AMENDMENT NO. 14
TO THE EIGHTH DISTRICT ELECTRICAL BENEFIT FUND
SUMMARY PLAN DESCRIPTION /PLAN RULES AND REGULATIONS
For Active Employees, Early (non-Medicare-eligible) Retirees and Medicare-eligible Retirees
effective January 1, 2014

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

Article VIII, Section 1 (d) is amended to read as follows:

d. SPECIAL REIMBURSEMENT PROVISION.

The following chart explains the Plan's special reimbursement for services when certain Out-of-Network providers are used. The Plan Administrator or its designee determines if and when the following special reimbursement circumstances apply to a claim after the normal claim adjudication processes have been followed/investigated. Medical records may be requested in order to assist with a determination on the need for a special reimbursement provision.

SPECIAL REIMBURSEMENT PROVISIONS This chart explains when the Plan's special reimbursement provisions apply if the services of certain Out-of-Network Providers are used.	**WHAT THE PLAN PAYS** **(toward eligible claims submitted by an Out-of-Network provider)**
a. The individual had Emergency Care at a provider/facility outside the In-Network service area. b. The participant has Emergency Care provided at an In-Network Facility, by an Out-of-Network provider. c. The individual schedules a surgery with an In-Network surgeon at an In-Network facility and during the procedure, Medically Necessary services are provided by an Out-of-Network Radiologist, Anesthesiologist, Pathologist, Assistant Surgeon or Surgical Assistant For this special reimbursement provision to apply, the individual must not have had any control in choosing the Out-of-Network Radiologist, Anesthesiologist, Pathologist, Assistant Surgeon or Surgical Assistant that was used during the procedure. d. Claims incurred for surgery to correct a Chiari malformation (a structural defect in the cerebellum of the brain) will be treated as In-Network regardless of whether the surgery is performed by an In-Network provider or an Out-of-network provider.	As if the care was provided In-Network (including deductible, coinsurance, copays, Coinsurance Maximum and Out-of-Pocket Limits), based on the Allowed Charge for Out-of-Network providers. The amount the Participant pays toward his or her copayment, coinsurance and/or deductible will be applied to the Participant's annual coinsurance maximum and/or out-of-pocket maximum. The Plan reserves the right to have the billed amount of an Out-of-Network provider's claim reviewed under the Plan's Out-of-Network Savings Program and/or negotiate a discount of the billed charges and/or review the billing/service by an independent medical review firm. See the definition of Allowed Charge in the Definitions Article of this document.

SPECIAL REIMBURSEMENT PROVISIONS This chart explains when the Plan's special reimbursement provisions apply if the services of certain Out-of-Network Providers are used.	WHAT THE PLAN PAYS (toward eligible claims submitted by an Out-of-Network provider)
e. Use of an Out-of-Network provider when an In-Network provider was available to be used. For example, provision applies if an In-Network provider refers the individual to an Out-of-Network provider or facility, including an Out-of-Network specialist or laboratory.	As if the care was provided Out-of-Network (including deductible, coinsurance, copays) based upon the Allowed Charge for Out-of-Network providers. The Plan reserves the right to have the billed amount of an Out-of-Network provider's claim reviewed under the Plan's Out-of-Network Savings Program and/or negotiate a discount of the billed charges and/or review the billing/service by an independent medical review firm.

Article XVII, Definitions, the definition of Allowed Charge is amended to add the text in italics:

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 *and the Special Reimbursement Provisions described in Article VIII;* 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. *See also the Special Reimbursement Provisions described in Article VIII.*

CONFIRMATION

The undersigned Chairman and Secretary of the Board of Trustees of the Eighth District Electrical Benefit Fund do hereby certify that the foregoing Amendment #14 to the 2014 Plan was duly adopted and executed at a meeting of the Board of Trustees called and held on _____, 20____.

By: _____
Chairperson

By: _____
Secretary

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