    - This 45-day period may be **extended for up to 30 calendar days** provided the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period, that additional time is needed to

process the claim, the special circumstances for this extension and the date by which it expects to render its determination.

- If, prior to the end of this first 30 day extension, the Appropriate Claims Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.
- A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. **If the Appropriate Claims Administrator needs additional information from you to make its decision**, you will have at least 45 calendar days to submit the additional information. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

4. Disability benefits begin when the claim for disability benefits has been determined to meet the definition of total disability under this Plan and it is determined that Plan disability exclusions do not apply to the claim.

5. **If the claim for disability benefits is approved**, benefit payments will begin.

6. **If the claim for disability benefits is denied** in whole or in part, a notice of this initial denial (adverse benefit determination) will be provided to the employee in writing (or electronically, as applicable). This notice of initial denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure along with time limits;
   - contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal; and
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

7. **If you disagree with a denial of a disability claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 11: APPEAL OF A DENIAL OF A DISABILITY CLAIM

Appeals must be in writing to the Board of Trustees whose address is listed on the Quick Reference chart in the front of this document. You will be provided with:

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. The Plan then will make a determination as follows:
   - no later than the date of the Board of Trustees meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed **within** 30 calendar days preceding the date of such meeting. In such

case, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the request for review.

- If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made no later than the third meeting of the Board following the Plans' receipt of the request for review.
- If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
- The Plan will notify you of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

2. **The Plan may obtain a 45-day extension if** you are notified of the need and reason for an extension before expiration of the initial 45-day period. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

3. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA section 502(a) following the appeal;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and (if applicable) your State insurance regulatory agency."

4. This concludes the disability appeal process under this Plan.

Section 12: HOW TO FILE A POST-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

A claim for post-service benefits is a request for Plan benefits (that is not a preservice claim) made by you or your authorized representative, in accordance with the Plan's claims procedures, described in this Article. See also the "Key Definitions" subheading of this Article for a definition of a "claim" and the information on what is and is not considered a claim.

1. Plan benefits for post-service claims are considered for payment on the receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim but sometimes additional information or records may be required.

2. Generally, Plan benefits for a Hospital or Health Care Facility will be paid directly to the facility. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services. This is because the Plan's financial responsibility for eligible benefits is generally automatically assigned to the provider of the service unless the claim is marked that the bills have been paid by the covered person. For eligible claims, the Plan pays their portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider.

3. If health care services are provided through the Preferred Provider Organization (PPO) the PPO Health Care Provider will usually submit the written proof of claim directly to the Appropriate Claims Administrator.

4. If you pay for non-PPO health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered dependent paid some or all of those charges. Plan benefits will be paid to you up to the amount allowed by the Plan for those eligible expenses. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.

5. **Claim Forms:** Occasionally a health care provider will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this Article) to find out if they require you to complete a claim form. If a claim form is required it may be obtained from the Appropriate Claims Administrator whose name and address are listed on the Quick Reference chart in the front of this document.
   - Complete the employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."

- The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or Health Care Practitioner or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:
  - A description of the services or supplies provided.
  - Details of the charges for those services or supplies, including CPT/CDT codes.
  - Diagnosis including ICD codes.
  - Date(s) the services or supplies were provided.
  - Patient's name, social security or ID number, address and date of birth.
  - Insured's name, social security or ID number, address and date of birth, if different from the patient.
  - Provider's name, address, phone number, professional degree or license, and federal tax identification number.
- Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Appropriate Claims Administrator.** This can reduce costs to you and the Plan.
- Complete a **separate claim form** for each person for whom Plan benefits are being requested.
- If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.
- Mail the claim form and a copy of the provider's actual claim to the Appropriate Claims Administrator.

6. In all instances, when Deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.

7. The Appropriate Claims Administrator will review your post-service claim no later than 30 calendar days from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.
   - This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30 day period using a written Notice of Extension.
   - The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
   - If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
   - The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.
   - **Proof of Dependent Status:** When processing claims submitted on behalf of a Dependent, follow the guidelines for Proof of Dependent Status located in Article III in this document.
     - When processing claims submitted on behalf of a **newborn Dependent** Child the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (*e.g.* copy of certified birth certificate for newborn).
     - When processing claims submitted on behalf of a **Dependent Child who is age 26 or older** the Appropriate Claims Administrator must receive confirmation of the child's eligibility (e.g. disability verification).
     - When processing claims submitted on behalf of a **new Spouse or Domestic Partner or Domestic Partner Dependent Child**, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility (e.g. copy of marriage certificate) **or Domestic Partner or Domestic Partner Dependent Child's eligibility**.
     - If claims are submitted on behalf of a **Dependent for whom the Plan has not yet received proof of dependent status**, the Appropriate Claims Administrator must receive the proof of eligibility, or confirmation from the Plan of the child's eligibility for coverage, before the claim can be considered for payment.
     - When processing **claims related to an accident** the Appropriate Claims Administrator will need information about the details of the accident.

8. The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with

the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

9. **If the post-service claim is approved,** you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.

10. **If the post-service claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing on the Explanation of Benefits or EOB form. This notice of initial denial will:
    - identify the claim involved;
    - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
    - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any plan standards used in denying the claim;
    - reference the specific Plan provision(s) on which the determination is based;
    - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    - provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
    - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
    - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
    - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
    - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

11. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
    - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
    - CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (801) 973-1001 or toll free (800) 628-6562.

12. **If you disagree with a denial of a post-service claim**, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 13: APPEAL OF A DENIAL OF A POST-SERVICE CLAIM

This Plan maintains 1 level of appeal process. Appeals must be in writing to the Board of Trustees, whose address is listed on the Quick Reference chart in the front of this document. You will be provided with:

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. The Plan will make an appeal determination according to the following timeframes:
   - **If an appeal is filed with the Plan <u>more than 30 days</u> before the next Board meeting**, the review will occur at the next Board meeting date.
   - **If an appeal is filed with the Plan <u>within 30 days</u> of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.
   - If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
   - After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.
2. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.
3. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
4. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for external review;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - an explanation of the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and (if applicable) your State insurance regulatory agency;" and
   - disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.

- CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (801) 973-1001 or toll free (800) 628-6562.

6. This concludes the post-service appeal process under this Plan.

Section 14: HOW TO FILE AN URGENT CARE CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves urgent care (as defined earlier in this Article and as determined by your attending Health Care Professional), you may file the claim or the Plan will honor a Health Care Professional as your authorized representative in accordance with the Plan's urgent care claims procedures described below.

1. Urgent care claims (as defined previously in this Article) may be requested by you orally or by writing to the Appropriate Claims Administrator whose phone number and mailing address are listed on the Quick Reference chart in the front of this document.

2. 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), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.

3. The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

4. You will be notified of the Plan's benefit determination as soon as possible but **no later than 72 hours** after receipt of an urgent care claim by the Appropriate Claims Administrator. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.

5. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the Appropriate Claims Administrator, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

6. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

7. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
   - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   - give the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's internal appeal procedure and external review process along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process and external review process for urgent care claims;
   - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
- you will be provided a description of the expedited appeal review process for urgent care claims.
- The Plan will disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

8. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
   - CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (801) 973-1001 or toll free (800) 628-6562.

9. **If you disagree with a denial of an urgent care claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 15: APPEAL OF A DENIAL OF AN URGENT CARE CLAIM

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, at their phone number or address listed on the Quick Reference chart in the front of this document.

2. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the Plan will:
     - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
     - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

3. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than 72 hours after receipt of the appeal.

4. The notice of appeal review of an urgent care claim will be provided orally with written confirmation (or electronic, as appropriate). If that determination is adverse, it will include:
   - information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

- a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal or external review;
- the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- reference the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- an explanation of the Plan's 2nd level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and (if applicable) your State insurance regulatory agency;" and

5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
   - CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (801) 973-1001 or toll free (800) 628-6562.
6. This concludes the urgent care claim appeal process under this Plan.

Section 16: HOW TO FILE A CONCURRENT CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves concurrent care (as that term is defined earlier in this Article), you may file the claim by writing (orally for an expedited review) to the Appropriate Claims Administrator whose phone number and mailing address are listed on the Quick Reference chart in the front of this document.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.
2. The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
3. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this Article.
4. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Preservice or Post-service claim sections of this Article.
5. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
6. **If the concurrent care claim is denied,** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
   - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

- state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
- give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
- reference the specific Plan provision(s) on which the determination is based;
- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- provide an explanation of the Plan's internal appeal procedure and external review process along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process and external review process for urgent care claims;
- contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

7. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
   - CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (801) 973-1001 or toll free (800) 628-6562.

8. **If you disagree with a denial of a concurrent claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 17: APPEAL OF A DENIAL OF A CONCURRENT CARE CLAIM

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, at their phone number or address listed on the Quick Reference chart in the front of this document.

2. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:

- consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
- provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

3. A determination will be made on the appeal (without the opportunity for extension) as soon as possible before the benefit is reduced or treatment is terminated.

4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with follow-up written (or electronic, as appropriate) notice. If that determination is adverse, it will include:
   - information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal or external review;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - an explanation of the Plan's 2nd level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and (if applicable) your State insurance regulatory agency;" and
   - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
   - CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (801) 973-1001 or toll free (800) 628-6562.

6. This concludes the concurrent claim appeal process under this Plan.

Section 18: HOW TO FILE A PRE-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

1. A claim for pre-service (as defined in this Article) must be made by a claimant or the claimant's authorized representative (as described in this Article) in accordance with this Plan's claims procedures outlined in this Article.

2. A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in Article IX of this document) to the Appropriate Claims Administrator (as defined in this Article).

3. The pre-service claim will be reviewed no later than 15 calendar days from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.

4. The 15 calendar day review period may be extended one time for up to 15 additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15-day period by using a written Notice of Extension.

5. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

6. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.

7. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.

8. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will make if no additional information is received.

9. The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

10. **If the pre-service claim is approved** you will be notified orally and in writing (or electronic, as applicable).

11. **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
    - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
    - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
    - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
    - reference the specific Plan provision(s) on which the determination is based;
    - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    - provide an explanation of the Plan's internal appeal procedure and external review process along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process and external review process for urgent care claims;
    - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed; and
    - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
    - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
    - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

12. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
    - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
    - CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (801) 973-1001 or toll free (800) 628-6562.

13. **If you disagree with a denial of a pre-service claim,** you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 19: APPEAL OF A DENIAL OF A PRE-SERVICE CLAIM

This Plan maintains a 2 level appeals process. Appeals must be in writing to the Appropriate Claims Administrator (as outlined under the Definitions section of this Article). You will be provided with:

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate,: the appropriate named fiduciary will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. Under this Plan's 2 level appeal process, the Plan subcontracts the first level of review to the Appropriate Claims Administrator who will make the first level determination on the pre-service appeal no later than 15 calendar days from receipt of the appeal.
2. There is **no extension permitted** to the Plan in the first or second level of the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
3. If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Board of Trustees whose address is listed on the Quick Reference chart in the front of this document.
4. A second level determination will be made no later than 15 calendar days from receipt of the second level appeal.
5. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
6. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
7. You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:
   - information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal or external review;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
   - a statement that you have the right to bring civil action under ERISA section 502(a) following the appeal;
   - an explanation of the Plan's 2nd level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and (if applicable) your State insurance regulatory agency;" and
- disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

8. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
   - CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (801) 973-1001 or toll free (800) 628-6562.
9. This concludes the pre-service appeal process under this Plan.

Section 20: OUTLINE OF THE TIMEFRAMES FOR THE CLAIM FILING AND CLAIM APPEAL PROCESS

For the insured benefits of the Plan, such as Life insurance and the Dental Plan, follow the claims and appeal procedures outlined in the documents produced by those insurers.

Overview of Claims and Appeals Timeframes					
	Urgent	**Concurrent**	**Pre-service**	**Post-service**	**Disability**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days	45 days
Extension permitted during initial benefit determination?	No[1]	No	Yes, one 15-day extension.	Yes, one 15-day extension.	Yes, up to 2 extensions each 30 days in duration.
First (initial) Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	30 days	within the timeframe for Board meetings, outlined below	within the timeframe for Board meetings outlined below
Second Appeal Review must be submitted to the Plan within:	NA	NA	180 days of receipt of the first level appeal determination	NA	NA
Extension permitted during appeal review?	No	No	No	NA	NA

[1]: no formal extension for urgent care claims but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

Post-service and Disability Appeal Timeframes for Multiemployer Plan with Committee or Boards of Trustees that meet at least Quarterly		
Appeal filed **within 30 days** of the next Board meeting:	Board review occurs no later than the second meeting following receipt of the appeal.	If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal.
Appeal filed **more than 30 days** before next Board meeting:	Board review occurs at the next Board meeting date.	If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal.

Board's decision on the appeal to be provided to claimant as soon as possible after the Board decision but no later than 5 days after the Board's decision date.

Section 21: LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until the Plan fails to respond to you in the timeframes applicable to your claim or appeal.

The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly. No lawsuit may be started more than three years after the end of the year in which services were provided.

Section 22: DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Section 23. ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Section 24. EXTERNAL REVIEW OF CLAIMS

This External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim including a claim under the PCA plan is denied and it fits within the following parameters:

- The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or
- The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. This **external review process does not pertain** to claims for life/death benefits, AD&D, or disability or if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. Generally, you may only request external review after you have exhausted the internal review and appeals process described above.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

1. **External Review of Standard (Non-Urgent) Claims**.

   Your request for external review of a standard (not urgent) claim must made, in writing, **within four (4) months of the date that you receive notice** of an Initial Claim Benefit Determination or adverse Appeal Claim Benefit Determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

   Because the Plan's internal review and appeals process, generally, must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Appeal Claim Benefit Determinations.

   A. **Preliminary Review of Standard Claims**.

      1.) Within five (5) business days of the Plan's receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

a. You are/were covered under the Plan at the time the health care item or service is/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 Determination satisfies the above-stated requirements for external review and does not relate to your failure to meet the requirements for eligibility under the terms of the Plan or to a denial that is based on a contractual or legal determination or to a failure to pay premiums causing a retroactive cancellation of coverage;

c. You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations you are not required to do so); and

d. You have provided all of the information and forms required to process an external review.

2.) Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

a. If your request is complete and eligible for external review; or

b. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

c. If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. **Review of Standard Claims by an Independent Review Organization (IRO)**.

1.) If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

b. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. **Reconsideration** by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

d. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

e. The assigned IRO will provide written notice of its final external review decision to you and the Plan **within 45 days** after the IRO receives the request for the external review.

(1) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed

claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(2) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

f. The assigned IRO's decision notice will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

(2) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

(4) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

(5) A statement that the IRO's determination is binding on the Plan and you (unless other remedies may be available to you or the Plan under applicable State or Federal law);

(6) A statement that judicial review may be available to you; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

g. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

2. External Review of Expedited Urgent Care Claims.

A. You may request an expedited external review if:

1.) you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal 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

2.) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which 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, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

B. **Preliminary Review for an Expedited Claim**.

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

C. **Review of Expedited Claim by an Independent Review Organization (IRO)**.

1.) Following the preliminary review that a request is eligible for expedited external review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

2.) The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

3.) The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

4.) The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

a. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

b. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

3. Overview of the Timeframes During the Federal External Review Process.

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan performs preliminary review	Within 5 business days following receipt of an external review request	Immediately
• Plan's notice to claimant regarding the results of the preliminary review	Within 1 business day after Plan's completion of the preliminary review	Immediately
• When appropriate, claimant's timeframe for perfecting an incomplete external review request	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan assigns case to IRO	In a timely manner	Expeditiously
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the Plan to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously
IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously
If (on account of the new information) the Plan reverses it denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's adverse benefit determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

ARTICLE XV: COORDINATION OF BENEFITS (COB)

Section 1: HOW DUPLICATE COVERAGE OCCURS

This Article describes the circumstances when you or your covered Dependents may be entitled to health care benefits (including medical and vision) under this Plan and may also be entitled to recover all or part of your health care expenses from some other source. In this Article the term "you" references all covered Plan Participants. In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

1. Another group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA continuation coverage); or
2. Medicare; or
3. Other government program, such as Medicaid, Tricare, or a program of the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical/dental/vision expenses, or any coverage provided by a federal, state or local government or agency; or
4. Workers' compensation.
5. Coverage resulting from a judgment at law or settlement.
6. Any responsible third party, its insurer, or any other source on behalf of that party.
7. Any first party insurance (e.g. medical, personal injury, no-fault, underinsured motorist or uninsured motorist coverage).
8. Any policy from any insurance company or guarantor of a third party
9. Any other source (e.g. crime victim restitution, medical, disability, school insurance).

The Plan's benefit coverage is excess to other responsible parties' coverage sources such as coverage from a judgment, settlement, or any responsible party.

Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

This Article describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the subrogation provisions in this Article). Duplicate recovery of health care expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

Section 2: COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits Article, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the Covered Individual or that provides health care services to the Covered Individual. A "group plan" provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage (including but not limited to a plan that provides the Covered Individual with COBRA continuation coverage).
2. Many families that have more than one family member working outside the home are covered by more than one medical, vision or dental plan. If this is the case with your family, **you must let this Plan and its Claims Administrators or its insurers know about <u>all</u> your coverages when you submit a claim.**
3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Section 3: WHICH PLAN PAYS FIRST: ORDER OF BENEFIT DETERMINATION RULES

The Overriding Rules

1. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**
2. When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee); then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose Birthday falls later in the calendar year pays second, if:
   1. the parents are married;
   2. the parents are not separated (whether or not they ever have been married); or
   3. a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

B. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

C. The word "Birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, that plan pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree. If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose Birthday falls later in the calendar year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their Spouses (if any) is:
   1. The plan of the custodial parent pays first; and
   2. The plan of the non-custodial parent pays second; and
   3. The plan of the Spouse of the custodial parent pays third; and
   4. The plan of the Spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

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

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

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

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:
   1. in the amount or scope of a plan's benefits;
   2. in the entity that pays, provides or administers the plan; or
   3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Section 4: HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY

a. Secondary Liability of this Plan For Active Employee Plan Participants and Early (non-Medicare eligible) Retirees: When this Plan pays second, it will pay, 100% of "Allowable Expenses" **less** whatever payments were actually made by the plan (or plans) that paid first. It will reduce its benefits so that the total benefits paid or provided by all coordinating plans is not more than 100% of total allowable expenses and in no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first.

b. Secondary Liability of this Plan for Medicare-eligible Retirees before their first self-payment is made: When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were actually made by the plan (or plans) that paid first. In no case will this Plan pay more in benefits for each claim as it is submitted than it would have paid had it been the Plan that paid first. This has the effect of maintaining this Plan's Deductibles, coinsurance and exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the covered health care services. After the first self-payment is made, this Plan pays in accordance with the provisions under the section on "Coordination with Medicare" in this Article.

c. Benefit Reserve for Active Employee Plan Participants and Early (non-Medicare eligible) Retirees: This Plan does administer a benefit reserve (also called a benefit bank, credit balance, credit reserve or credit savings) calculation in the coordination of benefits ONLY for Active Employee Plan Participants and Early Retirees. When it does so, this Plan will calculate its savings by subtracting the amount that it pays as the secondary plan from the amount that it would have paid had it been the primary plan. These savings will be recorded as a benefit reserve for the covered person for whom the claim is being determined and those savings in the benefit reserve will be used by the secondary plan to pay any allowable expenses not otherwise paid from all previous claims incurred by that covered person during the current calendar year.

At the end of the calendar year, all unused amounts in the benefit reserve are canceled and a new benefit reserve will be established with respect to claims incurred in the following calendar year. Guidelines about this Plan's benefit reserve include:

- The benefits reserve is used to pay claims incurred during any one calendar year and the benefit reserve cannot be carried over from one calendar year into the next.
- The benefits reserve must be used throughout the entire calendar year until the reserve amount is exhausted even though the other group health plan may have terminated during the calendar year.
- The benefits reserve cannot be transferred and cannot be used to pay claims incurred by another family member.
- Benefit reserve accumulations may be used to pay for allowable expenses that are covered only in part by both plans. The benefit reserve is not used to pay an amount the primary plan did not pay because the allowable expense was reduced (such as for failure to obtain precertification).
- The benefit reserve is not used to provide payments for benefits that have reached a plan limitation, or are excluded by the Plan.

d. "Allowable Expense" means the **lowest** of the a health care service or expense, including Deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is medically necessary.

- If the coordinating plans determine benefits on the basis of Usual and Customary Charges, any amount in excess of the highest Usual and Customary Charge is not an allowable expense.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If one coordinating plan determines benefits on the basis of Usual and Customary Charges and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Precertification/Medical Review in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Section 5: ADMINISTRATION OF COB

a. To administer COB, the Plan reserves the right to:
   - exchange information with other plans involved in paying claims;
   - require that you or your Health Care Provider furnish any necessary information;
   - reimburse any plan that made payments this Plan should have made; or
   - recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.

b. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

c. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

d. This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

e. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

f. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.

g. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Section 6: COORDINATION WITH MEDICARE

a. **Entitlement to Medicare Coverage:** Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (generally after a waiting period).

b. **Medicare Participants May Retain or Cancel Coverage Under This Plan:** If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible employee remains actively employed, that employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

   If an eligible individual under this Plan is covered by Medicare and an employee cancels coverage under this Plan, coverage of their Spouse and/or Dependent Child(ren) or Domestic Partner or Domestic Partner Dependent Child, will

terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA Article for further information about COBRA Continuation Coverage.

If any of the eligible employee's Dependents are covered by Medicare and the employee **cancels** that Dependent's coverage under this Plan, that Dependent will **not** be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

c. **Coverage Under Medicare and This Plan When Totally Disabled:** If an eligible employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the eligible employee will no longer be considered to remain actively employed. As a result, once the employee becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an eligible dependent of an Active Employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that dependent and Medicare pays second. This Medicare secondary payer rule applies to employers with 100 or more employees.

d. **Coverage Under Medicare and This Plan for End-Stage Renal Disease:** If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

e. **How Much This Plan Pays When It Is Secondary to Medicare**

1. **When Covered by this Plan and also by Medicare Parts A, and/or B:** When an eligible individual under this Plan is also covered by Medicare Parts A, and/or B and this Plan is secondary to Medicare, this Plan pays as follows: the Plan's Deductible is taken on the balance after Medicare's payment or allowance, then the Plan pays the appropriate coinsurance on the balance. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Billed Charges of the Health Care Provider.

IMPORTANT NOTE FOR MEDICARE-ELIGIBLE RETIREES AND THEIR MEDICARE-ELIGIBLE DEPENDENTS

Benefits that are paid for by this Plan for Medicare-eligible Retirees and their Medicare-eligible dependents are reduced by the amounts payable under Medicare Parts A (Hospital), and B (Professional services). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Part A and B; therefore, <u>if you are Medicare-eligible you should consider enrolling in Medicare Part A and B in order to receive the maximum amount of benefits under this Plan.</u>

2. **When Covered by this Plan and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) without prescription drug benefits:** If an individual is covered by both this Plan and a Medicare Advantage program, <u>this Plan will NOT reimburse any applicable copayments and will NOT pay the same benefits provided for active.</u>

3. **When Covered by this Plan and <u>Eligible for but Not Covered</u> by Medicare:** When the Covered individual is covered by this Plan and is also **eligible for, but is not enrolled in Medicare Parts A, B and/or D**, this Plan pays the same benefits provided for active employees less the amounts that would have been paid by Medicare had the individual been covered by Medicare Parts A, and B and not on the Billed Charges of the Health Care Provider.

4. **When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract:** Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare), under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract this Plan will <u>NOT</u> pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

5. **When Covered by this Plan and also by Medicare and the Veteran's Affairs benefits**: Either Medicare or Veteran's pays first, this Plan pays second. Under Medicare's COB rules, Veteran's (VA) claims will not be covered. If a claim is not filed with the VA, then Medicare will pay. VA and Medicare will not both reimburse on the same claim.

6. **When Covered by this Plan and also by a Medicare Part D Plan Prescription Drug Plan:** Any Medicare-eligible person can elect coverage under a Medicare prescription drug plan in place of, or in addition to, this group health Plan's prescription drug coverage. Medicare must be notified of any duplicate prescription drug coverage that you maintain.
    a. If you have dual coverage under both this Plan and Medicare Part D, the following explains if and how this Plan and Medicare will coordinate that dual coverage:
        1. For Medicare-eligible Retirees and their Medicare-eligible Dependents, Medicare Part D coverage is primary and this group health plan DOES NOT pay secondary.
        2. For Medicare eligible Active Employees and Early (non-Medicare eligible) Retirees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.
    b. For more information on Medicare Part D refer to the "Medicare and You" handbook provided to you by Medicare or www.medicare.gov or contact the Administrative Office.

Section 7: COORDINATION WITH OTHER GOVERNMENT PROGRAMS

a. **Medicaid**: If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or a State Children's Health Insurance Program (CHIP) pays second.

b. **Tricare**: If a Covered Dependent is covered by both this Plan and the Tricare Program, the program that provides health care services to dependents of active armed services personnel, this Plan pays first and Tricare pays second. For an employee called to active duty for more than 30 days, and who is covered by both Tricare and this Plan, Tricare is primary and this plan is secondary.

c. **Veterans Affairs Facility Services**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are an Allowed Charge.

d. **Motor Vehicle Coverage Required by Law**: If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage (or should have been covered because of state law), including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second.

e. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

f. **Other Coverage Provided by State or Federal Law**: If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Section 8: WORKERS' COMPENSATION

a. This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law (or should have been covered but such coverage was declined/not purchased). If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, the individual must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee.

Section 9: THIRD PARTY LIABILITY/SUBROGATION

1. **Reimbursement for Expenses paid as a result of Acts of Third Parties**. If a Participant or Beneficiary receives benefits from this Trust for an injury or illness sustained from the acts or omissions of any third party, the Trust shall have the right to be reimbursed in the event the Participant or Beneficiary recovers all or any portion of the benefits paid by the Trust by legal action, settlement, or otherwise, regardless of whether such benefits were paid by this Trust prior to or after the date of any such recovery. The Participant or Beneficiary will not be entitled to receive any benefits for such expenses under this Trust unless he executes a Subrogation Agreement and agrees in writing to the following conditions:

    a. **Reimbursement to Trust**. The Participant or Beneficiary authorizes reimbursement to the Trust upon obtaining any monetary recovery from any party or organization for such injury or illness, whether by action at law, settlement or otherwise by virtue of executing a Subrogation Agreement, with the understanding that any and all monies recovered as a result of the actions of a third party shall be reimbursed to the Trust in accordance with these provisions.

    b. **Assignment of Rights**. The Participant or Beneficiary irrevocably assigns to the Trust all rights to recover monetary compensation from the third party to the extent of all benefits paid by this Plan and to give notice of this assignment directly to such third parties, their agents or insurance carriers, or to any agent or attorney who may represent the

Participant or Beneficiary. The assignment shall entitle the Trust to reimbursement from any sums to be held or received by the following third parties which are due to the Participant or Beneficiary prior to any distribution of funds to the Participant or Beneficiary, and shall provide that such parties shall specifically direct that any and all monies recovered from any third party are to be reimbursed to the Trust in accordance with these provisions. The parties who shall be bound by such assignment are:

(1) Any party or its insurance carriers making payments to or on behalf of the Participant or Beneficiary, including pursuant to any uninsured or under-insured motorist provision of any insurance policy; or,

(2) Any agent or attorney receiving payments for or on behalf of the Participant or Beneficiary.

c. **Notice**. The Participant or Beneficiary agrees to notify the Trust of any claim or legal action asserted against any third party or any insurance carrier(s) for such injuries or illnesses, as well as the name and address of such third parties, insurance carrier(s), any agent or attorney who is representing or acting on behalf of the Participant or Beneficiary or the estate of the Participant or Beneficiary, or any person claiming a right through such Participant or Beneficiary, on a form to be supplied by the Trust.

d. **Schedule of Reimbursement**. The Trust shall be reimbursed in accordance with the following schedule based on the net recovery received by the Participant or Beneficiary from all sources, whether from more than one tortfeasor, under any Worker's Compensation law or otherwise:

Net Recovery	Trust Reimbursement
2 times or more of benefits paid by the Trust	100% of benefits paid
1½ times or more of benefits paid by the Trust	75% of benefits paid
Equal or more of benefits paid by the Trust	66 % of benefits paid
½ or more of benefits paid by the Trust	50% of benefits paid
Less than ½ of benefits paid by the Trust	33 % of benefits paid

(1) For the purpose of this Section "net recovery" means the actual amount to be received by the Participant or Beneficiary from all sources after deducting all attorney's fees and court costs actually incurred.

(2) In no event will the Trust's recovery exceed the amount of all proceeds received by the Participant or Beneficiary from the third party or its insurers.

e. **Subrogation.** The Plan shall have the independent right to bring suit in the name of the Participant or Beneficiary. The Plan shall also have the right to intervene in any action brought by the Participant or Beneficiary against any third party, to and including the insurance carrier of the Participant or Beneficiary under any uninsured or under-insured motorist provision or policy. The Participant or Beneficiary further agrees to take no action inconsistent with the requirements of this provision.

f. **Cooperation With Trust**. The Participant or Beneficiary agrees to cooperate fully with the Trustees in the exercise of any Assignment or right of Subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Trust.

g. **Withholding Future Benefits**. The Participant or Beneficiary agrees to acknowledge that this Trust shall have the Right of Recovery against the Participant or Beneficiary, should the Participant or Beneficiary and/or their legal representative fail to execute an Assignment, Subrogation Agreement or any other documents required herein, or fail to reimburse the Trust in accordance with these provisions. In addition, in such event, the Trust may withhold future benefit payments to be made on behalf of the Participant or Beneficiary until such time as the Trust is fully reimbursed as provided for in this Section.

h. **Disclaimer.** If there is any reasonable cause to believe that the injuries or illnesses sustained by a Participant or Beneficiary were in any way the result of the acts or omissions of a third party or parties, but the Participant or Beneficiary disclaims any third party involvement, the Trust shall have the right to require the Participant or Beneficiary to sign a declaration, under penalty of perjury, regarding such disclaimer as a pre-condition to the payment of any benefits.

i. **Separate Rights**. Each of the provisions set forth above relating to the right of this Trust to receive reimbursement for eligible expenses paid to or on behalf of a Participant or Beneficiary because of injuries sustained relating to or resulting from the acts and omissions of any third party is separate and any illegality or invalidity of any one provision shall not affect the legality or validity of any other provision.

j. **Medical Expenses Incurred After Settlement or Final Judgment in Third Party Claim**. In the event a Participant or Beneficiary incurs medical expenses relating to his or her injuries or disabilities which are the subject of a Subrogation Agreement following any settlement or final judgment received from the third party (ies) responsible for

the injuries, the Plan shall have no further responsibility to pay for such medical expenses, except as provided below. The Participant or Beneficiary shall agree to release and hold the Trust harmless from any further obligations under the Subrogation Agreement for any future medical expenses incurred following any settlement or final judgment received from the third party(ies) responsible for the injuries, except as provided below. Provision can be made for the continued payment of such medical expenses under the following circumstances:

(1) Payment by the responsible third party(ies) pursuant to a settlement agreement which is approved by the Fund in writing prior to the execution thereof. In that event, the rights of the Participant or Beneficiary to the continued payment of medical expenses shall also be assigned to the Trust under the Subrogation Agreement and the Participant or Beneficiary shall be required to reimburse the Trust for 100% of all medical expenses paid by the Trust under this provision following execution and payment by the responsible third party(ies) under the settlement agreement or final judgment.

(2) At the discretion of the Trustees, payment by the Fund following settlement or final judgment a Participant or Beneficiary receives from the third party(ies) responsible for the injuries or responsible for reimbursement of the injuries, to the extent that there are no remaining net settlement proceeds to pay for further medical expenses and all third party insurance policy limits have been exhausted, and the Participant or Beneficiary certifies under penalty of perjury that there are no further sources of third party recovery to pursue.

k. **This Plan does not recognize the Make-Whole Doctrine**. This Plan is entitled to obtain restitution of any amounts owed to it either from third-party funds received by the Participant or the Beneficiary, regardless of whether the Participant or the Beneficiary have been made whole for losses sustained as a result of the act of a third party.

l. **This Plan expressly rejects the Common Fund Doctrine with respect to payment of attorney's fees.** A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise this plan's equitable (or other) right to obtain full restitution.

m. **Cooperation with Trust**. The Participant or Beneficiary, as well as their attorney or agent, shall cooperate fully with the Trustees in the exercise of any Assignment or right of Subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Trust.

n. **Direction to Agent or Attorney**. The Participant or Beneficiary shall direct that the agent or attorney shall readily comply with the terms of the Subrogation Agreement to reimburse the Trust in accordance with the Reimbursement Schedule as outlined above.

ARTICLE XVI: GENERAL PROVISIONS AND ERISA INFORMATION

Section 1: NAME OF THE PLAN

Eighth District Electrical Benefit Fund

Section 2: NAME AND ADDRESS OF PLAN SPONSOR/PLAN ADMINISTRATOR

Board of Trustees of the Eighth District Electrical Benefit Fund
P. O. Box 30101
Salt Lake City, Utah 84130-0101
Phone: 801-973-1001 or 1-800-628-6562

This Plan is administered exclusively by the Board of Trustees which consists of representatives appointed by the Union and by the Employers through their collective bargaining associations. The Trustees serve without compensation.

Section 3: EMPLOYER IDENTIFICATION NUMBER (EIN)

84-0730298

Section 4: TYPE OF PLAN AND PLAN NUMBER

Employee Welfare Benefits Plan including:
1. Medical expense benefits (501);
2. Dental expense benefits (501);
3. Vision expense benefits (501);
4. Weekly Disability benefits (501)
5. Life Insurance and AD&D Insurance (501)
6. Dependent Life Insurance benefit (501)
7. Personal Care Account (501)

Section 5: TYPE OF ADMINISTRATION

The Eighth District Electrical Benefit Fund is a group health plan and self-funds the eligible medical (including transplants), personal care account (PCA), vision, weekly disability expense benefit and dependent life insurance benefits under the Plan. Claims for these benefits are administered by an independent claims administrator (referred to as the Administrative Office) as listed on the Quick Reference Chart in the front of this document.

Independent insurance companies (whose names and contact information is listed on the Quick Reference Chart in the front of this document) administer the fully insured benefits of this Plan (including dental plan, life insurance and accidental death and dismemberment (AD&D) insurance benefits) and provide payment of claims associated with these benefits.

Section 6: CLAIMS ADMINISTRATORS

With respect to all matters regarding eligibility and adjudication of medical, PCA, vision, weekly disability claims and dependent life insurance claims, please contact the Administrative Office at their address listed on the Quick Reference Chart in the front of this document.

With respect to the insured benefits of the Plan (Dental plan, Life insurance and accidental death and dismemberment (AD&D) insurance benefits), please contact the insurance companies whose names and contact information are listed on the Quick Reference Chart in the front of this document.

Section 7: AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the self-funded portion of the Plan, service of legal process may be made on any Plan Trustee or on the Plan's General Counsel:

Melissa W. Cook Esq.
3444 Camino Del Rio North, Suite 106
San Diego, CA 92108

or

Administrative Office
CompuSys
2156 West 2200 South
Salt Lake City, Utah 84119-1376

For disputes arising under those portions of the Plan that are insured, service of legal process may be made upon that Insurance Company at the address listed on the Quick Reference Chart in the front of this document, or upon the supervisory official of the State Insurance Department.

Section 8: COLLECTIVE BARGAINING AGREEMENT

This Plan is maintained according to collective bargaining agreements between employers and the Union. A copy of such agreement may be obtained by Plan participants upon written request to the Administrative Office, and is available for examination by Plan participants.

Section 9: FUNDING MEDIUM

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to Eligible Persons and defraying reasonable administrative expenses. All self-funded benefits are provided directly through the Trust Fund as set forth in the Plan Rules.

Section 10: CONTRIBUTION SOURCE

All contributions to the plan are made by employers in accordance with Collective Bargaining Agreements and participation agreements between the Eighth District Electrical Benefit Fund and employers in the industry. The Collective Bargaining and participation Agreements require contributions to the plan at a fixed rate per hour worked. The Administrative Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Eligible Persons working under the Collective Bargaining Agreement, additional information about the Collective Bargaining Agreement, and the Fund's investment of assets and checking accounts.

Section 11: PLAN YEAR

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31. Note that the contract year for Life and AD&D Insurance is from July 1 to June 30th.

Section 12: PLAN TRUSTEES (For current officer positions contact the Administrative Office)

Management Trustees

Patrick Carlson
Wyoming Chapter National Electrical Contractors Association
158 South Fenway
Casper, WY 82601

Union Trustees

Rodney James
IBEW Local #449
1537 Baldy Ave.
Pocatello, ID 83205-4949

Management Trustees

Klass DeBoer, Jr.
Intermountain Chapter National Electrical Contractors Association
2125 West 2300 South
West Valley City, UT 84119

Josh Wheeler
Wheeler Electric
469 W. 16th St
Idaho Falls, ID 83403

Jerry Grippa
Quality Service Corporation
2101 West Amherst Avenue
Englewood, CO 80110

James Peterson
Berwick Electric
3450 N. Nevada Ave, Suite 100
Colorado Springs, CO 80907

Mike Schmidt
Reddi Electric, Inc.
P. O. Box 20272
Billings, MT 59104

Rory Berumen, *Alternate*
Rocky Mountain Chapter, NECA
495 Uinta Way, Suite 240
Denver, CO 80203

Susan King, *Alternate*
Southern Colorado NECA
1070 S. Eighth St.
P. O. Box 61000
Colorado Springs, CO 80960

Union Trustees

Mike Ham
IBEW Local #113
2150 Naegele Rd
Colorado Springs, CO 80904

Keith Allen
IBEW Local #233
P. O. Box 131
Helena, MT 59624

Richard Kingery
IBEW Local #354
3400 West 2100 South
Salt Lake City, UT 84104

Charlie Dockham
IBEW Local #322
691 English Drive
Casper, WY 82601

Jim Mantele
IBEW Local #68
5660 Logan St
Denver, CO 80216

Dean Grinstead, *Alternate*
IBEW Local #12
P. O. Box 12
Pueblo, CO 81002

Jeff Morrow, *Alternate*
IBEW Local Union #415
810 Fremont Ave
Cheyenne, WY 82001

Section 13: PLAN'S REQUIREMENTS FOR ELIGIBILITY AND BENEFITS

The Plan's requirements with respect to eligibility as well as circumstance that may result in disqualification, ineligibility or denial or loss of benefits are described in the Eligibility Article in this document. The benefits provided by the Plan are described in the remaining Articles of this SPD/Plan Rules document such as in the Medical Plan, Dental Plan, Vision Plan, PCA Plan, Weekly disability benefits and other Articles described in the Table of Contents.

Section 14: STATEMENT OF ERISA RIGHTS

As a participant in the **Eighth District Electrical Benefit 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:

1. Examine, without charge, at the Administrative Office (whose address is listed on the Quick Reference Chart in the front of this document) 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 (formerly known as the Pension and Welfare Benefit Administration).
2. 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 Plan Administrator may make a reasonable charge for the copies.
3. 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

1. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the COBRA Article. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for Pre-Existing 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 insurer 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 Pre-Existing Condition exclusion for 12 months after your Enrollment Date in your coverage from another plan.

Prudent Actions by Plan Fiduciaries

1. In addition to creating rights for plan participants, ERISA imposes duties upon the 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.
2. 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

1. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a 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, as discussed in the Claims Filing and Appeals Information Article of this document.
2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents 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 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.
3. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the Plan's Claims Filing and Appeal information on the requirement to appeal a denied claim before filing a lawsuit.
4. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.
5. 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 suit in a 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 these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

1. 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 in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.
2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

Section 15: PAYMENT OF CLAIMS

Benefits under the Plan and this Restated Plan Document will be paid only after receipt by the Administrative Office of written notice of claim filed by the Participant or someone on the Participant's behalf if they are unable to file such written notice of claim, properly completed covering the occurrence, character and extent of the event for which the claim is made and supported by proper documentation.

Section 16: ASSIGNMENT OF BENEFITS

Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person; however, any Participant may direct that benefits due to them be paid to an institution in which the Participant or their Dependent is hospitalized, to any provider of medical services or supplies in consideration for medical, hospital, dental or vision services rendered or to be rendered, or supplies furnished or to be

furnished, or to any other person or agency that may have provided or paid for, or agreed to provide or pay for, any benefits payable hereunder. Benefits will be directly assigned to a Preferred Provider.

Section 17: FILING OF CLAIMS/APPEAL OF CLAIMS

Benefits will be paid by the Plan only if written notice of claim is filed in accordance with the Claim Filing and Claim Appeal Information Article of this document. Appeals may be made by following the appeals procedures discussed in the Claim Filing and Claim Appeal Information Article.

Section 18: AUTHORITY TO INTERPRET PLAN

The Board of Trustees, or where Board of Trustee responsibility has been delegated to others, such delegates shall have complete authority and discretion to determine the standard of proof required in any case, to determine eligibility and benefits, and to construe, apply and interpret this Restated Plan Document. The decisions of the Board of Trustees or its delegates shall be final and binding.

All questions or controversies, of whatsoever character, arising in any manner or between any parties or persons in connection with this Plan or its operation, whether as to any claim for benefits, or as to the construction of language or meaning of this Plan Document, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Board of Trustees or, where Board of Trustee responsibility has been delegated to others, to such delegates for decision. The decision of the Board of Trustees or its delegates shall be binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court having jurisdiction over such matters.

Section 19: PROOF OF CLAIM

The Board of Trustees, at its own expense, shall have the right and opportunity to examine the person of any Participant when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Notice of claim forms, as well as other forms and methods of administration and procedure, will be solely determined by the Trustees.

Section 20:WORKERS' COMPENSATION

The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance Laws or similar legislation.

Section 21: TRUST AGREEMENT

The provisions of this Restated Plan Document are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Restated Plan Document and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

Section 22: FACILITY OF PAYMENT

In the event the Plan determines that the Participant is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Participant has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Participant, pay any amount otherwise payable to the Participant to the husband or wife or relative by blood of the Participant, or to any other person or institution determined by the plan to be equitably entitled thereto; or in the case of the death of the Participant before all amounts payable under the Plan have been paid, the Plan may pay any such amount to any person or institution determined by the Plan to be equitably entitled thereto.

The remainder of such amount shall be paid to one (1) or more of the following surviving relatives of the Eligible Employee: lawful Spouse, Domestic Partner, child or children, mother, father, brothers or sisters, or to the Participant's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

Section 23: SUBROGATION

This Plan shall be subrogated and shall succeed to the Participant's rights of recovery from a third party or under any uninsured or underinsured automobile insurance coverage for incurred Hospital, medical and surgical expenses. The Participant shall pay over to the Plan all sums recovered by suit, settlement or otherwise in an amount equal to such services or benefits which the Plan provided, subject to the provisions of any Subrogation Assignment Agreement between the Participant and the Fund. The Participant shall, upon request, execute and deliver such instrument or papers including a written subrogation agreement with the Plan as may be required and do whatever else is necessary to carry out this provision. Refer also to the Coordination of Benefits Article.

Section 24: AMENDMENT AND TERMINATION

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all employees, the Board of Trustees expressly reserves the right, at any time and from time to time, but upon a non-discriminatory basis to:

a. terminate, change, or amend either the amount or the conditions with respect to any benefit;
b. alter or postpone the method of payment of any benefit;
c. amend, change, or rescind any provisions of this Restated Plan Document;
d. determine the amount of the required contribution by Contributing Employers and Participants;
e. change the providers for any portion of the plan of benefits; or
f. terminate the plan of benefits in its entirety or terminate portions of the plan of benefits.

Such amendment, termination or change shall be documented in written amendment form approved by action of the Board of Trustees.

Section 25: DISCLAIMER

None of the medical, personal care account, vision, dependent life insurance, or weekly disability benefits provided in this Restated Plan Document are insured by any contract of and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amounts in the Fund collected and available for such purpose.

Section 26: TITLES

Titles of provisions are for convenience of reference only and are not to be considered in interpreting this Plan. The headings of chapters/articles, sections, subchapters or subsections and text appearing in bold or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

Section 27: GENDER

Wherever any words are used in this Plan in masculine gender, they should be construed as though they were also used in the feminine gender in all situations where they would so apply; wherever any words are used in the Plan in the singular form, they should be construed as though they were also in the plural form in all situations where they would so apply, and vice versa.

Section 28: NON-REVERSION OF EMPLOYER REFUNDS

It is expressly understood that in no event shall any of the corpus or assets of the Plan revert to the Contributing Employers or Participants or be subject to any claims of any kind or nature by the Contributing Employers or Participants, except for employee benefits made available to Participants, under the Plan, provided, however, that contributions made by a Contributing Employer by mistake of fact or law (other than a mistake relating to whether the Plan is described in Section 401(a) of the Internal Revenue Code of 1986 or the Trust which is part of such Plan is exempt from taxation under Section 501(a) of such Code) may be returned to such Contributing Employer within six (6) months after the Administrative Office determines that the contribution was made by such a mistake.

Section 29: NO VESTED RIGHTS

No Participant, or any other person shall have any vested right to any benefit(s) provided by the Plan or under this Restated Plan Document.

Section 30: SUBMISSION OF FALSIFIED OR FRAUDULENT CLAIMS (RESCISSION OF COVERAGE)

All claims or enrollment cards submitted to the Fund shall be honest, accurate and as complete as possible. If the Board of Trustees finds, at any time, that there has been an intentional falsification of any document submitted in support of a claim, either by use of forgery or intentionally inaccurate information or any other fraudulent means whatsoever, it shall have the right to terminate coverage (after giving at least a 30-day written notice). The coverage to be terminated, if the Board of Trustees so determines, shall be that of the Eligible Employee and Dependents and Domestic Partners and Domestic Partner Dependent Children who are related to the person submitting the false or fraudulent claim. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent:

a. made a fraudulent statement, a material misrepresentation, or omitted any material information in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or
b. allowed anyone else to use the identification card that entitles you or your covered Dependent to coverage, services or benefits under the Plan.

You may appeal a rescission determination by following the post-service claims process outlined in Article XIV.

Section 31: NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Board of Trustees or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability

whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Section 32: WOMEN'S HEATH AND CANCER RIGHTS ACT (WHCRA) AND NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NEWBORNS' ACT)

This Plan complies with the Women's Health and Cancer Rights Act and the Newborns' and Mothers' Health Protection Act. See the information described under Reconstructive services and Maternity services in the Schedule of Medical Benefits chart in this document.

Section 33: HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Protected Health Information (PHI). The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH).

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

a. **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

b. **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

   1. determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
   2. coordination of benefits;
   3. adjudication of health benefit claims (including appeals and other payment disputes);
   4. subrogation of health benefit claims;
   5. establishing employee contributions;
   6. risk adjusting amounts due based on enrollee health status and demographic characteristics;
   7. billing, collection activities and related health care data processing;
   8. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
   9. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
   10. medical necessity reviews or reviews of appropriateness of care or justification of charges;
   11. utilization review/medical review, including precertification, preauthorization, concurrent review and retrospective review;
   12. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: 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.

c. **Health Care Operations** include, but are not limited to, the following activities:

   1. quality assessment, patient safety activities;
   2. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contracting health care providers and patients with information about treatment alternatives and related functions;
   3. rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
   4. underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding (surrendering), securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
   5. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. business planning and development, such as conducting cost-management and planning related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. business management and general administrative activities of the Plan, including, but not limited to (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or (b) customer service, including the provision of data analyses for Eighth District Electrical Benefit Funds, plan sponsors or other customers;
8. resolution of internal grievances; and
9. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

d. **The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary.** With a written authorization, the Plan will disclose PHI to another benefit plan for purposes related to administration of that plan. Generally the Plan will require that you sign a valid authorization form (available from the Administrative Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

e. **For Purposes of This Section the Board of Trustees Is the Plan Sponsor**. The Plan shall disclose PHI to the Plan Sponsor for the purpose of deciding health claim appeals. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

f. **With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions**. The Sponsor agrees to:

1. not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. ensure that any subcontractors or independent contractors, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
4. not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
5. report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. make PHI available to an individual in accordance with HIPAA's access requirements;
7. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. make available the information required to provide an accounting of disclosures;
9. make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
10. if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such 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).
11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

g. **Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained**. In accordance with HIPAA, only the Board of Trustees, other Plan contracted Covered Entities and Business Associates may be given access to PHI.

h. **Limitations of PHI Access and Disclosure**. The persons described in section g. may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan. If the persons described in section g. do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance.

i. **HIPAA Security Rule Compliance**. The Plan Sponsor will:

1. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan,
2. ensure that the adequate separation discussed in f. above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

3. ensure that any agent or independent contractor, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. report to the Plan any security incident of which it becomes aware concerning electronic PHI.

ARTICLE XVII: DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions pertaining to a particular Article are found in that Article.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related. See also the term Injury to Teeth.

Active Employee: means any employee who meets the hour bank eligibility rules or the Non-Bargaining Participation provisions as set forth in Article III.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

Administrative Office: means the individual or entity designated and engaged by the Board of Trustees to administer the Plan and process benefit claims. See the Quick Reference Chart in the front of this document.

Adverse Benefit Determination: See the Claim Filing and Appeal Information Article for the definition.

Allowable Expense: A health care service or expense, including Deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering a Plan Participant (see also the COB Article of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

Allowed Charge/Allowed Amount/Allowable Charge: means the amount this Plan allows as payment for eligible medically necessary services or supplies. The allowed charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. **With respect to a network provider** (PPO network Health Care or Dental Care provider/facility), the fee set forth in the agreement between the PPO network Health Care or Dental Care Provider/facility and the PPO network or the Plan; or
2. **With respect to a non-network provider**, allowed charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers. The Plan's allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR) or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this Article; or
3. **For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer,** including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed charge amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as an In-Network claim; or
4. The Health Care or Dental Care Provider's/facility's actual **billed charge**.
5. **With respect to a non-network provider for other than Emergency Room services**, allowed charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers.
6. **With respect to a non-network provider for Emergency Room services**, allowed charge amount means the greater of the following:
   a. the amount negotiated with in-network providers for emergency services (see "1" noted above), excluding any in-network copayment or coinsurance applied; or
   b. the amount for the emergency services calculated using the same method the plan generally uses to determine payments for out-of-network services, (see "4" above), excluding any in-network copayment or coinsurance applied, or
   c. the amount that would be paid under Medicare (part A or part B) for the emergency service, excluding any in-network copayment or coinsurance applied.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "allowed charge" amount for health care services or supplies. Any amount in excess of the "allowed charge" amount does not count toward the Plan's annual Coinsurance Maximum and/or Out-of-Pocket Limit. Participants are responsible for amounts that exceed "allowed charge" amounts by this Plan.

Ambulance: A vehicle, helicopter, airplane or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located. An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this Article, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Applied Behavior Analysis (ABA) Therapy: is the design, implementation, and evaluation of environmental modifications to attempt to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior. ABA strives to improve speech and social interaction skills and reduce disruptive behavior and includes instruction in a range of skills including speech, motor and socialization. ABA Therapy is a technique that some use for individuals diagnosed with Autism Spectrum Disorder (that refers to disorders defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) manual as autistic disorder, asperger's syndrome or pervasive developmental disorder). Applied Behavior Analysis Therapy is not a covered benefit.

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are medically necessary.

Assistant Surgeon: An assistant surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an assistant surgeon actively assists the physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This plan allows payment of an assistant surgeon under the following conditions:

a. the individuals functioning as an assistant surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Registered Nurse First Assistant (RNFA) or Certified Surgical Assistant (CSA, SA-C), but not an employee of a hospital or surgical facility, or an intern, resident or other trainee; and
b. the use of an assistant surgeon is determined by the Plan Administrator or its designee to be medically necessary; and
c. the assistant surgeon actively participated in the surgical procedure (was not stand-by).

Authorized Representative: See the Claim Filing and Appeal Information Article for the definition.

Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between what this Plan pays and what the provider actually charged. Generally, amounts for which balance billing is made are never covered by this Plan, even if the Plan's Coinsurance Maximum and/or Out-of-Pocket limits are reached because they usually involve expenses that are not covered by the Plan. See the provisions related to the Plan's Coinsurance Maximum and Out-of-Pocket Limits for more details. See also the definition of Allowed Charge in this Article. Note that amounts over Allowed Charges do not count toward the Plan's Coinsurance Maximum and/or Out-of-Pocket Limit and may result in balance billing to you. Typically, in-network providers do not balance bill. **Out-of-Network Health Care Providers commonly engage in balance billing a Plan participant for any balance that may be due in addition to the amount payable by the Plan. Generally you can avoid balance billing by using In-Network providers.**

Bargaining Employee. "Bargaining Employee" means an employee on whose behalf a Contributing Employer makes hourly contributions to the Fund under a collective bargaining agreement.

Behavioral Health Disorder: A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things, autism, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by Behavioral Health Practitioners as defined in this Article. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted

in the Medical Plan Exclusions Article of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Behavioral Health Practitioners: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a Master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Behavioral Health Treatment: Behavioral Health Treatment includes all inpatient services, including room and board, given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health or Substance Abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code is considered a Behavioral Health Treatment for the purposes of this Plan.

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.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the Allowed Charge, after calculation of all Deductibles, Coinsurance and Copayments, and after determination of the Plan's exclusions, limitations and maximums.

Biofeedback: Biofeedback is a technique an individual can learn in order to control certain of their bodily processes that normally happen involuntarily, such as heart rate, blood pressure, muscle tension, and skin temperature. With biofeedback, an individual is connected to electrical sensors that help them receive information (feedback) about their body (bio). This feedback (often shown on a display monitor) helps the individual focus on making subtle changes in their body, such as relaxing certain muscles, to achieve the desired results, such as reducing pain. Biofeedback can give a person the power to use their thoughts to control certain aspects of their body, often to help with control a health condition or reduce stress.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Birth (or Birthing) Center that is part of a Hospital, as defined in this Article, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Board of Trustees. "Board of Trustees" means the Board of Trustees established by the Trust Agreement.

Breastfeeding/Lactation Educator: is a provider who is currently certified as a lactation consultant by the International Board of Lactation Consultant Examiners (IBLCE). If not IBLCE certified, the provider MUST be a licensed, registered, or certified health care professional with referenced experience and training in lactation management. Breastfeeding/lactation educators help mothers initiate or maintain lactation and provide assessment, planning, intervention, and evaluation for optimal breastfeeding, working in conjunction with the mother's physician or midwife and/or baby's pediatrician. Under this Plan, a doula is not a payable breastfeeding education provider unless the doula also meets the definition here.

Calendar Year: The 12-month period beginning January 1 and ending December 31. For the Medical, Dental and Vision Plans, all annual Deductibles, Coinsurance Maximums, Out-of-Pocket Limits and Annual Maximum Plan benefits are determined during the calendar year.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home, the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open heart surgery.

Certified Surgical Assistant (CSA, SA-C): A person who is at least a high school graduate and who has successfully passed a national surgical assistant program. A CSA does not typically hold a valid healthcare license as a RN, Nurse Practitioner (NP), Physician Assistant (PA), Midwife, Podiatrist, Dentist, MD or DO. A CSA is typically not a licensed health professional. A CSA assists the primary surgeon with a surgical procedure in the operating room and is not an employee of a health care facility. Such individual may be payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA, SA-C), Certified Surgical Technologist (CST), Certified First Assistant (CFA), Certified Surgical Technologist (CST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT), **only IF** the use of an assistant surgeon is medically necessary.

Chemical Dependency: This is another term for Substance Abuse/Substance Use Disorder. See also the definitions of Behavioral Health Disorders and Substance Abuse.

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of Scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings. Christian Science Practitioners **are not** payable under this Plan.

Claim, Claimant: See the Claim Filing and Appeal Information Article for the definition.

Claims Administrator: See the term Administrative Office.

Coinsurance: That portion of Eligible Medical Expenses for which the covered person has financial responsibility. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered expenses in excess of the Plan's Deductible. In some instances, the Covered Individual may be responsible for paying a higher percentage of those expenses, and in other instances, no Coinsurance applies. Coinsurance amounts for the medical plan are listed on the Schedule of Medical Benefits.

Coinsurance Maximum: The maximum amount of coinsurance each covered person or family is responsible for paying during a Calendar Year before the coinsurance required by the Plan ceases to apply. When the Coinsurance Maximum is reached, the Plan will pay 100% of any additional covered expenses for the remainder of the Calendar Year. See the section on Coinsurance Maximum in the Medical Plan Article for details about what expenses do not count toward the Coinsurance Maximum.

Complications of Pregnancy: An added difficulty, complex state, disease or accident superimposed on a pregnancy without being specifically related, yet affecting or modifying the prognosis of the pregnancy, as determined by the Plan Administrator or its designee. Complications of pregnancy can include but are not limited to the following diagnoses: anemia, bleeding during pregnancy, cervical incompetence, ectopic or molar pregnancy, gestational diabetes, excessive vomiting, miscarriage, placenta abruptio or previa, preeclampsia, or preterm labor. Complications of pregnancy does not include common symptoms/discomforts associated with pregnancy such as spotting, false labor, morning sickness, skin changes, backache, headache, leg cramps, indigestion, constipation/hemorrhoids, or the usual lab/ultrasound tests to monitor status and progression of the pregnancy.

Compound Drugs: See the definition of Prescription Drugs.

Concurrent Care Claim: See the Claim Filing and Appeal Information Article for the definition.

Concurrent Review: A managed care program designed to assure that Hospitalization and Health Care Facility admissions and length of stay, surgery and other health care services are medically necessary by having the Medical Review firm conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Health Care Facility. Also called Continued Stay Review.

Contributing Employer: "Contributing Employer" means any employer who is required by a collective bargaining agreement with the union, the Trust Agreement, or any other written agreement, to make contributions to the Medical Plan for Active Employees or who, in fact, makes one (1) or more contributions to the Medical Plan for Active Employees. The term "Contributing Employer" shall also include the Local Unions, Affiliated Electrical Joint and Apprenticeship Training Programs and Affiliated Credit Unions if contributions are made to the Plan by a Local Union, Affiliated Electrical Joint and Apprenticeship Training Program or Affiliated Credit Union on behalf of its non-clerical employees; provided the inclusion of said Local Unions, Affiliated Electrical Joint and Apprenticeship Training Programs, or Affiliated Credit Unions is not a violation of any existing law or regulation. Clerical employees shall be eligible to participate under the Non-Bargaining Participation provisions as set forth in Article III. Bargaining Employees of utilities may participate under the Non-Bargaining Participation provisions as set forth in Article III, upon approval of the Board of Trustees.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits Article.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an Eligible Medical Expense for certain services. The services with a copay are listed on the Schedule of Medical Benefits in this document, such as under the Drug row.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are medically necessary.

Covered Individual: Any employee and/or retiree and that person's eligible Spouse, or Dependent Child, Domestic Partner or Domestic Partner Dependent Child (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Covered Medical Expenses: See the definition of Eligible Medical Expenses.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care include helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this plan under certain circumstances such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care or in conjunction with covered home health services.

Customary Charge: See the definition of Allowed Charge.

Days (as relates to claim filing and appeals): See the Claim Filing and Appeal Information Article for the definition.

Deductible: The amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of Deductibles is discussed in the Medical Plan Article of this document.

Dental: As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

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 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.

Disabled or Disability (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, (as that term is defined in this Plan) provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Disabled Child: means a child who is mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, determined by a qualified mental health practitioner as having a serious emotional disturbance, orthopedically impaired, other physical health impairment, blind, multi-handicapped, or having specific learning disabilities.

Domestic Partner: .A Domestic Partner is a person of the same gender (same sex) who have executed and filed with the Administrative Office, a Plan-approved "Declaration of Same Sex Domestic Relationship" form indicating they meet the following requirements:

- have had an intimate, committed relationship of mutual caring for a period of at least twelve (12) months immediately prior to the date of this Affidavit, and intend to remain sole Domestic Partners indefinitely, and
- have shared a common residence for at least twelve (12) months (proof required, such as rental agreement, mortgage, state or federal tax returns, etc); and
- both are 18 years of age or older and neither is legally married. Both are the same sex. Neither is related by blood in a way that would prevent them from being married to each other; and
- neither has a different Domestic Partner now or has had a different Domestic Partner in the last twelve (12) months.

If a Domestic Partner is enrolled in the Plan, the employee may also apply for coverage for the Domestic Partner's children (see the definition of a Domestic Partner Dependent Child).

Under this Plan, Domestic Partners are eligible for the same benefits as a Spouse, including but not limited to wellness benefits of the medical plan, authorized representatives to file claims and appeals and a Domestic Partner may be the beneficiary of the Life and AD&D Insurance benefit. Note however that the PCA account cannot be used to pay medical care expenses for a Domestic Partner or child of a Domestic Partner.

Domestic Partner Dependent Child:

1. The Eligible Domestic Partner's children 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).
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 which the child attains age 26, or when the guardianship ends.
3. Note that coverage for a child of a Domestic Partner may need to be imputed as income to the Employee/Retiree.
4. **Disabled Adult Child**: The Eligible Domestic Partner'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 26 years of age, and provided the child is dependent upon the Eligible Domestic Partner 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.
5. **When both Domestic Partners 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).
6. It is the Domestic Partner's obligation to **inform the Plan promptly if any of the requirements set out in this definition of a child of a Domestic Partner are NOT met** with respect to any child for whom coverage is sought or is being provided.
7. **The following individuals are not eligible dependents under this Plan**: foster child, grandchild, son-in-law or daughter-in-law.

Durable Medical Equipment: means items which can withstand repeated use, are primarily used to serve a medical purpose, are generally not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home and is not disposable or non-durable. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Early Retiree: Individuals who are eligible to participate under the Eighth District Electrical Benefit Fund Plan as a Retiree but who is not yet eligible for Medicare.

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: Your lawful Spouse and your Dependent Child(ren), Domestic Partner or Domestic Partner Dependent Child. An Eligible Dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility Article for further information. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility Article, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Eligible Employee: means each Active Employee and each Self-pay Employee.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that the expenses meet all of the following qualification as determined by the Plan Administrator or its designee: are medically necessary, as defined in this Definitions Article; and the charges for them are Allowed Charges, as defined in this Definitions Article; and coverage for the services or supplies is not excluded; and the Maximum Plan benefits for those services or supplies has not been reached; and are for the diagnosis or treatment of an injury or illness (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document.

Emergency Care/Emergency: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Emergency care means medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms, including severe pain,

which are severe enough that the lack of immediate medical or dental attention could reasonably be expected to result in any of the following:

1. The patient's life or health would be placed in serious jeopardy.
2. There would be a serious dysfunction or impairment of a bodily organ or part.
3. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

However for emergency services performed in a hospital Emergency Room, the following definition applies:
Emergency Services: means with respect to an emergency medical condition (defined below), a medical screening examination **within the emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient. The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver a newborn child (including the placenta).

The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman of her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: See the term Eligible Employee.

Enroll, Enrollment: The process of completing and submitting a written enrollment form indicating that coverage by the Plan is requested by the Employee. An Employee may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility Article for details regarding the mechanics of enrollment.

Essential Health Benefits: The Affordable Care Act defines essential health benefits as a set of health care service categories to include the following: 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.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the Medical, Vision and Weekly Disability Articles of this document for which the Plan does **not** provide Plan benefits.

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility Article.

Experimental and/or Investigational and/or Unproven: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational and/or Unproven. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Precertification under the Plan's Medical Review program, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will <u>not</u> be considered Experimental and/or Investigational if it is:

- approved by the FDA as an "investigational new drug for treatment use"; or
- classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or
- approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.
6. Under this medical plan, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** The routine costs that are covered by this Plan are discussed below:
   a. "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
   b. An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.
   d. The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.
   e. The plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. See the Claim Filing and Appeal Information Article for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered for Precertification under the Plan's Medical Review program:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";

5. The published opinions of: the American Medical Association (AMA); or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or clinical policy bulletins of major insurance companies in the US such as Aetna or CIGNA, or Milliman Care Guidelines; or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

Extended Care Facility: See the definition of Skilled Nursing Facility.

Federal Legend Drugs: See the definition of Prescription Drugs.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Formulary: A list of outpatient prescription drug products, including strength and dosages, available for use by Plan participants. A formulary is also called a Preferred drug list.

Genetic Counseling: Counseling services provided before or in the absence of Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services includes physician-prescribed therapy for a child who is not walking at the expected age. Expenses for Habilitation services are not covered unless it is speech therapy for children for the treatment of delays in childhood speech development.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include Outpatient Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities, as those terms are defined in this Definitions Article.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Nurse Practitioner, Nurse Midwife, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, (Ophthalmologist, Optometrist, or Optician for vision plan benefits), Breastfeeding/Lactation Educator who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility, as those terms are defined in this Definitions Article.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as those terms are defined in this Article.

Home Health Care Agency: An agency or organization that provides a program of home health care and is approved by Medicare; and is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances will produce symptoms of an Illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms.

Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." **Homeopathy is not a covered benefit under this plan**.

Hospice Benefit Period: means the period that begins on the date the Physician certifies that the Participant is a Terminally Ill Patient and ends six (6) months after it began or on the death of the Participant, if sooner. If the Hospice Benefit Period ends before the death of the Participant, a new Hospice Benefit Period may begin if the Physician again certifies that the Participant is a Terminally Ill Patient.

Hospice Care: means palliative and supportive medical and health care and other services provided to Terminally Ill Patients to meet special physical and emotional needs as part of dying so that a hospice patient may remain at home, to the maximum extent possible, with home-like inpatient care utilized only if and while it is necessary. A hospice agency must be licensed by the state of its situs and meet the certification requirements of a hospice agency as required by Medicare.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must be approved by Medicare; and be licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Hospice that is part of a Hospital, as defined in this Article, will be considered a Hospice for the purposes of this Plan.

Hospital: A public or private facility or institution, licensed and operating according to law, that:

1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and
2. is approved by Medicare as a Hospital; and
3. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.

A hospital may include facilities for Behavioral Health treatment that are licensed and operated according to law. Any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Subacute Care Facility, or other residential treatment facility or place for rest, Custodial Care, or the aged will **not** be regarded as a Hospital for any purpose related to this Plan. A stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited metabolic disorders are also referred to inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia and diabetes are not inherited metabolic disorders under this Plan.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable under Oral services in the Schedule of Medical Benefits.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board. A stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service.

Intensive Care Unit or Coronary Care Unit. means a section or wing within the Hospital which is operated for critically ill patients and provides special supplies, equipment and supervision and care by a registered nurse (R.N.) or other trained Hospital personnel.

Investigational: See the definition of Experimental and/or Investigational.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Maximum Plan Benefits: The maximum amount of benefits payable by the Plan (and described more fully in the Medical Plan Article of this document) on account of medical expenses incurred by any covered Plan Participant, described below:

- **Limited Overall Maximum Plan Benefits:** Certain Plan benefits are subject to limitations that are not considered Lifetime maximums or Annual maximums. These other types of maximums are referred to under this Plan as Limited Overall Maximums. Examples include: Morbid Obesity and Respite care services.

  The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of these maximums are identified in the Schedule of Medical Benefits. Once the Plan has paid the Limited Overall Maximum Plan benefit for any of those services or supplies on behalf of any Covered Individual, it will not pay any further Plan benefits for those services or supplies on account of that Covered Individual.

- **Annual Maximum Plan Benefits:** Plan benefits for certain Eligible Medical Expenses are subject to Annual Maximums per Covered Individual or family during each Calendar Year. Once the Plan has paid the Annual Maximum Plan Benefit for any of those services or supplies on behalf of any Covered Individual or family, it will not pay any further Plan benefits for those services or supplies on account of that Individual or family for the balance of the Calendar Year. The services or supplies that are subject to Annual Maximum Plan Benefit are identified in the Schedule of Medical Benefits.

Medically Necessary:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:
   1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
   2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
   3. is determined by the Plan Administrator or its designee to meet <u>all</u> of the following requirements:
      - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
      - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
      - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
      - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:
   1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
   2. It is care or treatment that is as likely to produce a significant positive outcome as <u>and</u> no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.

E. A Hospitalization or confinement to a Health Care Facility will <u>not</u> be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

F. A medical or dental service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

G. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is medically necessary.

H. A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

Medical Review: A managed care procedure to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to Precertification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee

negotiation. Medical Review is sometimes referred to as Utilization Management, UM services, Utilization Review services, or UR services. Medical Review is provided by professionals employed by the Medical Review firm operating under a contract with the Plan.

Medicare: means the benefits provided under Title XVIII of the U.S. Social Security Act of 1965 as it is amended from time to time.

Member Assistance Program (MAP): means the program approved by the Board of Trustees, as amended from time to time, whereby a Participant may obtain counseling for mental, nervous, and emotional disorders and/or substance abuse problems. MAP is also referred to as an Employee Assistance Program or EAP.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a midwife or certified as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient. A Midwife may **not** independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Minimum Contribution: means the contribution determined, established and fixed by the Board of Trustees, from time to time, as the Board of Trustees, in their absolute discretion, deem appropriate and necessary to maintain a uniform Plan of benefits for Eligible Employees.

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:

$$\text{BMI} = \frac{\text{(weight in kilograms)}}{\text{(height in meters) times (height in meters)}}$$

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.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage or herbal tea. Naturopathy is not a covered benefit under this Plan.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Device). Only those nondurable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-Participating Provider (Non-Preferred Provider): A Health Care Provider who **does not participate** in the Plan's Preferred Provider Organization (PPO).

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate Health Care Practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and who is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence. Other occupational therapy services can include assessment of perceptual motor and sensory activity, the design, fabrication or application of selected support devices (orthotics) such as a wrist brace or ankle support, training on how to utilize prosthetic devices to maximize independence, guidance in the selection and use of adaptive equipment, teaching exercises to enhance functional performance and adaptation of environments for people with mental and physical disabilities.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. The following are not considered an office visit: a telephone discussion with a Physician or other Health Care Practitioner, internet/virtual office visit, a visit to a Health Care Practitioner's office where no office visit code is billed or a visit to a Health Care Practitioner's office for blood drawing, leaving a specimen, or receiving a routine injection.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or TMJ syndrome/dysfunction. See the definitions of Prognathism, Retrognathism, and TMJ syndrome/dysfunction.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Out-of-Network Services (Non-network): Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO) as distinguished from In-Network Services, that are provided by a Health Care Provider that is a member of the PPO.

Outpatient Services: Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are **not** incurred. However, a stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service.

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.

Participant. "Participant" means:

a. an Eligible Employee or Retiree
b. an Eligible Employee's or Retiree's eligible Dependents; and
c. COBRA Qualified Beneficiaries.

Participating Provider: A Health Care Provider who participates in the Plan's Preferred Provider Organization (PPO).

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and who is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform physical therapy services including the evaluation and treatment of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

Physical Therapy: means rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain activities of daily living such as walking and getting in and out of bed.

Physician: means a Physician or Surgeon (M.D. or D.O.) licensed to practice medicine in the state in which he/she practices and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient. To the extent that benefits are provided and while practicing within the scope of his license the term Physician includes a dentist, podiatrist, and chiropractor. In addition, the term Physician will include, to the extent that benefits are provided for herein and while practicing within the scope of his/her license, the following providers of care:

a. a licensed psychologist;
b. a licensed clinical social worker or clinical specialist psychiatric registered nurse (CSPRN) to the extent that he/she shall render services which he/she is legally qualified and licensed to perform; and
c. any licensed and/or certified practitioner rendering counseling and therapy services when regulated by the appropriate state agency.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the definition in the section on Adopted Dependent Children in the Eligibility Article.

Plan or Fund: means the Eighth District Electrical Benefit Fund (established by the Trust Agreement) which is described in this document.

Plan Administrator: The Board of Trustees, who has the fiduciary responsibility for the overall administration of the Plan.

Plan Participant: See the definition of Participant.

Plan Year: means the fiscal year, which begins January 1 and ends December 31. Benefits of the Medical Plan are provided on a calendar year basis beginning January 1 and ending December 31 of each year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Post-service Claim: See the Claim Filing and Appeal Information Article for the definition.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.

Precertification: Precertification is a review procedure performed by a Medical Review firm under contract to the Plan **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service is appropriate and medically necessary. See Article IX for information.

Preferred Provider. "Preferred Provider" means any Plan recognized provider, corporation, organization or entity which has contracted with the Plan to provide discounted fees for covered charges in accordance with this Plan.

Preferred Provider Organization (PPO): An independent group or network of Health Care Providers (*e.g.* hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.
3. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic drug**: means a generic form of a brand-name drug. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA), and is basically a "copy" of a brand name drug. Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
5. **Specialty drug**: see the separate definition of Specialty drugs in this Article.

Pre-service Claim: See the Claim Filing and Appeal Information Article for the definition.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face. See also Orthognathic.

Progressive Lenses (Vision): Bifocal or trifocal lenses that appear to be single vision with no distinct lines between the various focal lengths.

Prophylactic Surgery: A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on Genetic Information or Genetic Testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Provider: See the definition of Health Care Provider.

Qualified Beneficiary: means an individual who, on the day before a COBRA Qualifying Event is an Eligible Employee or Retiree or is the Dependent of an Eligible Employee or Retiree.

- In the case of a Qualifying Event described in Article IV, Qualified Beneficiary means an individual who on the day before such Qualifying Event is an Active Employee or Retiree.
- A newborn child, adopted child of a Qualified Beneficiary or a child placed for adoption with a Qualified Beneficiary who was not a covered employee or retiree will be entitled to the same continuation coverage period available to the Qualified Beneficiary, however, such child shall not become a Qualified Beneficiary.
- A newborn child, adopted child or child placed for adoption with a Qualified Beneficiary who was a covered employee or retiree shall become a Qualified Beneficiary in his/her own right and shall be entitled to benefits as a Qualified Beneficiary.
- A Qualified Beneficiary must notify the Administrative Office within thirty-one (31) days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

Qualifying Event: A Qualifying Event triggers the opportunity to elect COBRA when the covered individual loses health care coverage under this Plan. If a covered individual has a Qualifying Event but does not lose their health care coverage under this Plan, (*e. g.,* employee continues working even though entitled to Medicare) then COBRA is not yet offered. A Qualifying Event means any of the following:

a. termination of coverage as a result of termination of the hour bank or non-bargaining participation due to the death of an Active Employee or Retiree;
b. termination of coverage as a result of termination of the hour bank or non-bargaining participation due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct), reduction in hours of an Active Employee, or retirement;
c. Termination of Domestic Partnership (Declaration of Termination of Domestic Relationship form must be completed);
d. the divorce or legal separation of an Eligible Employee or Retiree from his/her Spouse;

e. commencement of entitlement to Medicare coverage of a former Active Employee during an eighteen (18) month continuation period; and

f. a Dependent Child ceases to be a Dependent Child as that term is defined in this document.

g. A child of a Domestic Partner ceases to be a Domestic Partner Dependent Child as that term is defined in this Article.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also Article III, the Eligibility Article of this document.

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Facility: means a facility that is recognized by the Plan and licensed or certified to perform rehabilitative health care services by the state or jurisdiction where services are provided. Services of such a facility must also be among those covered by the Plan.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. See the Schedule of Medical Benefits and the Medical Plan Exclusions Article of this document to determine the extent to which Rehabilitation Therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy, Habilitation and Cardiac Rehabilitation.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be medically necessary for the purposes of this Plan.**

Respite Care: means care that is furnished to a Terminally Ill Patient when confined as an inpatient so that the family unit may have relief from the stress of the care of the Participant.

Restatement Effective Date. "Restatement Effective Date" means January 1, 2014. This Plan has been amended and restated to incorporate all amendments and to update the wording of this Plan Document. This Plan Document/Summary Plan Description replaces all previously issued Plan Document/Summary Plan Descriptions and amendments to those documents.

Retired Employee or Retiree: means an Early (non-Medicare eligible) Retired Employee or a Medicare-eligible Retired Employee who meets the eligibility requirements set forth in Article III. The terms Retired Employee or Retiree shall not include a Dependent Child or the surviving Spouse, Domestic Partner or Domestic Partner Dependent Child of a deceased Retiree.

Retiree Plan: means the Eighth District Electrical Benefit Fund's Medical plan of benefits (as described in this document) that is maintained by the Board of Trustees and which is available to eligible Early (non-Medicare eligible) Retirees or eligible Medicare-eligible Retirees as outlined in the Schedule of Medical Benefits in this document.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face. See also Orthognathic.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were medically necessary and/or if the charges for them are Allowed Charges.

Second Opinion: A consultation and/or examination, by a board certified Physician not affiliated with the primary attending Physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Self-Pay Employee: means an Active Employee who subsequently loses eligibility or, a Retired Employee who elects to continue coverage under the Plan in accordance with the Self-Pay provisions of this plan as described in Article IV.

Self-Pay Participant: means a Self-Pay Employee or eligible Dependent of a deceased Active Employee, or Retired Employee who subsequently loses eligibility and elects to continue coverage under the Plan under the Self-Payment Provisions for described in Article IV.

Service Area: The geographic area serviced by the In-Network Health Care Providers who have agreements with the Plan's PPO. See Article VIII, the Article on Medical Networks for additional information.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Special Education: means specially designed instruction to meet unique needs of an individual, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Specialty Drugs: Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injectable, require an infusion, are taken orally or inhaled, may need to be administered by a health care practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before self-administration, and/or unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Specialty drugs are managed by the Prescription Drug Program under contract to the Plan. Examples of specialty drugs can include certain medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer.

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and who is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by Physicians.

Spouse: See the definition of Dependent.

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a

disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse.

Subacute care facility is sometimes referred to as a specialty hospital or post-acute care or long term care acute facility.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability section in the Article on Coordination of Benefits for an explanation of how the Plan may use the right of subrogation to be substituted in place of a Covered Individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical and/or dental benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit. See also the definition of Tortfeasor.

Substance Abuse/Substance Use Disorder: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowed Charge will be allowed as the Plan's benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of the Allowed Charge
Secondary and additional procedures	50% of the Allowed Charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of the Allowed Charge
First site secondary and additional procedures	50% of the Allowed Charge per procedure
Second site primary and additional procedures	50% of the Allowed Charge per procedure

Surgical Assistant: See Certified Surgical Assistant.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Terminally Ill Patient: means a patient whose Physician certifies that such patient is terminally ill and who is expected to live six (6) months or less.

Therapist: A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient. For further information, see the definition of Occupational, Physical and Speech Therapy.

Third Opinion: A consultation and/or examination, by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing Surgery or receiving a medical service, provided by the Plan when the Second Opinion indicates that the recommended Surgery or medical service is not medically necessary.

Tort, Tortfeasor: A civil wrong or injury, typically arising negligent or intentional act of an individual, who is called a tortfeasor. See also the definition of Subrogation.

Total Disability, Totally Disabled: The inability of a covered employee to perform all the duties of his or her occupation as a result of an illness or injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age and sex. See also the definition of Disabled.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

- **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
- **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.
- **Xenographic/xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan.

See the Schedule of Medical Benefits and the Medical Plan Exclusions Articles for additional information regarding Transplants. See also the Article IX of this document for information about precertification requirements for transplantation services.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Trust Agreement or Trust: means the Agreement and Declaration of Trust establishing the Eighth District Electrical Benefit Fund, as modified or amended.

Urgent Care Claim: See the Claim Filing and Appeal Information Article for the definition.

Urgent Care Facility: A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Management/Utilization Review: see Medical Review.

Visit: See the definition of Office Visit.

Vocational Rehabilitation: means teaching and training which allows an individual to resume his/her previous job or to train for a new job.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary even though they are not provided as a result of illness, injury or congenital defect. The Plan's coverage of Well Child Care is described under Wellness/Preventive Care in the Schedule of Medical Benefits.

You, Your: When used in this document, these words refer to the employee who is covered by the Plan. They do **not** refer to any Dependent of the employee.

ARTICLE XVIII: LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Section 1: OVERVIEW

This Article outlines the coverage for group Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance as provided by an independent Life Insurance Company whose name and address are listed on the Quick Reference Chart in the front of this document. Since this Article is only a summary of benefits, you should refer to the Group Certificate of Insurance and documents provided to you by the Life Insurance Company. If there is a difference between the information contained in this Article and the documents of the Life Insurance Company, the Life Insurance Company documents will prevail. See also the Dependent Life Insurance described in another Article in this document.

Section 2: WHO IS ELIGIBLE FOR LIFE and AD&D INSURANCE BENEFITS

To become insured for Life and AD&D Insurance you must:

a. Be an "eligible employee" as described below; and
b. Complete your Eligibility Waiting Period (described below); and
c. Meet the requirements outlined in the Life Insurance section in this Article.

Eligible employees (who are eligible for Life and AD&D Insurance) are one of the following:

a. **An active employee** of an Employer who is subject to a collective bargaining agreement between the Employer and the Eighth District Electrical Benefit Fund; or

b. **An active employee** of an Employer who is not subject to a collective bargaining agreement between the Employer and the Eighth District Electrical Benefit Fund, but who is eligible to participate in the Eighth District Electrical Benefit Fund's group life insurance plan under the terms of a participation agreement between the Employer and the Eighth District Electrical Benefit Fund; or

c. **A retired employee** of an Employer who is under age 65 and self-paying the required premium.

You are not eligible if you are a temporary or seasonal employee, a leased employee, an independent contractor, or a full-time member of the armed forces of any country. **Active Employees, under these Life and AD&D Insurance benefits, are also referred to as Class 1 and Retired Employees are referred to as Class 2**.

Section 3: ELIGIBILITY WAITING PERIOD

a. You are eligible for Life and AD&D Insurance benefits on the date you become eligible for coverage under the terms of the Eighth District Electrical Benefit Fund's Medical Plan as an Active or Early Retiree.

b. **Life Insurance becomes effective** for eligible persons on the date you become eligible for life insurance.

c. If you were insured under the Prior Life Insurance Plan on the day before the effective date of this life insurance coverage your eligibility waiting period is waived.

d. **Evidence of Insurability (EOI)** is not required.

Section 4: WHAT IS THE COST FOR LIFE AND AD&D COVERAGE?

a. Class 1 employees (actives): There is no cost to you for the Life and AD&D Insurance outlined in this Article.

b. Class 2 employees (retirees): You are eligible to elect Life and AD&D Insurance under this group policy however you must pay the required initial premium for the coverage. If you elect to continue this coverage, the premium is included in the self-payment amount. Contact the Administrative Office for details.

Section 5: HOW THE LIFE INSURANCE BENEFIT WORKS

If you, the eligible employee, die while insured for Life Insurance benefits under this Plan, the Life Insurance Company will pay benefits according to the terms of the Group Life Insurance Policy after they receive satisfactory "Proof of Loss."

a. **The Life Insurance benefit under this Plan is $20,000**.

b. **"Proof of Loss"** means written proof that a loss occurred for which the Group Life Insurance Policy provides benefits and which is not subject to any exclusions and which meets all other conditions for benefits. Proof of Loss includes any other information the Life Insurance Company may reasonably require in support of a claim. Proof of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be provided until the Life Insurance Company receives Proof of Loss.

Repatriation Benefit is a benefit that pays the expenses incurred to transport your body to a mortuary near your primary place of residence. The repatriation benefit pays an amount not to exceed $5,000 or 10% of the Life Insurance Benefit, whichever is less. Repatriation Benefits are payable if all of the following requirements are met:

a. A Life Insurance Benefit is payable because of your death and
b. You die more than 200 miles from your primary place of residence and
c. Expenses are incurred to transport your body to a mortuary near your primary place of residence.

When Life Insurance Ends: Life Insurance ends automatically on the earliest of:

1. The date the last period ends for which you made a premium contribution, if your insurance coverage requires you to pay the premium (is Contributory);
2. The date the Group Life Insurance Policy terminates;
3. With respect to Class 2 Retirees, the last day of the calendar month in which you reach age 65;
4. The last day of the calendar month in which your employment terminates, unless your insurance is continued under the Retirement Continuation Provision (discussed later in this Article);
5. The date you cease to be eligible for coverage under the terms of the Eighth District Electrical Benefit Fund's Medical Plan as an Active Employee or Retiree; and
6. The last day of the calendar month in which you cease to be eligible. However, if you cease to be eligible because you are working less than the required minimum number of hours, your Life Insurance will be continued (with premium payment) during the following periods, unless it ends under 1 through 5 above.
    a. While your ability to work is limited because of Sickness, Injury, or Pregnancy. **Continuation During Total Disability**: If you are Totally Disabled and you are not eligible for Waiver of Premium (see Waiver of Premium discussed later in this Article), your Life Insurance will continue, while you remain Totally Disabled, for a period of

not less than six months, but not beyond the date the Group Life Insurance Policy terminates. (See Waiver of Premium for definition of Total Disability).

b. During a leave of absence if continuation of your insurance under the Group Life Insurance Policy is required by a state-mandated family or medical leave act or law.

Reinstatement of Life Insurance: If your Life Insurance ends, you may become insured again as a new individual. If your Life Insurance ends because you are on a federal or state-mandated family or medical leave of absence, and you become eligible again immediately following the leave period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.

Section 6: HOW THE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFIT WORKS

If you have an accident, including accidental exposure to adverse conditions, while insured for AD&D Insurance, and the accident results in a "Loss" (defined in this Article), the Life Insurance Company will pay benefits according to the terms of the Group Life Insurance Policy after the Life Insurance Company receives satisfactory Proof of Loss.

The amount of your AD&D Insurance Benefit is equal to the amount of your Life Insurance Benefit. The amount payable for certain Losses is less than 100% of the AD&D Insurance Benefit. See AD&D Table of Losses described in this Article. Changes in your AD&D Insurance will become effective on the date your Life Insurance changes.

- **Class 1 employees become eligible for AD&D Insurance on the date the Life Insurance is effective.**

Definition of "Loss" For AD&D Insurance: Loss means loss of life, hand, foot, sight, speech, hearing in both ears, thumb and index finger of the same hand and Quadriplegia, Hemiplegia or Paraplegia which meets all of the following requirements:

1. Is caused solely and directly by an accident.
2. Occurs independently of all other causes.
3. Occurs within 365 days of the accident.
4. With respect to Loss of life, is evidenced by a certified copy of the death certificate.
5. With respect to all other Losses, is certified by a Physician in the appropriate specialty as determined by the Life Insurance Company.
6. With respect to Loss of life, death will be presumed if you disappear and the disappearance:
   1. Is caused solely and directly by an accident that reasonably could have caused Loss of life;
   2. Occurs independently of all other causes; and
   3. Continued for a period of 365 days after the date of the accident, despite reasonable search efforts.
7. With respect to a hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint, whether or not surgically reattached.
8. With respect to sight, Loss means entire, uncorrectable, and irrecoverable loss of sight. With respect to speech, Loss means entire, uncorrectable, and irrecoverable loss of audible speech. With respect to hearing, Loss means entire, uncorrectable, and irrecoverable loss of hearing in both ears. With respect to thumb and index finger of the same hand, Loss means actual and permanent severance from the body at or above the metacarpophalangeal joints.
9. With respect to Quadriplegia, Hemiplegia, and Paraplegia, Loss must be permanent, complete, and irreversible. Quadriplegia means total paralysis of both upper and lower limbs. Hemiplegia means total paralysis of the upper and lower limbs on the same side of the body. Paraplegia means total paralysis of both lower limbs.

Amount Payable under AD&D Insurance

The amount of your AD&D Insurance Benefit is equal to the amount of your Life Insurance Benefit; however, the amount payable for certain Losses is less than 100% of the AD&D Insurance Benefit and may be a percentage of the AD&D Insurance Benefit in effect on the date of the accident and is determined by the Loss suffered. See AD&D Table of Losses below:

AD&D TABLE OF LOSSES

- No more than 100% of your AD&D Insurance will be paid for all Losses resulting from one accident.
- * No AD&D Insurance Benefit will be paid for Loss of thumb and index finger of the same hand if an AD&D Insurance Benefit is payable for the Loss of that entire hand.

Loss	Percentage of the AD&D Insurance Benefit that is Payable
a. Life	100%
b. One hand or one foot	50%
c. Sight in one eye, speech, or hearing in both ears	50%
d. Two or more of the Losses listed in b. and c. above	100%

e. Thumb and index finger of the same hand	25%*
f. Quadriplegia	100%
g. Hemiplegia	50%
h. Paraplegia	50%

Schedule Of Additional AD&D Insurance Benefits

- **Seat Belt Benefit**: The amount of the Seat Belt Benefit is the lesser of (1) $10,000 or (2) the amount of AD&D Insurance Benefit payable for Loss of your life. The Life Insurance Company will pay a Seat Belt Benefit if all of the following requirements are met:
  1. You die as a result of an Automobile accident for which an AD&D Insurance Benefit is payable for Loss of your life; and
  2. You are wearing and properly utilizing a Seat Belt System at the time of the accident, as evidenced by a police accident report.

  Seat Belt System means a properly installed combination lap and shoulder restraint system that meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. Seat Belt System will include a lap belt alone, but only if the Automobile did not have a combination lap and shoulder restraint system when manufactured. Seat Belt System does not include a shoulder restraint alone. Automobile means a motor vehicle licensed for use on public highways.

- **Air Bag Benefit:** The amount of the Air Bag Benefit is the lesser of (1) $5,000; or (2) the amount of AD&D Insurance Benefit payable for Loss of your life. The Life Insurance Company will pay an Air Bag Benefit if all of the following requirements are met:
  1. You die as a result of an automobile accident for which a Seat Belt Benefit is payable for Loss of your life.
  2. The Automobile is equipped with an Air Bag System that was installed as original equipment by the Automobile manufacturer and has received regular maintenance or scheduled replacement as recommended by the Automobile or Air Bag manufacturer.
  3. You are seated in the driver's or a passenger's seating position intended to be protected by the Air Bag System and the Air Bag System deploys, as evidenced by a police accident report.

  Air Bag System means an automatically inflatable passive restraint system that is designed to provide automatic crash protection in front or side impact Automobile accidents and meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. Automobile means a motor vehicle licensed for use on public highways.

- **Career Adjustment Benefit**: The Career Adjustment Benefit is the tuition expenses for training incurred by your Spouse within 36 months after the date of your death, exclusive of room and board, but not to exceed $5,000 per year, or the cumulative total of $10,000 or 25% of the AD&D Insurance Benefit, whichever is less. (No Career Adjustment Benefit will be paid if you have no surviving Spouse.) The Life Insurance Company will pay a Career Adjustment Benefit to your Spouse if all of the following requirements are met:
  1. You are insured for AD&D Insurance under the Group Life Insurance Policy.
  2. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
  3. Your Spouse is, within 36 months after the date of your death, registered and in attendance at a professional or trades training program for the purpose of obtaining employment or increasing earnings.

- **Child Care Benefit:** The Child Care Benefit is the total child care expense incurred by your Spouse within 36 months after the date of your death for all Children under age 13, but not to exceed $5,000 per year, or the cumulative total of $10,000 or 25% of the AD&D **Insurance Benefit, whichever is less. (**No Child Care Benefit will be paid if you have no surviving Spouse.**)**

  The Life Insurance Company will pay a Child Care Benefit to your Spouse if all of the following requirements are met:
  1. You are insured for AD&D Insurance under the Group Life Insurance Policy.
  2. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
  3. Your Spouse pays a licensed child care provider who is not a member of your family for child care provided to your Child(ren) under age 13 within 36 months of your death.
  4. The child care is necessary in order for your Spouse to work or to obtain training for work or to increase earnings.

- **Higher Education Benefit:** The Higher Education Benefit is the tuition expenses incurred per Child within 4 years after the date of your death at an accredited institution of higher education, exclusive of room and board, but not to exceed $5,000 per year, or the cumulative total of $20,000 or 25% of the AD&D Insurance Benefit, whichever is less. The Life Insurance Company will pay a Higher Education Benefit to your Child if all of the following requirements are met:
  1. You are insured for AD&D Insurance under the Group Life Insurance Policy.
  2. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
  3. Your Child is, within 12 months after the date of your death, registered and in full-time attendance at an accredited institution of higher education beyond high school.

The Higher Education Benefit will be paid annually to each Child who meets the requirements of item 3 above, for a maximum of 4 consecutive years beginning on the date of your death. No Higher Education Benefit will be paid if there is no Child eligible to receive it.

- **Occupational Assault Benefit:** The Occupational Assault Benefit is the lesser of (1) $25,000; or (2) 50% of the amount of the AD&D Insurance Benefit otherwise payable for the Loss. The Life Insurance Company will pay an Occupational Assault Benefit if all of the following requirements are met:
  1. While actively at work for your Employer you suffer a Loss for which an AD&D Insurance Benefit is payable.
  2. The Loss is the result of an act of physical violence against you that is punishable by law and is evidenced by a police report.

- **Public Transportation Benefit:** The Public Transportation Benefit is the lesser of (1) $200,000; or (2) 100% of the amount of the AD&D Insurance Benefit otherwise payable for Loss of your life. The Life Insurance Company will pay a Public Transportation Benefit if all of the following requirements are met:
  1. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
  2. The accident occurs while you are riding as a fare-paying passenger on Public Transportation.

  Public Transportation means a public passenger conveyance operated by a licensed common carrier for the transportation of the general public for a fare and operating on regular passenger routes with a definite schedule of departures and arrivals.

AD&D Insurance Exclusions:

No AD&D Insurance benefit is payable if the accident or Loss is caused or contributed to by any of the following:

1. War or act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
2. Suicide or other intentionally self-inflicted Injury, while sane or insane.
3. Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.
4. The voluntary use or consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a Physician.
5. Sickness or Pregnancy existing at the time of the accident.
6. Heart attack or stroke.
7. Medical or surgical treatment for any of the above.

When AD&D Insurance Ends:

AD&D Insurance ends automatically on the earliest of

1. The date your Life Insurance ends.
2. The date the last period ends for which you made a premium contribution, if your insurance is Contributory.
3. The date your Waiver of Premium begins.
4. The date your Life Insurance is continued under Continuation During Total Disability. (See the section on When Life Insurance Ends outlined earlier in this Article.)
5. The date AD&D Insurance terminates under the Group Life Insurance Policy.

Section 7: PORTABILITY OF INSURANCE

If your insurance under the Group Life Insurance Policy ends because your employment with your Employer terminates, you may be eligible to buy portable group insurance coverage, as described in this Article, for yourself, without submitting Evidence of Insurability. To be eligible you must satisfy the following requirements:

1. On the date your employment terminates, you must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience. (If you are unable to meet this requirement, see the Right To Convert and Waiver of Premium provisions for other options that may be available to you under the Group Life Insurance Policy.)
2. On the date your employment terminates, you are under age 65.
3. On the date your employment terminates, you must have been continuously insured under the Group Life Insurance Policy for at least 12 consecutive months. In computing the 12 consecutive month period, the Life Insurance Company will include time insured under the Prior Plan.
4. You must apply in writing and (when applicable) pay the first premium directly to the Life Insurance Company Home Office within 31 days after the date your employment terminates. You must purchase portable group life insurance coverage for yourself in order to purchase any other insurance eligible for portability.

This portable group insurance will be provided under a Life Portability Insurance Policy and will contain provisions that differ from your Employer's coverage under the Group Life Insurance Policy.

Amount of Portable Insurance: The minimum and maximum amounts that you are eligible to buy under the Group Life Portability Insurance Policy are shown in the chart below. You may buy less than the maximum amounts in increments of $1,000. The combined amounts of insurance purchased under this Portability of Insurance provision and the Right To Convert provision cannot exceed the amount in effect under the Group Life Insurance Policy on the day before your employment terminates.

	Minimum Combined Amount	Maximum Combined Amount
Life Insurance	$10,000	$300,000
AD&D Insurance	$10,000	$300,000

When Portable Insurance Becomes Effective: Portable group insurance will become effective the day after your employment with your Employer terminates, if you apply within 31 days after the date your employment terminates. If death occurs within 31 days after the date insurance ends under the Group Life Insurance Policy, life insurance benefits, if any, will be paid according to the terms of the Group Life Insurance Policy in effect on the date your employment terminates and not the terms of the Group Life Portability Insurance Policy. AD&D benefits, if any, will be paid according to the terms of the Group Life Insurance Policy or the Group Life Portability Insurance Policy, but not both. In no event will the benefits paid exceed the amount in effect under the Group Life Insurance Policy on the day before your employment terminates.

Section 8: RETIREMENT CONTINUATION PROVISION

Insurance may be continued during your retirement under your Employer's retirement program if you are eligible. You must apply in writing (to the Life Insurance Company) for a continuation of insurance on or before the date of your retirement and agree to pay any premiums required. Insurance under this provision will end on the earliest of:

1. Any Premium Due Date if you fail to make the required premium contribution on or before that date.
2. The date the Group Life Insurance Policy terminates.

You will not become eligible for Waiver of Premium or the Accelerated Benefit if you become Totally Disabled while your insurance is continued under this provision.

Section 9: WAIVER OF PREMIUM IF TOTALLY DISABLED (for Class 1 Employees only)

Insurance will be continued without payment of premiums while you are Totally Disabled if:

1. You become Totally Disabled while insured under the Group Life Insurance Policy and you are under age 60;
2. You complete your Waiting Period; and
3. You give the Life Insurance Company satisfactory Proof of Loss.

The Life Insurance Company may have you examined at their expense at reasonable intervals. Any such examination will be conducted by specialists of their choice.

Premium payment must continue until the later of the date you complete your Waiting Period; and the date the Life Insurance Company approves your claim for Waiver of Premium. The Life Insurance Company will refund up to 12 months of the premiums that were paid for Insurance after the date you become Totally Disabled.

Definitions For Waiver of Premium:

1. **Insurance** means all your insurance under the Group Life Insurance Policy, except AD&D Insurance.
2. **Totally Disabled** means that, as a result of Sickness, accidental Injury, or Pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.
3. **Waiting Period** means the 180 consecutive day period beginning on the date you become Totally Disabled. Waiver of Premium begins when you complete the Waiting Period.

Other Provisions About Waiver of Premium

Amount of Insurance: The amount of Insurance eligible for Waiver of Premium is the amount in effect on the day before you become Totally Disabled. However, the following will apply:

1. Insurance will be reduced or terminated according to the Group Life Insurance Policy provisions in effect on the day before you become Totally Disabled.
2. If you become insured under a group life insurance plan that replaces this Group Life Insurance Policy while you are eligible for Waiver of Premium, any death benefit payable under this Group Life Insurance Policy will be reduced by the amount payable under the replacement group life insurance plan.
3. If you receive an Accelerated Benefit, Insurance will be reduced according to the Accelerated Benefit provision.

Effect of Death During The Waiting Period: If you die during the Waiting Period and are otherwise eligible for Waiver of Premium, the Waiting Period will be waived.

Termination Or Amendment of The Group Life Insurance Policy: Insurance will not be affected by termination or amendment of the Group Life Insurance Policy after you become Totally Disabled.

Waiver of Premium ends on the earliest of:

1. the date you cease to be Totally Disabled;
2. 90 days after the date the Life Insurance Company mail you a request for additional Proof of Loss, if it is not given;
3. the date you fail to attend an examination or cooperate with the examiner; and
4. with respect to the amount of Insurance which an insured has converted, the effective date of the individual life insurance policy issued to the insured.

Section 10: ACCELERATED BENEFIT (for Class 1 employees only)

If you qualify for Waiver of Premium and give the Life Insurance Company satisfactory proof of having a Qualifying Medical Condition (defined below) while you are insured under the Group Life Insurance Policy, you may have the right to receive during your lifetime a portion of your "Insurance" as an Accelerated Benefit. "Insurance" means your Life Insurance Benefit under the Group Life Insurance Policy.

You must have at least $10,000 of Insurance in effect to be eligible. If your Insurance is scheduled to end within 24 months following the date you apply for the Accelerated Benefit, you will not be eligible for the Accelerated Benefit. The Life Insurance Company may have you examined at their expense in connection with your claim for an Accelerated Benefit. Any such examination will be conducted by one or more Physicians of their choice.

"Qualifying Medical Condition" means you are terminally ill as a result of an illness or physical condition which is reasonably expected to result in death within 12 months.

You must apply for an Accelerated Benefit. To apply you must give the Life Insurance Company satisfactory Proof of Loss on the Life Insurance Company forms. Proof of Loss must include a statement from a Physician that you have a Qualifying Medical Condition.

You may receive an Accelerated Benefit of up to 80% of your Insurance. The maximum Accelerated Benefit is $500,000. The minimum Accelerated Benefit is $5,000 or 10% of your Insurance, whichever is greater. If the amount of your Insurance is scheduled to reduce within 24 months following the date you apply for the Accelerated Benefit, your Accelerated Benefit will be based on the reduced amount. The Accelerated Benefit will be paid to you once in your lifetime in a lump sum. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, the Life Insurance Company will not ask you for a refund.

Effect On Insurance And Other Benefits: For any purpose other than premium payment, the amount of your Insurance after payment of the Accelerated Benefit will be the greater of the amounts in (1) and (2) below; however, if you assign your rights under the Group Life Insurance Policy, the amount of your Insurance will be the amount in (2) below.

(1) 10% of the amount of your Insurance as if no Accelerated Benefit had been paid; or

(2) The amount of your Insurance as if no Accelerated Benefit had been paid; minus the amount of the Accelerated Benefit; minus an interest charge calculated as follows: A times B times C divided by 365 = interest charge.

A = The amount of the Accelerated Benefit.

B = The monthly average of the Life Insurance Company variable policy loan interest rate.

C = The number of days from payment of the Accelerated Benefit to the earlier of (1) the date you die, and (2) the date you have a Right To Convert.

Your AD&D Insurance, if any, is not affected by payment of the Accelerated Benefit.

Accelerated Benefit Exclusions: No Accelerated Benefit will be paid if:

1. All or part of your Insurance must be paid to your Child(ren), or your Spouse or former Spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
2. You are married and live in a community property state unless you give the Life Insurance Company a signed written consent from your Spouse.
3. You have filed for bankruptcy, unless you give the Life Insurance Company written approval from the Bankruptcy Court for payment of the Accelerated Benefit.
4. You are required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement.
5. You have previously received an Accelerated Benefit under the Group Life Insurance Policy.

Section 11: RIGHT TO CONVERT

You may buy an individual policy of life insurance without Evidence of Insurability if your Insurance ends or is reduced due to a Qualifying Event (defined below) and you apply in writing and pay the Life Insurance Company the first premium during the Conversion Period (defined below). Except as limited under the section below titled "Limits On Right To Convert," the maximum amount you have a Right To Convert is the amount of your Insurance which ended.

Definitions For Right To Convert:

- **Conversion Period** means the 31-day period after the date of any Qualifying Event.
- **Insurance** means all your insurance under the Group Life Insurance Policy, including insurance continued under Waiver of Premium, but excluding AD&D Insurance.
- **Qualifying Event** means termination or reduction of your Insurance for any reason except:
  a. The eligible person's failure to make a required premium contribution.
  b. Payment of an Accelerated Benefit.
- **You and your** mean any person insured under the Group Life Insurance Policy.

Limits On Right To Convert: If your Insurance ends or is reduced because of termination or amendment of the Group Life Insurance Policy, 1 and 2 below will apply.

1. You may not convert Insurance which has been in effect for less than the Minimum Time Insured (5 years).
2. The maximum amount you have a Right To Convert is the lesser of:
   a. The amount of your Insurance which ended, minus any other group life insurance for which you become eligible during the Conversion Period; and
   b. The Maximum Conversion Amount ($10,000).

You may select any form of individual life insurance policy the Life Insurance Company issues to persons of your age, except:

1. A term insurance policy;
2. A policy with disability, accidental death, or other additional benefits; or
3. A policy in an amount less than the minimum amount the Life Insurance Company issue for the form of life insurance you select.

The individual policy of life insurance will become effective on the day after the end of the Conversion Period. The Life Insurance Company will use the Life Insurance Company's published rates for standard risks to determine the premium. If you die during the Conversion Period, the Life Insurance Company will pay a death benefit equal to the maximum amount you had a Right To Convert, whether or not you applied for an individual policy. The benefit will be paid according to the Benefit Payment and Beneficiary Provisions (described earlier in this Article). You will receive a written Notice of Right To Convert from the Eighth District Electrical Benefit Fund at least 30 days before the date your Insurance ends because of termination or amendment of the Group Life Insurance Policy.

Section 12: CLAIMS

Filing A Claim: Claims should be filed on Life Insurance Company forms. If the Life Insurance Company does not provide forms within 15 days after they are requested, the claim may be submitted in a letter to the Life Insurance Company.

Proof of Loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible. Proof of Loss for Waiver of Premium must be provided within 12 months after the end of the Waiting Period. The Life Insurance Company will require further Proof pf Loss at reasonable intervals, but not more often than once a year after you have been continuously Totally Disabled for two years. If Proof of Loss is filed outside these time limits, and the Life Insurance Company can demonstrate that they are prejudiced by the delay, the claim will be denied. These limits will not apply while the eligible person or Beneficiary lacks legal capacity.

Proof of Loss means written proof that a loss occurred:

1. For which the Group Life Insurance Policy provides benefits;
2. Which is not subject to any exclusions; and
3. Which meets all other conditions for benefits.

Proof of Loss includes any other information the Life Insurance Company may reasonably require in support of a claim. Proof of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be provided until the Life Insurance Company receives Proof of Loss.

Investigation of Claim: The Life Insurance Company may have you examined at the Life Insurance Company's expense at reasonable intervals. Any such examination will be conducted by specialists of their choice. The Life Insurance Company may have an autopsy performed at their expense, except where prohibited by law.

Time of Payment: The Life Insurance Company will pay benefits within 15 days after Proof of Loss is satisfied.

Notice of Decision On Claim: The Life Insurance Company will evaluate a claim for benefits promptly after the Life Insurance Company receives it. With respect to all claims except Waiver of Premium claims, within 90 days after the Life Insurance Company receives the claim the Life Insurance Company will send the claimant: (a) a written decision on the claim; or (b) a notice that the Life Insurance Company is extending the period to decide the claim for an additional 90 days.

With respect to Waiver of Premium claims, within 45 days after the Life Insurance Company receives the claim the Life Insurance Company will send the claimant: (a) a written decision on the claim; or (b) a notice that the Life Insurance Company is extending the period to decide the claim for 30 days. Before the end of this extension period the Life Insurance Company will send the claimant: (a) a written decision on the Waiver of Premium claim; or (b) a notice that the Life Insurance Company is extending the period to decide the claim for an additional 30 days. If an extension is due to the claimant's failure to provide information necessary to decide the Waiver of Premium claim, the extended time period for deciding the claim will not begin until the claimant provides the information or otherwise responds.

If the Life Insurance Company extend the period to decide the claim, the Life Insurance Company will notify the claimant of the following: (a) the reasons for the extension; (b) when the Life Insurance Company expects to decide the claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information the Life Insurance Company needs to resolve those issues.

If the Life Insurance Company request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, the Life Insurance Company may decide the claim based on the information the Life Insurance Company has received.

If the Life Insurance Company denies any part of the claim, the Life Insurance Company will send the claimant a written notice of denial containing:

1. The reasons for their decision.
2. Reference to the parts of the Group Life Insurance Policy on which their decision is based.
3. Reference to any internal rule or guideline relied upon in deciding a Waiver of Premium claim.
4. A description of any additional information needed to support the claim.
5. Information concerning the claimant's right to a review of the Life Insurance Company decision.
6. Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

Review Procedure: If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing:

1. Within 180 days after receiving notice of the denial of a claim for Waiver of Premium;
2. Within 60 days after receiving notice of the denial of any other claim.

The claimant may send written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. The review will include any written comments or other items the claimant submits to support the claim.

The Life Insurance Company will review the claim promptly after the Life Insurance Company receives the request. With respect to all claims except Waiver of Premium claims, within 60 days after the Life Insurance Company receives the request for review the Life Insurance Company will send the claimant: (a) a written decision on review; or (b) a notice that the Life Insurance Company is extending the review period for 60 days. With respect to Waiver of Premium claims, within 45 days after the Life Insurance Company receives the request for review the Life Insurance Company will send the claimant: (a) a written decision on review; or (b) a notice that the Life Insurance Company is extending the review period for 45 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds. If the Life Insurance Company extends the review period, the Life Insurance Company will notify the claimant of the following: (a) the reasons for the extension; (b) when the Life Insurance Company expects to decide the claim on review; and (c) any additional information the Life Insurance Company needs to decide the claim.

If the Life Insurance Company request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, the Life Insurance Company may conclude the Life Insurance Company review of the claim based on the information the Life Insurance Company has received.

With respect to Waiver of Premium claims, the person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgment, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgment and will not be subordinate to that person. The claimant may request the names of medical or vocational experts who provided advice to the Life Insurance Company about a claim for Waiver of Premium.

If the Life Insurance Company denies any part of the claim on review, the claimant will receive a written notice of denial containing:

1. The reasons for their decision.
2. Reference to the parts of the Group Life Insurance Policy on which their decision is based.
3. Reference to any internal rule or guideline relied upon in deciding a Waiver of Premium claim.
4. Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.
5. Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Life Insurance Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

Section 13: ASSIGNMENT

You may make an absolute assignment of all your Life and AD&D Insurance, subject to 1 through 8 below.

1. All insurance under the Group Life Insurance Policy, including AD&D Insurance, is assignable.
2. You may not make a collateral assignment.
3. The assignment must be absolute and irrevocable. It must transfer all rights, including:
   a. The right to change the Beneficiary;
   b. The right to buy an individual life insurance policy on your life under Right To Convert;
   c. The right to receive accidental dismemberment benefits; and
   d. The right to apply for and receive an Accelerated Benefit.
4. The assignment will apply to all of your Life and AD&D Insurance in effect on the date of the assignment or becoming effective after that date.
5. The assignment may be to any person permitted by law.
6. The assignment will have no effect unless it is: made in writing, signed by you, and delivered to the Eighth District Electrical Benefit Fund or Employer in your lifetime. Neither the Life Insurance Company, the Eighth District Electrical Benefit Fund, nor the Employer are responsible for the validity, sufficiency or effect of the assignment.
7. All accidental dismemberment benefits will be paid to the assignee. All death benefits will be paid according to the beneficiary designation on file with the Eighth District Electrical Benefit Fund or Employer, and the Benefit Payment and Beneficiary Provisions.
8. The assignment will not change the Beneficiary, unless the assignee later changes the Beneficiary. Any payment the Life Insurance Company make according to the beneficiary designation on file with the Eighth District Electrical Benefit Fund or Employer, and the Benefit Payment and Beneficiary Provisions will fully discharge the Life Insurance Company to the extent of the payment.

You may not make an assignment that is contrary to the rules in 1 through 8 above.

Section 14: BENEFIT PAYMENT AND BENEFICIARY PROVISIONS

Payment of Benefits: Except as provided under the Additional Benefits paragraph below, benefits payable because of your death will be paid to the Beneficiary you name. AD&D Insurance benefits payable for Losses other than Loss of life will be paid to the person who suffers the Loss for which benefits are payable. Any such benefits remaining unpaid at that person's death will be paid according to the provisions for payment of a death benefit. Accelerated Benefits will be paid to you if you are living.

Additional Benefits will be paid as follows:

1. The Child Care Benefit will be paid to your surviving Spouse. No Child Care Benefit will be paid if you have no Spouse.
2. The Career Adjustment Benefit will be paid to your Spouse. No Career Adjustment Benefit will be paid if you have no Spouse.
3. The Higher Education Benefit will be paid annually to each eligible Child. No Higher Education Benefit will be paid if there is no Child eligible to receive it.
4. The Repatriation Benefit will be paid to the person who incurs the transportation expenses.

Naming A Beneficiary: Beneficiary means a person you name to receive death benefits. You may name one or more Beneficiaries. If you name two or more Beneficiaries in a class:

1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, the Life Insurance Company will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, the Life Insurance Company will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
3. If only one Beneficiary in a class survives, the Life Insurance Company will pay the total death benefits to that Beneficiary.

You may name or change Beneficiaries at any time without the consent of a Beneficiary. Your Beneficiary designation must be the same for Life Insurance and AD&D Insurance death benefits. You must name or change Beneficiaries in writing. Your Beneficiary designation:

1. Must be dated and signed by you;
2. Must be delivered to the Eighth District Electrical Benefit Fund or Employer during your lifetime;
3. Must relate to the insurance provided under the Group Life Insurance Policy; and
4. Will take effect on the date it is delivered to the Eighth District Electrical Benefit Fund or Employer.

If the Life Insurance Company approves it, a designation, which meets the requirements of a Prior Plan will be accepted as your Beneficiary designation under the Group Life Insurance Policy.

Simultaneous Death Provision: If a Beneficiary or a person in one of the classes listed in the "No Surviving Beneficiary" section (below) dies on the same day you die, or within 15 days thereafter, benefits will be paid as if that Beneficiary or person had died before you, unless Proof of Loss with respect to your death is delivered to the Life Insurance Company before the date of the Beneficiary's death.

No Surviving Beneficiary: If you do not name a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below.

1. Your Spouse.
2. Your children.
3. Your parents.
4. Your brothers and sisters.
5. Your estate.

Method of Payment:

1. **Lump Sum**: If the amount payable to a Recipient is less than $25,000, the Life Insurance Company will pay it in a lump sum. "Recipient" means a person who is entitled to benefits under this Benefit Payment and Beneficiary Provisions section.
2. **Standard Secure Access Checking Account**: If the amount payable to a Recipient is $25,000, or more, the Life Insurance Company will deposit it into a Standard Secure Access checking account which:
   a. Bears interest;
   b. Is owned by the Recipient;
   c. Is subject to the terms and conditions of a confirmation certificate which will be given to the Recipient; and
   d. Is fully guaranteed by the Life Insurance Company.
3. **Installments**: Payment to a Recipient may be made in installments if:
   a. The amount payable is $25,000 or more;
   b. The Recipient chooses; and
   c. The Life Insurance Company agrees.

To the extent permitted by law, the amount payable to the Recipient will not be subject to any legal process or to the claims of any creditor or creditor's representative.

Section 15: RESERVATION OF DISCRETION:

Benefits under this Group Life Insurance Policy will be paid only if the Life Insurance Company decides in their discretion that you are entitled to them. The Life Insurance Company also has discretion to determine eligibility for benefits and to interpret the terms and conditions of the Group Life Insurance Policy. Determinations made by the Life Insurance Company pursuant to this reservation of discretion does not prohibit or prevent you from seeking judicial review in court of their determinations. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when you seek judicial review of their determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the Group Life Insurance Policy. The Life Insurance Company provides insurance to this benefit plan and the court will determine the level of discretion that it will accord their determinations.

Section 16: TIME LIMITS ON LEGAL ACTIONS:

No action at law or in equity may be brought until 60 days after the Life Insurance Company has been given Proof of Loss. No such action may be brought more than three years after the earlier of the date the Life Insurance Company receives Proof of Loss, and the time within which Proof of Loss is required to be given.

Section 17: INCONTESTABILITY PROVISIONS:

1. Incontestability of Insurance: any statement made to obtain or to increase insurance is a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim unless:
   a. The insurance would not have been approved if the Life Insurance Company had known the truth; and
   b. The Life Insurance Company has given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

The Life Insurance Company will not use a misrepresentation to reduce or deny a claim after the insured's insurance has been in effect for two years during the lifetime of the insured.

2. Incontestability of Group Life Insurance Policy: Any statement made by the Eighth District Electrical Benefit Fund or Employer to obtain the Group Life Insurance Policy is a representation and not a warranty. No misrepresentation by the Eighth District Electrical Benefit Fund or Employer will be used to deny a claim or to deny the validity of the Group Life Insurance Policy unless:
   a. The Group Life Insurance Policy would not have been issued if the Life Insurance Company had known the truth; and
   b. The Life Insurance Company has given the Eighth District Electrical Benefit Fund or Employer a copy of a written instrument signed by the Eighth District Electrical Benefit Fund or Employer which contains the misrepresentation.

   The validity of the Group Life Insurance Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.

Section 18: CLERICAL ERROR, AGENCY, AND MISSTATEMENT:

Clerical error by the Eighth District Electrical Benefit Fund, your Employer, or their respective employees or representatives will not cause a person to become insured, invalidate insurance otherwise validly in force, or continue insurance otherwise validly terminated. The Eighth District Electrical Benefit Fund and your Employer act on their own behalf as your agent, and not as the Life Insurance Company agent. If a person's age has been misstated, the Life Insurance Company will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the amount of insurance based on the correct age; and the difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

Section 19: TERMINATION OR AMENDMENT OF THE GROUP LIFE INSURANCE POLICY:

The Group Life Insurance Policy may be terminated by the Life Insurance Company or the Eighth District Electrical Benefit Fund according to its terms. It will terminate automatically for nonpayment of premium. The Eighth District Electrical Benefit Fund may terminate the Group Life Insurance Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving the Life Insurance Company written notice.

Benefits under the Group Life Insurance Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of the Life Insurance Company executive officers and given to the Eighth District Electrical Benefit Fund for attachment to the Group Life Insurance Policy. If the terms of the Certificate differ from the Group Life Insurance Policy, the terms stated in the Group Life Insurance Policy will govern. The Eighth District Electrical Benefit Fund, your Employer, and their respective employees or representatives have no right or authority to change or amend the Group Life Insurance Policy or to waive any of its terms or provisions without the Life Insurance Company signed written approval. The Life Insurance Company may change the Group Life Insurance Policy in whole or in part when any change or clarification in law or governmental regulation affects the Life Insurance Company obligations under the Group Life Insurance Policy, or with the Eighth District Electrical Benefit Fund's consent. Any such change or amendment of the Group Life Insurance Policy may apply to current or future Members or to any separate classes or groups thereof.

Section 20: DEFINITIONS PERTINENT TO THE LIFE AND AD&D INSURANCE

a. **AD&D Insurance** means accidental death and dismemberment insurance, if any, under the Group Life Insurance Policy.

b. **Annual Earnings** means your annual rate of earnings from your Employer. Your Annual Earnings will be based on your earnings in effect on your last full day of active work for your Employer. Annual Earnings includes:
   1. Contributions you make through a salary reduction agreement with your Employer to an Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), or 457 deferred compensation arrangement; or an executive nonqualified deferred compensation arrangement.
   2. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

   Annual Earnings does not include: bonuses, commissions overtime pay, shift differential pay, your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan, or any other extra compensation.

c. **Contributory** means you pay all or part of the premium for insurance.

d. **Eligibility Waiting Period** means the period before you become eligible for insurance. See the Eligibility section of this Article.

e. **Evidence of Insurability** means an applicant must:
   1. Complete and sign the Life Insurance Company medical history statement;
   2. Sign the Life Insurance Company form authorizing the Life Insurance Company to obtain information about the applicant's health;
   3. Undergo a physical examination, if required by the Life Insurance Company, which may include blood testing; and

4. Provide any additional information about the applicant's insurability that the Life Insurance Company may reasonably require.

f. **Group Life Insurance Policy** means the group life insurance policy issued by the Life Insurance Company to the Eighth District Electrical Benefit Fund and identified by the Group Life Insurance Policy Number.

g. **Injury** means an injury to your body.

h. **Life Insurance** means life insurance under the Group Life Insurance Policy.

i. **Noncontributory** means the Eighth District Electrical Benefit Fund or your Employer pays the entire premium for insurance.

j. **Physician** means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

k. **Pregnancy** means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

l. **Prior Plan** means your Employer's group life insurance plan in effect on the day before the effective date of your Employer's coverage under the Group Life Insurance Policy and which is replaced by the Group Life Insurance Policy.

m. **Sickness** means your sickness, illness, or disease.

n. **Spouse** means a person to whom you are legally married. However, for purposes of insurance under the Group Life Insurance Policy, Spouse does not include a person who is a full-time member of the armed forces of any country or a person from whom you are divorced or legally separated.

Section 21: ERISA INFORMATION AND NOTICE OF RIGHTS: See Article XVI.

ARTICLE XIX: DEPENDENT LIFE INSURANCE

Section 1: Overview

The benefits described in this Article are self-funded by the Trust and payable by the Administrative Office whose name and address are listed on the Quick Reference Chart in the front of this document.

Section 2: LIFE BENEFIT

a. **Maximum Benefit.** If an Eligible Employee's or Qualified Beneficiary's Dependent dies, the Plan will, subject to the provisions hereafter stated pay a benefit of:

Dependent	Benefit
Dependent Spouse	$2,000
Dependent Children - birth to six (6) months of age	$1,000
Dependent Children - six (6) months to the end of the month in which the Dependent Child attains age 26.	$2,000

b. **Beneficiary.** The Dependent life benefit payable by the Plan due to the death of a Dependent shall be paid to the Eligible Employee/Qualified Beneficiary, if living, or if the Eligible Employee/Qualified Beneficiary is not living at the time of payment, payment may be made to the executors or administrator of the survivor of the Eligible Employee/Qualified Beneficiary or such Dependent as the Board of Trustees, in its sole discretion, may designate.

Section 3: EXCLUSIONS

This Dependent Life Insurance benefit is not extended to self-pay individuals not enrolled under the appropriate benefit option providing Dependent life benefits.