Eighth District Electrical Fringe Benefit Funds
P.O. Box 30751
Salt Lake City, UT 84130
Toll Free: (844) 989-2321
Website: www.8thDistrictBenefits.org

Participant Member Benefit Website
www.8thDistrictBenefits.org

Dear Member:

The Trustees of the Eighth District Electrical Fringe Benefit Funds are pleased to announce a new member benefit website, www.8thDistrictBenefits.org. This website is intended to provide you with a more effective way to access and manage your benefits.

The website enables you to obtain basic benefit information about the Plan, review answers to frequently asked questions, access your personal benefit information, and to better communicate with the Benefit Office, including via e-mail. You can also find helpful links regarding benefits provided by the Plan.

To access your personal benefit information, such as your benefit elections, work history detail, forms, and Plan documents, you need to register as a new user by clicking the ***Create an Account*** link at the top right-hand corner in the Login box. More detailed instructions are shown on the back of this letter. Once you are registered, you can access your personal benefit information by entering your ***Username*** and ***Password***, so please keep these confidential. **Please note, only one username and password are permitted per email address. If more than one person in your family requires website access, each family member must use a different email address.** Every member, spouse, and dependent over the age of 18 will need to create their own login that will give them access to their own Protected Health Information (PHI). Each person that creates their own username and password will not have their PHI available for viewing by any other user.

If you encounter any difficulty retrieving your Username and Password, or if you have any questions regarding the Member Benefit website, please contact the Benefit Office toll free at 844-989-2321. You can also email the Benefit Office directly by using the ***"Contact Us"*** section of the website.

Additionally, we ask that you please review and verify the eligible dependents on your account. If any changes are needed, please note that the enrollment forms required for updating this information are located under the Documents tab under the Health Care Forms section. Please select a form from the following based on your type of coverage: Active (regular), Basic, or Non-bargaining Enrollment. Please submit the form to the Eligibility Department via email at: eligibility@8thdistrictbf.org, or by mail to: P.O. Box 30751, Salt Lake City, UT 84130. If you have any questions, please contact the Eligibility Department at 844-989-2321.

Please visit the Member Benefit website soon and see all that it has to offer!

Board of Trustees,

Eighth District Electrical Fringe Benefit Funds

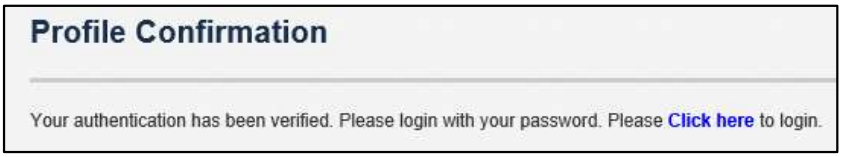
HOW TO REGISTER ON THE WEBSITE

When registering for the first time, please follow these instructions:

1) From your computer or mobile device, connect to the website listed on the front page of this letter.
2) Locate the Login box in the upper right-hand corner of the screen.
3) Click on "Create an Account" to get started.

4) The Registration Screen will display next. Please enter all information, as all fields are required. Once all information has been entered, please click "Submit" on the bottom of the screen.

5) After registering you will receive an email notification with a link to confirm your registration. Your email address will also be used in the event you forget your username and password.



Eighth District Electrical Fringe Benefit Funds

NEW MEMBER ENROLLMENT PACKET

Dear Participant:

This enrollment package was sent to you because you are or will soon be eligible for health care coverage. In order to better understand the benefits that are available to you, it is important that you carefully read all the information included in this package. This letter is a brief breakdown of some of the important information and forms that are enclosed in this package. It is important that you fully and legibly complete and return all required documents as soon as possible.

Any missing information or incomplete forms, will delay the processing of your medical claims

Enclosed in this package please find the following:

Enrollment Form – This is required for all new participants. Only dependents listed on this form will have coverage from the Plan. Please complete accordingly, sign/date, and return form to the Trust Fund Office.

Coordination of Benefits Form – Complete this form if you, your spouse, or any of your dependents have other health insurance coverage. If you and/or dependents ***do not*** have any other coverage, please check the indicator box and sign/date the bottom of the page under "Member Statement" and return to the Trust Fund Office.

Authorization for Release of Protected Health Information (PHI) – Please read the enclosed HIPAA and Protected Health Information (PHI) notice, which explains your rights and how and when information may be disclosed. You may give permission for the Trust Fund to release your information to someone else by completing, signing, and returning the Authorization for Release of Protected Health Information Form to the Trust Fund Office.

Beneficiary Designation Forms – It is strongly recommended that you complete these forms in order to ensure that death benefits are paid according to your wishes. Please complete, sign, and return to the Trust Fund Office.

Benefit Summaries – Please refer to these sheets for a summary of the medical benefits available through the plan. Additional coverage information can also be found using the Participant Portal www.8thDistrictBenefits.org.

You will also find other forms and information included in this packet. Please feel free to contact the Fund Office at (844) 989-2321 or Eligibility@8thdistrictbf.org with any questions.

-OVER-

Physical Address: 4704 Harlan Street, Suite 104 • Denver, CO 80212
Physical Address: 5295 South Commerce Drive, Suite 220• Murray, UT 84107
Mailing Address: P.O. Box 30751 • Salt Lake City, UT 84130
Toll Free: 844-989-2321
www.8thDistrictBenefits.org

Eighth District Electrical Fringe Benefit Funds

CHECK-OFF LIST

Forms to be returned to Fund office:

☐ **Enrollment Form** – ***required for all participants.*** Only dependents listed on this form will have coverage from the Plan. **(Please make sure to attach ALL LEGAL DOCUMENTS that apply to adding your dependents).**

☐ **Coordination of Benefits Form** – ***required for all participants.*** Complete this form if you, your spouse, or any of your dependents have other healthcare insurance coverage. If you and/or dependents do not have any other coverage, please check the indicator box and sign/date the bottom of the page under "Member Statement" and return to the Trust Fund office with your Enrollment Form.

☐ **Authorization for Release of Protected Health Information (PHI)** - ***required for all participants.*** It is strongly recommended that you, your spouse, and your eligible dependents over the age of 18 complete the Authorization for Release of Protected Health Information (PHI) form.

☐ **Beneficiary Designation Forms** - ***required for all participants.*** It is strongly recommended that you complete these in order to ensure that death benefits are paid according to your wishes.

Certificate(s) to be included:

☐ Certified Marriage Certificate to enroll spouse
☐ Certified Birth Certificate for natural children, stepchildren & adopted children
☐ Adopted Child (include birth certificate, legal adoption documents or documents placing child with you (member) for purposes of adoption.
☐ Disabled Dependent (include birth certificate and physician's certificate)

Coverage will not be provided for your dependents until all the proper documentation is received

Please do not mail original certificates or other documents; a photocopy is sufficient

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Eighth District Electrical Fringe Benefit Funds

ENROLLMENT FORM (ACTIVE PLAN)

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME: _____SSN: _____

ADDRESS: _____CITY: _____

STATE: _____ZIP: _____DATE OF BIRTH: _____GENDER: (Mark One) Male _____Female _____

PHONE NUMBER: (_____) _____EMAIL:_____

EMPLOYER:_____DATE OF HIRE:_____LOCAL UNION #_____

MEDICAL PLAN (Provided By):	**DENTAL (Provided By):**	**PRESCRIPTION (Provided By):**
CIGNA	**ANTHEM DENTAL**	**SAV-RX**

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:

Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SSN	GENDER

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

MEMBER SIGNATURE: _____ DATE: _____

Physical Address: 4704 Harlan Street, Suite 104 • Denver, CO 80212
Physical Address: 5295 South Commerce Drive, Suite 220 • Murray, UT 84107
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Toll Free: 844-989-2321
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Coordination of Benefits

Member's Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____

☐ ***If you and/or spouse/dependents DO NOT have any other insurance coverage, please check this box turn over and sign/date the bottom of the next page (under "Member Statement").***

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

A MEMBER HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? ☐ Yes or ☐ No If yes, is this plan an: ☐ HMO or ☐ PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? ☐ Yes or ☐ No If yes, is this plan an: ☐ HMO or ☐ PPO

Name of Dental Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? ☐ Yes or ☐ No If yes, is this plan an: ☐ HMO or ☐ PPO

Name of Vision Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? ☐ Age ☐ Disability ☐ ESRD

Part: A ☐ B ☐ C ☐ D ☐ Effective Date: A) _____ B) _____ C) _____ D) _____

B SPOUSE AND DEPENDENTS HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? ☐ Yes or ☐ No If yes, is this plan an: ☐ HMO or ☐ PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? ☐ Yes or ☐ No If yes, is this plan an: ☐ HMO or ☐ PPO

Name of Dental Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? ☐ Yes or ☐ No If yes, is this plan an: ☐ HMO or ☐ PPO

Name of Vision Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? ☐ Age ☐ Disability ☐ ESRD

Part: A ☐ B ☐ C ☐ D ☐ Effective Date: A) _____ B) _____ C) _____ D) _____

1.) Dependent: _____

☐ **Medical/Rx** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

2.) Dependent: _____

☐ **Medical/Rx** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

Continuation on other Side

For additional dependents, ATTACH A SEPARATE sheet with employee's name at top. (Last, First, MI)

3.) Dependent: _____

☐ **Medical/Rx** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

4.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

C

FILL OUT THIS SECTION ONLY IF YOUR CHILD(REN) HAVE ADDITIONAL HEALTHCARE COVERAGE DUE TO •DIVORCE •SEPARATION •COURT ORDER •MEDICARE OR •OTHER FEDERAL-STATE HEALTH INSURANCE PROGRAMS.

*****(Indicate which child by marking appropriate circle) *****

1.) Is child(ren) covered by Medicare or other Federal-State coverage? □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

Medi-Cal/Medicaid: Policyholder name: _____ Policy Number: _____

2.) Does one parent/guardian have full custody of the child(ren): □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

3.) Is one parent required by court decree to provide health insurance for child(ren): □ Yes or □ No ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

Name of person responsible for child's healthcare coverage? _____

Employer: _____ Date of Birth: _____

Insurance Company name: _____ Insurance Company City & State: _____

Insurance Company Phone Number: _____ Enrollee ID/ policy number: _____

Group Number: _____ Effective date: _____ Cancellation date (if applicable): _____

******If court decree is present please PROVIDE A COPY of the court documents** ****

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I am also aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers because of such material in any matter.

Signature: _____ **Phone #:** _____ **Date:** _____

Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Member/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Member Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-
   If you are not married or **you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says, "I do not want my Health Information released to anyone but myself". **Please sign and date below the box**.

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).
   If you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says, "I do not want my Health Information released to anyone but myself".

3. **Please sign and date form below the box**.

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
   If want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says, "I do not want my Health Information released to anyone but myself".

3. **Please sign and date form below the box**.

Only an electronic image copy of the Authorization Form will be kept on file at the Health Care Office. If you wish to retain a copy of the document for your records, please make one before mailing.

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, (**Name, Please Print**)_____, (**Social Security #**)_____, authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons for benefit and claims inquiries:

Name:_____ Relationship: _____ _____

Name:_____ Relationship: _____ _____

I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

Eighth District Electrical Fringe Benefit Fund
Attn: Eligibility Department
PO Box 30751
Salt Lake City, UT 84130

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member_____ **Date Signed:**_____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member_____ **Date Signed**: _____

SPOUSE SECTION

I, the **spouse** **(Name, Please Print**) _ _____, (**Spouse's Social Security #**) _____of the above-named member, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name:_____ Relationship: _____ _____

Name:_____ Relationship: _____ _____

Signature of Spouse_____**Date Signed**: _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse _____**Date Signed**:_____

DEPENDENT(S) 18 AND OVER SECTION

I, the dependent **child(ren) 18** or older (**Name, Please Print**) _____ , **(Social Security #)** _____have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name:_____ Relationship: _____ _____

Name:_____ Relationship: _____ _____

Signature of Dependent_____**Date Signed**: _____

OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Dependent_____**Date Signed**:_____

NOTE: If there is more than one dependent 18 and over, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Fund Office.

Eighth District Electrical Fringe Benefit Funds

Life Insurance Beneficiary Designation

I, _____, Social Security Number _____
(Print Name)

Do hereby designate the following named persons as my beneficiary or beneficiaries to receive any monies that may be payable by reason of my death, under the Eighth District Electrical Fringe Benefit Fund. (If additional space is needed, please use second sheet)

Beneficiary Name:	**Date of Birth:**
SSN:	**Relationship:**
Address:	**Phone:**
Percentage of Benefit to be Received: ***(see examples below*)***	**%**
Beneficiary Name:	**Date of Birth:**
SSN:	**Relationship:**
Address:	**Phone:**
Percentage of Benefit to be Received:	**%**
Beneficiary Name:	**Date of Birth:**
SSN:	**Relationship:**
Address:	**Phone:**
Percentage of Benefit to be Received:	**%**
Beneficiary Name:	**Date of Birth:**
SSN:	**Relationship:**
Address:	**Phone:**
Percentage of Benefit to be Received:	**%**
Secondary Beneficiary Name: ***(see explanation below*)***	
Date of Birth:	
SSN:	**Relationship:**
Address:	**Phone:**

-OVER-

Physical Address: 4704 Harlan Street, Suite 104 • Denver, CO 80212
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www.8thDistrictBenefits.org

Custodial Designation:

If my above named beneficiary is a minor, I hereby designate (print full name) _____ to act as Custodian to receive such benefits on behalf of such child (or children). I understand that I may change this Custodial Designation at any time. I also understand that if I fail to name a Custodian, then the natural parent(s) of the minor will automatically be designated as Custodian. I also understand that if the amount of the benefit is more than $10,000, and I fail to name a Custodian, the benefit cannot be paid until a Custodian is appointed by the Superior Court.

Custodian Name: _____ Date of Birth: _____

SSN: _____ Relationship: _____

Address: _____ Phone: _____

*If you designate more than one Beneficiary, benefits will be paid to them in equal shares, unless you fill in a different percentage to be received where indicated on this form. For example, if you name two beneficiaries you may state that one will receive 75% and the other 25%. Benefits will be paid to the person you list as a Secondary Beneficiary only in the event your designated Beneficiaries have died. If you fail to designate a Beneficiary or if all of your designated Beneficiaries have died, the benefits will be paid in accordance with Trust rules.

Check one:

□ Single □ Divorced □ Separated
□ Widowed □ Married *(if checked, fill in date)* _____
DATE OF MARRIAGE

Member's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____**

**If you are currently married and are naming someone other than your spouse as your beneficiary, your spouse must also sign this Beneficiary Designation Form. Your beneficiary designation will be automatically deemed revoked upon certain changes in marital status. If you are currently married and later divorce, your beneficiary designation of your spouse will be deemed revoked unless a Court order requires you to maintain the beneficiary designation you are making at this time. If you are currently single and later marry, the beneficiary designation you are making at this time will be automatically revoked unless the person you are naming as your beneficiary at this time is the person who becomes your spouse. Should your beneficiary be automatically revoked due to either of the foregoing events, benefits will be paid to your estate.

EIGHTH DISTRICT ELECTRICAL PENSION AND/OR ANNUITY FUNDS

BENEFICIARY DESIGNATION FORM

PART A: General Information *(Please print all information)*

Last Name:	**First Name:**	**Middle Name:**
Soc. Sec. No.:_____-_____-_____	**Birth Date:** Mo_____Day_____Year _____	**Telephone #:** (_____)_____-_____
Street Address:	City, State, Zip Code	**Local Union No./NECA Chapter**
Current Marital Status ☐ **Single, Never Married** ☐ **Divorced**	☐ **Married, If Married, Spouse Name:** _____ ☐ **Divorced and Remarried**	**Date Joined Union/NECA**

This Beneficiary Designation Form applies to the Eighth District Electrical Pension and Annuity Plans. **If you do not select individual Plans, All PLANS will apply.** You should submit another form if designating a different beneficiary for each plan benefit.

PART B: Beneficiary Designations *(Please print all information) (Additional forms may be used if needed)*

☐ ALL PLANS
If you do not select individual Plans, ALL PLANS will apply

OR

☐ ANNUITY PLAN
☐ PENSION PLAN

The Beneficiary(ies) listed below shall receive benefits payable upon the listed participant's death from the Plans selected above. You may add a page if additional space is needed. List your beneficiary(ies) in the spaces provided below. At least one primary beneficiary must be selected. The percentages of your primary beneficiary(ies) must total 100%. If you designate a secondary beneficiary, the percentages for those beneficiaries must also total 100%. Otherwise, the remaining beneficiaries who do not have a stated percentage will equally share the remaining percentage

Full Name of **PRIMARY** Beneficiary	Relationship to You	Social Security No.	Date of Birth
Street Address	City, State, Zip Code		Percentage of Interest
Full Name of **PRIMARY** Beneficiary	Relationship to You	Social Security No.	Date of Birth
Street Address	City, State, Zip Code		Percentage of Interest

Full Name of **SECONDARY** Beneficiary	Relationship to You	Social Security No.	Date of Birth
Street Address	City, State, Zip Code		Percentage of Interest
Full Name of **SECONDARY** Beneficiary	Relationship to You	Social Security No.	Date of Birth
Street Address	City, State, Zip Code		Percentage of Interest
Full Name of **SECONDARY** Beneficiary	Relationship to You	Social Security No.	Date of Birth
Street Address	City, State, Zip Code		Percentage of Interest

I designate as a Beneficiary(ies) the person(s) named above for my death benefits. I understand that the designation of a spouse will automatically be revoked upon divorce, and a new designation will be required to name the ex-spouse as my beneficiary. I will inform the Plan Administrator IMMEDIATELY of any change in my marital status. This designation revokes any prior beneficiary designations, made by me, for my death benefits.

✖ _____

Participant Signature Date

Spouse Waiver Section – Only Complete this Section if the Spouse is not the Sole Primary Beneficiary:
I am the legal spouse of the above-named participant. I have read an explanation of my right to receive a Qualified Pre-Retirement Survivor Annuity (lifetime monthly annuity) from the Pension and/or Annuity Plan if my spouse dies before benefit payments commence. I also understand the other death benefit(s) to which I may otherwise be entitled under the Pension and/or Annuity Plan(s). I hereby voluntarily consent to the beneficiary designation(s) my spouse has made above. I acknowledge the effect of my consent is that I will not receive the lifetime monthly annuity benefit that would otherwise may have been payable to me upon the participant's death.

✖ _____

Spouse Signature Date

Subscribed and sworn to before me this _____day of_____.

_____

Witness (Notary Public)

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.8thdistrictbenefits.org or call 844-989-2321. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 844-989-2321 to request a copy

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network, Out-of-Network* and Out-of-Area combined: $400 per person / $1,200 per family per calendar year. **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Outpatient Prescription Medicines and in-network preventive benefits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain in-network preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Dental Benefits: $50 per person / $150 per family per calendar year. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical In-Network and Out-of-Area providers total out-of-pocket limit: $2,500 per person or $5,000 per family Prescription In-Network: $4,100 per person or $8,200 per family Out-of-Network* – No out-of-pocket limits **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, charges in excess of benefit maximums & allowed charges, penalties for non-compliance with Utilization Management programs, expenses for out-of-network providers, out-of-network deductibles, copayments & coinsurance (but emergency services in an emergency room accumulate to the in-network out-of-pocket limit), the amount of any coupon, rebate, or	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit? (continued)	other financial assistance applied directly toward a specialty drugs copayment at the time of purchase, & health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes.* See www.cignasharedadministration.com (Choose Cigna Open Access) or call Cigna at (800) 768-4695 for a list of network providers. **Out-of-network providers may be treated as network providers as required by No Surprises Act.*	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	50% coinsurance	Doctor on Demand Telehealth Program - no copayment, deductible or coinsurance. Doctor on Demand is a PPO Provider Benefit only – no coverage for any online program other than Doctor on Demand. Physician office visits include in person or virtual appointments. Certain services and transplant services, including testing, may require precertification to avoid non-payment of services. See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.*
	Specialist visit			
	Preventive care/screening/ immunization	No charge	Not covered	In-Network providers not subject to the deductible. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See Summary Plan Description at Article VII for further information and for a list of all covered Preventive Services or call (800) 628-6562.* ACA required preventive services provided at a health fair or wellness gathering are paid at 100% of Plan's allowed charge.

*For more information about limitations and exceptions, see summary plan description (SPD)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	Transplant related services, including testing, may require precertification. See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.*
	Imaging (CT / PET scans, MRIs)			----------none----------
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** contact Express Scripts at (855) 202-9582 or visit www.express-scripts.com.	Generic drugs	Retail (30-day) – 10% coinsurance ($10 min and $20 max) Retail – Walgreen's Smart 90 (90-day) - $20 copayment Mail Order (90-day) – $20 copayment	You pay 100% coinsurance at time of purchase and can submit claim to Express Scripts for reimbursement.	If the cost of the drug is less than the copayment, you will only pay the cost of the drug. Some prescriptions are subject to preapproval, quantity limits or step therapy requirements. See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification & Article X, Section 2G for Prescription Exclusions.* Drugs considered preventive services under the ACA covered at 100% & not subject to prescription drug copayment. See "Drug Row" in Article VII of the Plan, Article VI, Section 13 of the Plan & Amendment No. 6 to the Plan for additional information & limitations. For eligible Out-of-Network prescriptions, you will be reimbursed the billed charges minus the appropriate coinsurance & copayment. If a generic equivalent is available & you choose the brand name drug, you will pay the applicable copayment plus the difference in the actual cost between the generic drug & the brand name drug. However, if your doctor believes there are special reasons you should continue using a brand name drug, he or she can request a coverage review through the online portal available at www.esrx.com/PA. If the request is approved, you will not pay more than the base copayment for the brand name drug.
	Preferred brand drugs	Retail (30-day) – 25% coinsurance ($25 min and $50 max) Retail – Walgreen's Smart 90 (90-day) – $50 copayment Mail Order (90-day) – $50 copayment		
	Non-preferred brand drugs	Retail (30-day) – greater of 50% coinsurance or $50 copayment Retail – Walgreen's Smart 90 (90-day) – 50% coinsurance Mail Order (90-day) – 50% coinsurance		
	Specialty drugs	(Up to 30-day supply) $35 copayment	Not covered	Specialty drugs must be preapproved by calling Express Scripts at (855) 202-9582. Alternate copayments may apply to certain specialty drugs eligible for manufacturer discount coupons applied by Express Scripts at the time of purchase.

*For more information about limitations and exceptions, see summary plan description

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	A stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service.
	Physician/ surgeon fees			Certain outpatient services, including testing, may require precertification. See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.*
If you need immediate medical attention	Emergency room care	$500 copayment per ER visit and then 25% coinsurance	$500 copayment per ER visit and then 25% coinsurance unless otherwise required by No Surprises Act	Doctor on Demand Telehealth Program - no copayment, deductible or coinsurance. Doctor on Demand is an In-network benefit only – no coverage for any telemedicine program other than Doctor on Demand. Emergency room copayment is waived if patient is admitted to hospital during visit or if the patient has proof of an attempt to get treatment at a lower cost facility prior to treatment in the ER.
	Emergency medical transportation	25% coinsurance	25% coinsurance unless otherwise required by No Surprises Act	
	Urgent care		50% coinsurance unless otherwise required by No Surprises Act	
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment per admission and then 25% coinsurance	$200 copayment per admission and then 50% coinsurance unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate. Elective hospital admission, including transplant services and testing, may require precertification. See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.*
	Physician/ surgeon fees	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	

*For more information about limitations and exceptions, see summary plan description

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	Doctor on Demand Telehealth Program - no copayment, deductible or coinsurance. Doctor on Demand is an In-network benefit only – no coverage for any telemedicine program other than Doctor on Demand. Physician office visits include in person or virtual appointments.
	Inpatient services	$200 copayment per admission and then 25% coinsurance	Residential Treatment Program: Not covered Any other inpatient services: $200 copayment per admission and then 50% coinsurance unless otherwise required by No Surprises Act	Elective hospital admission and in-network residential treatment program admission requires precertification. See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.* You pay 100% for an out-of-network residential treatment program.
If you are pregnant	Office visits	No charge for office visits for all pregnant females.	50% coinsurance unless otherwise required by No Surprises Act	Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). Cost-sharing does not apply to preventive services. Depending on the type of services, coinsurance or a deductible may apply. Pregnancy-related care is covered for all females. No coverage is provided for the baby of a dependent child.
	Childbirth/ delivery professional services	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	
	Childbirth/ delivery facility services	$200 copayment per admission and then 25% coinsurance	$200 copayment per admission and then 50% coinsurance unless otherwise required by No Surprises Act	Precertification required if inpatient stay is longer than 48 hours (vaginal delivery) or 96 hours (cesarean section delivery). Pregnancy-related care is covered for all females. The deductible applies separately to both the mother and baby. No coverage is provided for the baby of a dependent child.

*For more information about limitations and exceptions, see summary plan description

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Plan covers part-time or intermittent skilled nursing care. Home health and home infusion therapy require precertification.
	Rehabilitation services	25% coinsurance	Outpatient: 50% coinsurance Inpatient Not covered	Outpatient physical, occupational & speech therapy combined maximum benefit of 50 visits per year. Inpatient rehabilitation requires precertification. You pay 100% for an out-of-network inpatient rehabilitation facility. Sword Health Physical Therapy - no copayment, deductible or coinsurance.
	Habilitation services	Speech therapy for childhood developmental delays: 25% coinsurance	Speech therapy for childhood developmental delays: 50% coinsurance	
	Skilled nursing care	$200 copayment per admission and then 25% coinsurance	Not covered	Maximum benefit is 70 days per calendar year. Elective admission requires precertification. You pay 100% for an out-of-network skilled nursing facility
	Durable medical equipment	25% coinsurance	50% coinsurance	Equipment repair or replacement limited to payment once in a five calendar year period. Durable medical equipment requires precertification.
	Hospice services			Covered if terminally ill. Inpatient respite max 8 days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge up to $100		Limit 1 eye exam each calendar year. No coverage for retirees. Vision Benefits are an excepted benefit under HIPAA and PPACA. You can contact the Fund Office for information on how to opt out of Vision Benefits.
	Children's glasses	Frames: No charge up to $65 Lenses: No charge up to the following maximums: Single Vision: $36 Bifocal: $51 Trifocal: $65 Lenticular: $94 Contact Lenses: No charge up to $165		Limit 1 pair of frames and lenses every 24 months. Available only to active employees and their dependents if their local union has negotiated enhanced Vision Benefits. No coverage for retirees. Vision Benefits are an excepted benefit under HIPAA and PPACA. You can contact the Fund Office for information on how to opt out of Vision Benefits.
	Children's dental check-up	No charge	No charge up to Dental Plan's Reasonable & Customary Charges	$1,000 per person dental maximum. Limit 2 exams each 12 months.

*For more information about limitations and exceptions, see summary plan description

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery (unless necessary due to accidental injury)	• Hearing aids • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private duty nursing • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery (maximum benefit 1 surgical procedure per lifetime) • Chiropractic care (up to 20 visits/year) • Dental care	• Routine eye care (actives only, if negotiated by your local union) • Routine foot care payable when treating diabetic (metabolic) or peripheral vascular disease

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 628-6562.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$400
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$200
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$400
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$400
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$400
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

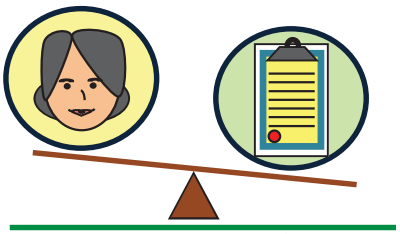
Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance



Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

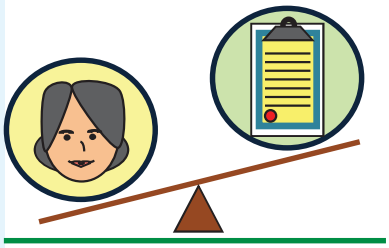
Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

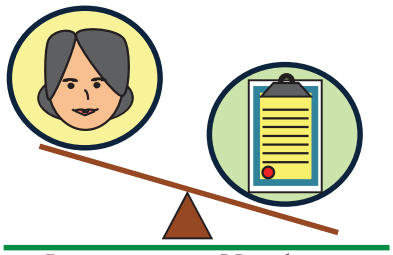
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

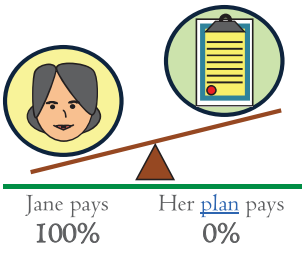
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

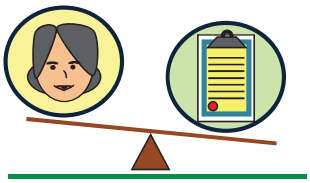
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



more costs



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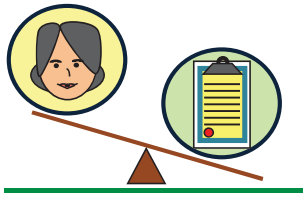

Jane hasn't reached her $1,500 deductible yet
Her plan doesn't pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins
Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.
Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $125
Jane pays: $0
Her plan pays: $125

Summary of Benefits
Anthem Dental Essential Choice

Eighth District Electrical Benefit Fund
Anthem Blue Cross and Blue Shield Dental Complete Network

WELCOME TO YOUR DENTAL PLAN!

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

Powerful and easily accessible member tools.

- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in about 24 hours.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **More Capabilities:** With our latest mobile application, members can find a network dentist as well as view their claims. Our application is available for both Android and Apple phones.

Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.

- To find a dentist by name or location, go to anthem.com or call dental customer service at the number listed on the back of your ID card.

Ready to use your dental benefits?

- Choose a dentist from the network
- Make an appointment
- Show the office staff your member ID card
- Pay any deductible or copay that is part of your plan

Need to contact us?

See the back of your ID card for who to call, write or email us.

Your dental benefits at a glance

The following benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your policy.

	In-Network	Out-of-Network
Coverage Year	**Calendar Year**	
Annual Benefit Maximum		
• Per insured person	**$1,000**	**$1,000**
• Diagnostic & Preventive Services are applied to the Annual Maximum		
Annual Maximum Carryover	**No**	**No**
Orthodontic Lifetime Benefit Maximum		
• Not applicable	**Not applicable**	**Not applicable**
Annual Deductible		
• Per insured person	**$50**	**$50**
• Family maximum	**3x single member deductible**	**3x single member deductible**
Deductible Waived for Diagnostic/Preventive Services	**Yes**	**Yes**
Out-of-Network Reimbursement:	**95th percentile**	

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Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services ● Periodic oral exam ○ Limited to 2 per 12 months ● Teeth cleaning (prophylaxis) ○ Limited to two per 12 months combined with periodontal maintenance ● Bitewing X-rays ○ Limited to two sets per 12 months ● Full-Mouth or Panoramic X-rays ○ Limited to one per 36 months ● Fluoride application ○ Limited to two per 12 months through age 18 ● Space maintainer insertion ○ Limited to one per tooth space per lifetime through age 14	100% Coinsurance	100% Coinsurance	No Waiting Period
Basic (Restorative) Services ● Consultation (second opinion); only with X-rays and no other services ○ 2 per 12 months ● Amalgam (silver-colored) filling ○ Covered no frequency ● Composite (tooth-colored) filling ○ Covered no frequency posterior (back) fillings not paid as an amalgam (silver-colored filling) ● Brush Biopsy (cancer test) ○ Limited to one per 12 months; all ages ● Sealant application ○ 1 per 36 months; through age 14	80% Coinsurance	80% Coinsurance	No Waiting Period
Endodontics (Non-Surgical) ● Root Canal (permanent teeth only) ○ Limited to one per tooth per lifetime; permanent teeth only	80% Coinsurance	80% Coinsurance	No Waiting Period
Endodontics (Surgical) ● Apicoectomy - Limited to one per tooth per lifetime; permanent teeth only ● Apexification - Covered no frequency	80% Coinsurance	80% Coinsurance	No Waiting Period
Periodontics (Non-Surgical) ● Periodontal maintenance ○ Limited to four per 12 months combined with teeth cleanings ● Scaling and root planning; when the tooth pocket has a depth of four millimeters or greater ○ Limited to one per quadrant per 24 months	80% Coinsurance	80% Coinsurance	No Waiting Period
Periodontics (Surgical) ● Periodontal surgery (osseous, gingivectomy, graft procedures) ○ Limited to one per quadrant per 36 months	80% Coinsurance	80% Coinsurance	No Waiting Period
Oral Surgery (Simple) ● Simple extraction ○ Limited to one per tooth per lifetime	80% Coinsurance	80% Coinsurance	No Waiting Period
Oral Surgery (Complex) ● Surgical extraction ○ Limited to one per tooth per lifetime	80% Coinsurance	80% Coinsurance	No Waiting Period
Major (Restorative) Services ● Crowns, onlays, veneers ○ Limited to one per tooth/arch per 60 months	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthodontics ● Dentures and bridges ○ Limited to one per tooth/arch per 60 months ● Implant placement ○ Limited to one per tooth/arch per 60 months ● Implant prosthodontics ○ Limited to one per tooth/arch per 60 months as a non-implant crown, bridge, and/or denture	50% Coinsurance	50% Coinsurance	No Waiting Period
Repairs/Adjustments ● Crown, denture, bridge repairs ○ Limited to one per 12 months not within 6 months of placement ● Denture and bridge adjustments: ○ Limited to one per tooth per 12 months not within 6 months of placement	50% Coinsurance	50% Coinsurance	No Waiting Period

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Dental Services (continued)	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Orthodontic Services ○ Not covered	Not covered	Not covered	N/A
Temporomandibular Joint Disorder (TMJ) ● X-rays, splints, and surgical procedures including arthroscopy and orthotic devices ○ Not Covered	Not Covered	Not Covered	N/A
Cosmetic Teeth Whitening ○ Not covered	Not Covered	Not Covered	N/A

NOTE: Cosmetic benefits, such as teeth bleaching, in an insurance policy may have income tax implications for both employer groups and plan members. For example, the dollar value of the cosmetic benefit may be considered part of an individual's taxable income. For more information concerning the tax ramifications of cosmetic insurance benefits, please consult a legal or tax advisor.

Additional Services and Programs	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Anthem Whole Health Connection® - Dental ● For members with certain health conditions, additional dental benefits are available without a deductible, office visit copay, nor waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable).	Included	Included	No waiting period
Accidental Dental Injury Benefit ● Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, office visit copay, member coinsurance, nor waiting periods apply.	Included	Included	No waiting period
Extension of Benefits ● Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered.	Included	Included	No waiting period
International Emergency Dental Program ● Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, office visit copay, member coinsurance, nor waiting periods and won't reduce the member coverage year annual maximum (if applicable).	Included	Included	No waiting period

Additional Limitations & Exclusions

Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

Cosmetic dentistry (unless included as part of you dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There

is a 24 month waiting period for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your policy. **In the event of a discrepancy between the information in this summary and the policy, your policy will prevail.**

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Eighth District Electrical Fringe Benefit Funds

Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you have recently become covered under the Eighth District Electrical Fringe Benefit Funds ("The Fund"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Fund Office.

The Plan Administrator is BeneSys Administrators (the "Fund Office") located at P.O. Box 30751, Salt Lake City, UT 84130. You can call the office at 844-989-2321. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You may send written notice of the event to: Eighth District Electrical Fringe Benefit Funds, P.O. Box 30751, Salt Lake City, UT 84130, or you can report a qualifying event by calling the Fund Office at 844-989-2321 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation to the Fund Office at: P.O. Box 30751, Salt Lake City, UT 84130.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both) your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent along with a copy of the Social Security Administration's determination to the Eighth District Electrical Fringe Benefit Funds, P.O. Box 30751, Salt Lake City, UT 84130.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Eighth District Electrical Fringe Benefit Funds, P.O. Box 30751, Salt Lake City, UT 84130, or you can report a qualifying event by calling the Fund Office at 844-989-2321 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation, or Medicare Card to the Fund Office at: P.O. Box 30751, Salt Lake City, UT 84130.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Fund Office by calling 844-989-2321. Written correspondence should be sent to: Eighth District Electrical Fringe Benefit Funds, P.O. Box 30751, Salt Lake City, UT 84130. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.