AMENDMENT NO. 23
TO THE EIGHTH DISTRICT ELECTRICAL BENEFIT FUND
SUMMARY PLAN DESCRIPTION /PLAN RULES AND REGULATIONS
For Active Employees, Early (non-Medicare-eligible) Retirees and Medicare-eligible Retirees
effective January 1, 2014

Effective as listed below, the Summary Plan Description/Plan Rules and Regulations is amended as follows:

ARTICLE I: INTRODUCTION

Effective January 1, 2021, Article I shall be amended at "Suggestions for Using This Document" by deleting the current 3rd bullet and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

- 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.

ARTICLE III: ELIGIBILITY

Effective November 1, 2020, Article III shall be amended at Section 1 – Eligibility for Bargaining Employees at subsection f by adding the following new 5 to the end of the subsection:

5. **Short Hour Self-Pay.** Active Bargaining Employees will be allowed to make short hours self-payments to maintain coverage under the plan if the following provisions are met:

   a. was covered by the Plan in the month prior to the month the Active Bargaining Employee is in danger of losing eligibility due to a period of unemployment or under-employment; and
   b. has at least 100 hours in their hour bank and/or has the equivalent in current contributions received.

   If a Bargaining Employee does not have at least 100 hours multiplied by the current contribution rate combined in his hour bank and current contributions received, he is not eligible to make a short hour self-payment to continue eligibility.

   Extending eligibility through short hour self-payments will provide the same benefits that the Bargaining Employee was provided as an Active Employee as applicable to the Bargaining Employee, with the exception that no Contributions will be allowed to the PCA Account on short-hour self-pay hours. In addition, the Plan's Weekly Disability benefits will be provided to those covered by the Plan pursuant to the short-hour self-payment provisions, if the Employee was eligible for Weekly Disability benefits when (s)he had coverage from the Plan as an Active Employee. Travelers qualifying for short hour self-payment will receive Weekly Disability Benefits.

   If the requirements listed above are met, a short hour self-payment in an amount equal to the difference between the total amount of current hours in the hour bank and the required 143 hours multiplied by the current contribution rate for the agreement you are working under in order to meet the monthly eligibility requirement.

   Short hour self-payment coverage is offered when the Bargaining Employee who had coverage in the month prior to the month (s)he is in danger of losing eligibility due to a period of unemployment or under-employment. This is the same time that COBRA Continuation Coverage is offered and will be concurrent with COBRA. The Bargaining Employee who satisfies the short hour self-payment requirements can make up to two short hour self-payments and then continue to receive the remaining months of COBRA as described in Article IV of the Plan. If you are eligible for a COBRA subsidy from the Fund, such COBRA subsidy will apply for the first three months in which you make a COBRA payment.

   A Bargaining Employee can obtain coverage from the Plan via short-hour self-payment for two months within a 12-month lookback period. Unless there are extenuating circumstances, as determined solely by the Board of Trustees, your coverage from the Plan through self-payments will terminate if the Fund Office does not receive your short hour self-payment in full by the 15th of the month in which coverage would have been lost had you not made a short-hour self-payment.

   Failure to make a timely or making an incorrect short hour self-contribution payment shall result in a loss of

eligibility and the right to make future self-contribution payments until your eligibility is reinstated according to Article III, Section 1.i of the Plan. Your unused hour bank will remain as is and can be used for future eligibility within six months.

Effective January 1, 2021, Article III shall be amended at Section 4 – Eligibility for Dependents of Bargaining and Non-Bargaining Employees by deleting the current subsection a and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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

1. **Dependent Eligibility**: Employees must enroll their eligible Dependent (including a spouse or child) 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. **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.
3. **New Dependent Enrollment**: This is the first opportunity for the employee to enroll a Dependent because of an event such as marriage, birth, adoption or placement for adoption. If an employee enrolls a new dependent child (newborn/adopted/placed for adoption/new stepchild) or a new spouse within 90 days of the event (the child's birth, adoption, placement for adoption, or the employee marriage), 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.

Effective January 1, 2021, Article III shall be further amended at Section 4 –Eligibility for Dependents of Bargaining and Non-Bargaining Employees by deleting the current subsections d and e in their entirety and renumbering the subsequent subsections accordingly.

Effective January 1, 2021, Article III shall be further amended at Section 4 –Eligibility for Dependents of Bargaining and Non-Bargaining Employees by deleting the current subsection f (renumbered to subsection d by this amendment) and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

d. **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) 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 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 Continuation Coverage.

Effective January 1, 2021, Article III shall be amended at Section 5 – Eligibility for Retirees: Early (non-Medicare Eligible) Retirees and Medicare-Eligible Retirees) at subsection f by deleting the subsection and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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,
3. Surviving (Medicare-eligible) Spouse of a deceased Retired Employee or Medicare-eligible Retiree with no dependents,
4. Retired Employee and Spouse, one of which is covered by Medicare.

Effective January 1, 2021, Article III shall be amended at Section 5 – Eligibility for Retirees: Early (non-Medicare Eligible) Retirees and Medicare-Eligible Retirees) at subsection i by deleting the subsection and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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).
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.

Effective January 1, 2021, Article III shall be amended at Section 6 – Eligibility for Dependents of a Retiree at subsection a by deleting the subsection and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

a. **Eligibility of Dependents of a Retired Employee (Retiree):**
   1. **Dependent Eligibility**: Retirees must enroll their eligible Dependent (including a spouse or child) 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. **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.
   3. **New Dependent Enrollment**: This is the first opportunity for the retiree to enroll a Dependent because of an event such as marriage, birth, adoption, or placement for adoption. If a retiree enrolls a new dependent child (newborn/adopted/placed for adoption/new stepchild) or a new spouse within 90 days of the event (the child's birth, adoption, placement for adoption, or the retiree's marriage), 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.
   4. **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.

Effective January 1, 2021, Article III shall be amended at Section 6 – Eligibility for Dependents of a Retiree at subsection c by deleting the subsection and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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);
   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.

Effective January 1, 2021, Article III shall be amended at Section 6 – Eligibility for Dependents of a Retiree at subsection d by deleting the subsection and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

d. **Coverage for Surviving Spouse and Dependent Children 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) will remain in effect until the Surviving Spouse and Surviving Dependent Children 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.

Effective January 1, 2021, Article III shall be amended at Section 5 – Eligibility for Retirees: Early (non-Medicare Eligible) Retirees and Medicare-Eligible Retirees) at subsection l by deleting the subsection and replacing it with the following:

l. Medicare Retiree One-Time Reenrollment Opportunity
Effective January 1, 2020 – December 31, 2020, a new Medicare-eligible Retiree will be allowed to opt out of the MA-PD Plan and transition to an individual Medicare Supplement Plan, Medicare Advantage Plan, and/or a Medicare Part D Plan, with the opportunity to reenroll in coverage from the MA-PD Plan the following year if the Medicare-eligible Retiree meets the following criteria:

1) (s)he must opt back into this Plan with an effective date of Plan coverage of January 1, 2021;

2) (s)he must provide proof of other coverage from a Medicare Supplement Plan, Medicare Advantage Plan, or a Medicare Part D Plan for the time period they did not have coverage from this Plan; and

3) (s)he must provide the appropriate premium payment to this Plan by January 1, 2021.

Effective January 1, 2021, Article III shall be amended at Section 6 – Eligibility for Dependents of a Retiree at subsection a by adding the following 6:

6. Medicare-Eligible Dependent One-Time Reenrollment Opportunity
Effective January 1, 2020 through December 31, 2020, a Medicare-eligible Dependent will be allowed to opt out of the MA-PD Plan and transition to an individual Medicare Supplement Plan, Medicare Advantage Plan, and/or a Medicare Part D Plan, with the opportunity to reenroll in coverage from the Eighth District Electrical Benefit Fund the following year if the Medicare-eligible Dependent meets the following criteria:

1) (s)he must opt back into this Plan with an effective date of Plan coverage of January 1, 2021;

2) (s)he must provide proof of other coverage from a Medicare Supplement Plan, Medicare Advantage Plan, or a Medicare Part D Plan for the time period they did not have coverage from this Plan; and

3) (s)he must provide the appropriate premium payment to this Plan by January 1, 2021.

Effective January 1, 2021, Article III shall be further amended at Section 6 – Eligibility for Dependents of a Retiree at subsection c by adding the following 9:

9. December 31, 2020 for a Medicare Retiree who opted out of the MA-PD Plan and transitioned to a different Medicare coverage and does not reenroll in coverage in the MA-PD Plan by December 31, 2020.

Effective January 1, 2021, Article III shall be amended at Section 7 – Proof of Dependent Status by deleting subsections h & i to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child". The updated Section 7 is as follows:

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 and a document that shows your spouse resides with you
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.

Effective January 1, 2021, Article III shall be amended at Section 13 – Notice to the Plan by deleting the text box and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

NOTICE YOU NEED TO GIVE TO THE PLAN
You, your Spouse, or any of your Dependent Children **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);

Failure to give this Plan a timely notice will cause your Spouse and/or Dependent Child(ren) 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.

Effective January 1, 2021, Article III shall be amended at Section 14 – HIPAA Certificate of Credible Coverage when Coverage Ends at subsection c by deleting the current subsection and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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) 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

Effective January 1, 2021, Article IV shall be amended at Section 4 – Who is Entitled to COBRA Continuation Coverage, When and How Long at subsection c by deleting the current subsection and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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 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.
c. "**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 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 is not entitled to elect COBRA for him/herself.

d. **"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.

Effective January 1, 2021, Article IV shall be amended at Section 6 – Special Enrollment Rights by deleting the current Section and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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 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.

Effective January 1, 2021, Article IV shall be amended at Section 9 – COBRA Qualifying Events by deleting the current table headings and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1] and individuals entitled to COBRA-like benefits		
	Employee	Spouse	Dependent Child(ren)

Effective January 1, 2021, Article IV shall be amended at Section 15 – Confirmation of Coverage Before Election or Payment of COBRA Coverage by deleting the current Section and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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) 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) 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.

Effective January 1, 2021, Article IV shall be amended at Section 16 – Addition of Newly Acquired Dependents by deleting the current Section and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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, that now qualifies for benefits, you may enroll that Spouse or child 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 may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

Effective January 1, 2021, Article IV shall be amended at Section 17 – Loss of Other Group Health Plan Coverage by deleting the current Section and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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 loses coverage under another group health plan, you may enroll the Spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or dependent 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 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 may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Effective January 1, 2021, Article IV shall be amended at Section 19 – Extended COBRA Coverage when a Second Qualifying Event Occurs During and 18-Month COBRA Continuation Period by deleting the current Section and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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 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.

Effective January 1, 2021, Article IV shall be amended at Section 24 – COBRA Questions or to Give Notice of Changes is your Circumstances by deleting the current Section and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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 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**.

Effective January 1, 2021, Article IV shall be amended at Section 26 – Continuation of Benefits Under Non-COBRA Self-Payment Provisions by deleting the current subsection b and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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

1. The surviving Spouse 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.

Effective January 1, 2021, Article IV shall be amended at Section 26 – Continuation of Benefits Under Non-COBRA Self-Payment Provisions by deleting the current subsection c and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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, 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 of a deceased disabled employee** may continue coverage under the Medical Plan including coverage for Dependent Children.

5. **Coverage for a surviving Spouse 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 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.

ARTICLE V: PERSONAL CARE ACCOUNTS (PCA)

Effective January 1, 2021, Article V shall be amended at Section 1 – Establishment of Personal Care Account(s) at subsection d by deleting the current definition of "PCA Participant" and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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.

ARTICLE VI: MEDICAL PLAN

Effective January 1, 2021, Article VI shall be amended at Section 9 – Out-of-Pocket Limit (Annual Limit on In-Network Cost Sharing) in Subsection a by deleting "and Vision" in the first sentence. The updated Subsection will be as follows:

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 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.

Effective January 1, 2021, Article VI shall be amended at Section 9 – Out-of-Pocket Limit (Annual Limit on In-Network Cost Sharing) in Subsection b by deleting "and Vision" from the 2nd column in the table. The updated table will be as follows:

Annual Limit on Cost Sharing is:	***Out-of-Pocket Limit Applies to:**
$2,500 per individual $5,000 per family	Deductibles, copayments and coinsurance related to In-Network essential health benefits for Medical Plan expenses accumulate to the Out-of-Pocket Limit.

Effective January 1, 2021, Article VI shall be amended at Section 9 – Out-of-Pocket Limit (Annual Limit on In-Network Cost Sharing) in Subsection c by deleting "and Vision" from item #6. The updated item #6 will be as follows:

6) Charges in excess of the Medical Plan's Maximum Benefits,

Effective January 1, 2021, Article VII shall be amended at Annual Coinsurance Maximum by deleting the entire row for Annual Coinsurance Maximum.

Effective January 1, 2021, Article VII shall be amended by deleting Vision Exam Services.

ARTICLE IX: PRECERTIFICATION AND MEDICAL REVIEW

Effective September 22, 2020, Article IX shall be amended at Section 5 – Precertification (Preservice) Review at the table is subsection a by deleting the current table and replacing it with the following:

WHAT SERVICES MUST BE PRECERTIFIED: ***(The services listed below are on a list maintained by the Administrative Office and are subject to change. Please contact the Administrative Office with any questions)***	MEDICAL REVIEW FIRM TO BE CONTACTED	PENALTY FOR FAILURE TO PRECERTIFY
If you use a CIGNA participating provider, your doctor will work with CIGNA to arrange precertification. If you use a provider who does not participate in CIGNA, YOU are responsible for obtaining precertification of these services by calling the Utilization Management Company listed on the Quick Reference Chart in the front of the document: 1. All Elective Hospital admissions, including an admission for mental health and/or substance abuse. *(Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section).* 2. Partial hospitalization, Residential treatment program admission, skilled nursing facility admission and inpatient rehabilitation admission. (Note that there is no coverage for a non-network residential treatment program, skilled nursing facility or inpatient rehabilitation facility even if precertified.) 3. An upcoming transplant as soon as the participant is identified as a potential transplant candidate. Transplantation-related outpatient services and admission to a hospital for a transplant may require precertification. 4. 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. 5. Home Health Care services and home infusion services. 6. Outpatient injectable drugs administered in an outpatient facility. 7. Diagnostic radiology type services (such as MRI, CT scan, PET scan, nuclear radiology service, etc.). 8. Speech therapy. 9. Orthotic devices. 10. Prosthetic devices including implantable hearing aids such as cochlear implant. 11. Durable Medical Equipment. 12. For individuals who will participate in a clinical trial, precertification is required in order to notify the Plan that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.	**Utilization Management (UM) Company** whose name and phone number are listed on the Quick Reference Chart in the front of this document.	**If you fail to notify the Utilization Management (UM) Company before receiving any services requiring precertification (noted to the left) then, benefits may NOT be paid for the related expenses.**

Certain specialty prescription drugs	**Prescription Drug Program** whose name and phone number are listed on the Quick Reference Chart in the front of this document.	**If you fail to notify the Prescription Drug Program before receiving any services requiring precertification then benefits may NOT be paid for the related expenses.**

ARTICLE X: MEDICAL PLAN EXCLUSIONS

Effective October 1, 2020, Article X shall be amended at Section 1 – General Exclusions by deleting "Chiropractor," from Exclusion 25. The updated exclusion will be as follows:

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.

ARTICLE XI: VISION PLAN

Effective January 1, 2021, Article XI shall be amended at Section 1 – Overview of the Vision Plan by deleting the second paragraph in subsection a and replacing it with the following:

a. Vision Plan Benefits are treated as an excepted benefit under HIPAA and the PPACA. Upon written request to the Administrative Office, Eligible Employees or Eligible Dependents may opt out of (and, if applicable, opt back in to) Vision Plan Benefits from this Plan. Because contribution rates to the Fund are included in Collective Bargaining Agreements, the contribution on behalf of an Eligible Employee or Eligible Dependent who has opted out will not be reduced. Any such opt out (or, if applicable, opt in) will be effective the first day of the second calendar month after the written request is received by the Fund Office.

Effective January 1, 2021, Article XI shall be amended at Section 3 – Schedule of Vision Benefits by deleting the Vision Examination row. The updated table is as follows:

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. • For All Eligible Employees and Eligible Dependents.	100% up to $100 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. • Only for Eligible Employees and Eligible Dependents that work under a Local 768 Utility Agreement that have negotiated collective bargaining agreements with extra vision benefits.	100% to a maximum of $50.
Lenses for Eyeglasses	• Lenses are payable every 24 months. • Only for Eligible Employees and Eligible Dependents that work under a Local 768 Utility Agreement that have negotiated collective bargaining agreements with extra vision benefits	• Single Vision (Standard): 100% to a maximum of $30 • Bifocal: 100% to a maximum of $40 • Trifocals: 100% to a maximum of $55 • Lenticular: 100% to a maximum of $80

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**
Contact Lenses	• One set of contact lenses are payable every 24 months. • Only for Eligible Employees and Eligible Dependents that work under a Local 768 Utility Agreement that have negotiated collective bargaining agreements with extra vision benefits	100% to a maximum of $150

Effective March 1, 2021, Article XI shall be further amended at Section 3 – Schedule of Vision Benefits by updating the benefits maximums as shown below. The updated table is as follows:

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. • For Eligible Employees and Eligible Dependents.	100% up to $100 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. • Only for Eligible Employees and Eligible Dependents that work under a Local 768 Utility Agreement that have negotiated collective bargaining agreements with extra vision benefits	100% to a maximum of $65.
Lenses for Eyeglasses	• Lenses are payable every 24 months. • Only for Eligible Employees and Eligible Dependents that work under a Local 768 Utility Agreement that have negotiated collective bargaining agreements with extra vision benefits	• Single Vision (Standard): 100% to a maximum of $36 • Bifocal: 100% to a maximum of $51 • Trifocals: 100% to a maximum of $65 • Lenticular: 100% to a maximum of $94
Contact Lenses	• One set of contact lenses are payable every 24 months. • Only for Eligible Employees and Eligible Dependents that work under a Local 768 Utility Agreement that have negotiated collective bargaining agreements with extra vision benefits	100% to a maximum of $165

ARTICLE XIV: CLAIM FILING AND APPEAL INFORMATION

Effective January 1, 2021, Article XIV shall be amended at Section 12 – How to File a Post Service Claim for Benefits Under this Plan at subsection 7 by deleting the current subsection and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

1. 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**, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility (e.g. copy of marriage certificate).
  - 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.

ARTICLE XV: COORDINATION OF BENEFITS (COB)

Effective January 1, 2021, Article XV shall be amended at Section 6 – Coordination with Medicare at subsection b by deleting the current subsection and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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), 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.

ARTICLE XVI: GENERAL PROVISIONS AND ERISA INFORMATION

Effective January 1, 2021, Article XVI shall be amended at Section 22 – Facility of Payment by deleting the current Section and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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, 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.

Effective January 1, 2021, Article XVI shall be amended at Section 30 – Submission of Falsified or Fraudulent Claims (Rescission of Coverage) by deleting the current Section and replacing it with the following to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

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 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.

ARTICLE XVII: DEFINITIONS

Effective December 10, 2020, Article XVII will be amended at the definition for Allowed Charge/Allowed Amount/Allowable Charge by deleting the current subsections 5 & 6 and replacing them with the following:

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:

5. **With respect to a non-network provider for other than Emergency Room services**, allowed charge amount means the reference-based pricing schedule at the 90th percentile 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 based on or is 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; or
6. **With respect to a non-network provider for Emergency Room services**, allowed charge amount means the lesser of 100% of the billed charges or a lower charge that may be negotiated with the non-network provider.

Effective January 1, 2021, Article XVII will be amended by deleting the definitions for "Domestic Partner" and "Domestic Partner Dependent Child".

Effective January 1, 2021, Article XVII will be amended at the following definitions to remove the references to "Domestic Partner" and "Domestic Partner Dependent Child":

Covered Individual: Any employee and/or retiree and that person's eligible Spouse or 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.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse 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 a person to whom the Eligible Employee is legally married and to whom the Eligible Employee is not legally separated from; and

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**: A Disabled Adult Child is a Dependent Child who over the age of 26 and is incapable of self-sustaining employment by reasons of mental or physical disability that commenced (1) while the child was covered by the Fund as a dependent and (2) before the child would have lost coverage from the Fund if not for the disability. You must submit proper notification and proof of such disability to the Administrative Office within thirty-one (31) days of the child's 26th birthday. 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.

Eligible Dependent: Your lawful Spouse and your Dependent Child(ren). 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.

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;

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.

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 of a deceased Retiree.

ARTICLE XVIII: LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Effective September 24, 2020, Article XVIII shall be amended at Section 14 – Benefit Payment and Beneficiary Designation adding the following to the end of the Section:

Notwithstanding the foregoing, an Employee's designation of his/her Spouse as beneficiary shall become null and void automatically upon divorce. Should the Employee wish to maintain the beneficiary designation of an ex-Spouse, he/she must fill out a new Enrollment Card dated after the divorce. In the event that you have designated your Spouse and another individual as your designated beneficiaries, only the portion of the Enrollment Card that relates to your ex-Spouse will automatically become null and void upon divorce.

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 #23 to the 2014 Plan was duly adopted and executed at a meeting of the Board of Trustees called and held on June 22, 2021.

By: _____
Chairperson

By: _____
Secretary