

Eighth District Electrical Benefit Fund

Summary Plan Description/Plan Rules and Regulations

describing the

**Basic Medical Plan, Personal Care Account, and
Death and Accidental Death and Dismemberment Benefits**

Amended, Restated and Effective January 1, 2026

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Eighth District Electrical Benefit Fund

Dear Participant:

We are pleased to present you with this updated Summary Plan Description/Plan Rules and Regulations document describing the self-funded Basic Medical Plan, Personal Care Account (PCA) benefits, Death and Accidental Death and Dismemberment benefits of the Eighth District Electrical Benefit Fund. This booklet replaces all other Summary Plan Descriptions and Plan rules previously provided to you.

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

The benefits described in this booklet are self-funded and provided by the Fund.

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

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

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

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

Sincerely,

The Board of Trustees

ARTICLE I: INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This Summary Plan Description/Plan Rules and Regulations Document describes the Basic Medical Plan, Personal Care Account ("PCA"), Death and Accidental Death and Dismemberment (AD&D) benefits of the Eighth District Electrical Benefit Fund hereafter referred to as the "Plan" or 'the Fund.'" Contributions provide coverage for applicable Medical, PCA, Death and AD&D benefits.

The Plan described in this document is **effective January 1, 2026**, except for those provisions that specifically indicate other effective dates, and replaces all other Plan documents, summary plan descriptions and applicable amendments to those documents previously provided to you.

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

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

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

- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.
- No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Plan Benefits are not vested and are not guaranteed.

IMPORTANT NOTE

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

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

This Plan is established under and subject to the federal law, the Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. Benefits of the Plan are self-funded with contributions from Contributing Employers and Eligible Employees held in a Trust. An independent Claims Administrator pays benefits out of Trust assets.

YOU MUST KEEP THE PLAN INFORMED

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

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

SPANISH LANGUAGE ASSISTANCE

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Ingles. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contactó con la Administrative Office a la dirección y teléfono en el (Quick Reference Chart) de este documento.

QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Administrative Office at the phone number and address located on the Quick Reference Chart in this Plan Document. As a courtesy to you, the staff of the Administrative Office may respond informally to oral questions; **however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits.**

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

SUGGESTIONS FOR USING THIS DOCUMENT

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

- Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. If you do not understand a term, look it up in the **Definitions** Article. The **Table of Contents** provides you with an outline of all the Articles. The **Definitions** Article explains many technical, medical and legal terms that appear in the text.
- This document contains a **Quick Reference Chart** following this introductory text. This is a handy resource for the names, addresses, and phone numbers of the key contacts for your benefits such as the Claims Administrator.
- The **Eligibility Article** outlines who is eligible for coverage and when coverage begins and ends. The **Self-Payment Provisions for COBRA** Article discusses how you can temporarily continue health coverage when your eligibility for benefits terminates.
- Review the **Medical Plan, Schedule of Medical Benefits and Medical Plan Exclusions Articles**. These describe your benefits in more detail. There are examples, charts, and tables to help clarify key provisions and more technical details of the coverages. The Personal Care Account Article explains the Plan's reimbursement of your Medical Care Expenses on a nontaxable basis from a Personal Care Account.
- Review the **Medical Networks and Precertification Articles**. They describe how you can maximize Plan Benefits by following the provisions explained in these Articles. They also describe how the Plan complies with the No Surprises Act.
- Refer to the **General Provisions Article** for information regarding your rights and information about ERISA.
- The **Claim Filing and Appeal Information Article** tells you what you must do to file a claim and how to seek review (appeal) if you are dissatisfied with a claims decision.
- The Article on **Coordination of Benefits** discusses situations where you have coverage under more than one group health care plan, Medicare, another government plan, personal injury protection under mandatory no-fault automobile insurance coverage, workers' compensation, or where you can recover expenses from any other source.
- Review the **Death and Accidental Death and Dismemberment Benefit Article** for information on how these benefits work for you and your family.

ENROLLMENT CARD, BENEFICIARY DESIGNATION, AND CLAIM FORM

Enrollment Card: A completed Enrollment card must be on file with the Plan in order to allow the processing of claims. You will need to provide the Social Security number of each Dependent enrolled for coverage. There are certain timelines for you to enroll your Dependents when you become eligible under the Plan. Please see the Eligibility Article, Section 3 for the rules on enrolling your Dependents. Enrollment cards can be obtained from and returned to the Administrative Office, whose address is listed on the Quick Reference Chart in the front of this document. The Enrollment card also contains your beneficiary designation related to death and AD&D benefits.

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

Coordination of Benefits Inquiry: You must complete a Coordination of Benefits (COB) inquiry form if you receive a COB inquiry request from the Administrative Office. These forms are sent every twelve months unless the Administrative Office receives an update from the Spouse or Dependent before twelve months have lapsed.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal **Medicare coordination of benefit regulations and certain IRS reporting rules**, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for which you have elected, or are electing, Plan coverage, and information on whether you or any of such Dependents are currently enrolled in Medicare or have dis-enrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a Dependent does not yet have a Social Security Number, you can go to this website to complete a form to request a SSN: <http://www.socialsecurity.gov/online/ss-5.pdf>. Applying for a Social Security Number is FREE.

Failure to provide the SSN or complete the CMS model form (form is available from the Claims Administrator or means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

ARTICLE II: QUICK REFERENCE CHART FOR HELP OR INFORMATION

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

ARTICLE II: QUICK REFERENCE CHART	
Information Needed	Please Contact...
<p>Claims Administrator (Administrative Office)</p> <ul style="list-style-type: none"> • Claims and appeals for Medical Plan Benefits Death Benefits and Accidental Death & Dismemberment (AD&D) • Claim Forms (Medical, Death, AD&D) • Eligibility for Coverage • Plan Benefit Information • Personal Care Account (PCA) Administration and Benny cards (the Prepaid Benefits cards) • Medicare Part D Notice of Creditable Coverage • ID cards • Summary of Benefits and Coverage (SBC) 	<p>BeneSys Administrators, Inc. P.O. Box 30751 Salt Lake City, UT 84130 Phone: (844) 989-2321</p>
<p>PPO Network</p> <ul style="list-style-type: none"> • Medical Network Provider Directory • Additions/Deletions of Providers • Price Comparison Tools as required by the No Surprises Act 	<p>CIGNA Open Access Plus (aka OAP) 1-800-768-4695 Website to find Participating Providers: www.cignasharedadministration.com</p>
<p>Transplant Network</p> <ul style="list-style-type: none"> • A national network that provides access to solid organ and bone marrow/stem cell transplantation. Lifesource is your IN-NETWORK transplant provider network. 	<p>CIGNA Lifesource Network Phone: 1-800-768-4695</p>
<p>Prescription Drug Program for Retail and Specialty Drugs</p> <ul style="list-style-type: none"> • Retail Pharmacy locations • Walgreens Pharmacy for 90-Day Retail Supply (Smart 90) • Mail Order (Home Delivery) Service • Prescription Drug Information • Formulary of Preferred Drugs • Precertification/prior authorization of Certain Drugs and Level 1 claim appeal • Specialty Drug Program: Precertification and Ordering 	<p>Sav-Rx Customer Service: Phone: 1-866-233-IBEW Website: www.savrx.com 224 North Park Avenue Fremont, NE 68025</p>
<p>Utilization Management (UM) Company (Medical Review firm)</p> <ul style="list-style-type: none"> • Precertification as outlined in Article X, Precertification and Medical Review • Level One Appeals for Preservice Claims; Urgent Care Appeals • Case Management 	<p>CIGNA CareAllies Telephone: 1-800-768-4695</p>

ARTICLE II: QUICK REFERENCE CHART

Information Needed	Please Contact...
Sword Health - Virtual Physical Therapy Solution	Sword Health Phone: 1-888-492-1860 Website: sword.health/thrive/eighthdistrict/go
Hello Heart - Virtual Hypertension Solution	Hello Heart Phone: 1-800-767-3471 Website: support@helloheart.com
Member Assistance Program (MAP) Employee Assistance Program (EAP) <ul style="list-style-type: none"> • EAP counseling at no cost to the Employee and their family members, along with referral services. 	Blomquist Hale Phone: 1-800-926-9619 or 1-801-262-9619
COBRA Administrator <ul style="list-style-type: none"> • Information About Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments 	BeneSys Administrators, Inc. Mailing Address: Eighth District Electrical Benefit Fund - Self Payment P.O. Box 561284 Denver, CO 80256-1284 For Overnight or Express Mail: US Bank Denver Lockbox Attn: Eighth District Electrical Benefit Fund - Self-Payment - Utah 561284 10035 East 40th Ave., Suite 100 Denver, CO 80238 Phone: 844-989-2321
Doctor On Demand <ul style="list-style-type: none"> • Telehealth benefit that gives Participants the capability to consult with a certified healthcare Provider online via a webcam or through a mobile app • Service is available 24 hours a day/7 days a week 	Doctor on Demand Website: https://www.doctorondemand.com/ To download Doctor on Demand Mobile App: Search “Doctor On Demand” in the mobile app store
Board of Trustees (Plan Administrator) <ul style="list-style-type: none"> • Post Service Claim Appeals • Level Two Preservice Claim Appeals 	Board of Trustees of the Eighth District Electrical Benefit Fund BeneSys Administrators, Inc. P. O. Box 30751 Salt Lake City, UT 84130 Phone: 844 989-2321
HIPAA Privacy Officer and HIPAA Security Officer <ul style="list-style-type: none"> • HIPAA Notice of Privacy Practice 	HIPAA Privacy/Security Officer for the Eighth District Electrical Benefit Fund P. O. Box 30751 Salt Lake City, UT 84130 Phone: 844 989-2321

ARTICLE III: ELIGIBILITY

This Article explains who is eligible from the Plan, and when such coverage begins and ends. It is divided up into Ten Sections to explain how Employees and their Dependents may be eligible for coverage from the Plan.

Section 1: ELIGIBILITY FOR BARGAINING EMPLOYEES

- a. **General Provisions.** Bargaining Employees will become eligible for coverage in accordance with the following rules. Hours worked for a Contributing Employer will **not** be credited to a Bargaining Employee until the required contributions have been made by the Contributing Employer. No medical examination is required in order to become covered under this Plan.
- b. **Eligibility.** Eligibility for benefits provided by the Plan will be established under an “hour bank” system.
 1. **Classifications of Employees eligible for Basic Plan.** Unless excluded from coverage under Section 1(b)(2) below, Bargaining Employees that work in the following classifications under a Collective Bargaining Agreement for a Contributing Employer are eligible to participate in this Basic Plan:
 - i. Construction Wiremen/Construction Electricians (CW/CEs)
 - ii. Material Handlers
 - iii. Unindentured Apprentices
 - iv. Manufacturing
 - v. Residential
 - vi. Foreman
 - vii. Drill Operator/Locator
 - viii. Potholer
 - ix. Groundmen
 - x. Directional Drill Operator/Locator Trainees 1st, 2nd and 3rd
 - xi. All classifications in a Voice Data Video (“VDV”) Collective Bargaining Agreement
 - xii. Communications Trainee
 2. **Employees NOT eligible for Basic Plan coverage.** The following Employees are not eligible for Basic Plan coverage:
 - i. A Bargaining Employee that works in a classification that is not listed in subsection 1(b)(1) above;
 - ii. Non-bargaining unit Employees; and
 - iii. An Employee who previously had coverage from the Regular Plan, but then works in a classification in subsection 1(b)(1) that requires contributions to the Basic Plan is not eligible to participate in the Basic Plan, unless one of the following exceptions applies:
 - A. If the Employee moves from the Apprentice classification to one of the classifications listed in Section 1(b)(1) above, the Employee is eligible for Basic Plan coverage.
 - B. If an Employee had been participating in the Regular Plan pursuant to a non-bargaining agreement and the Employee then works in one of the classifications listed in Section 1(b)(1) above that requires contributions to the Basic Plan, the Employee is eligible for coverage from the Basic Plan.

Hours Transfer to Regular Plan: If an Employee is not eligible for Basic Plan coverage pursuant to this subsection 1(b)(2)(iii), the hours contributed at the Basic Plan wage rate for the Employee will transfer dollar for dollar to the Employee’s Regular Plan hour bank. Please reference the Regular Plan for more information on the Regular Plan’s eligibility requirements.

Hours Transfer to Basic Plan: If the Employee has contributions made on his behalf at the Regular Plan wage rate, but the Employee is eligible or has coverage from the Basic Plan, the hours reported at the Regular Plan wage rate may be transferred dollar for dollar to the Basic Plan. Limitations on the number of hours a Bargaining Employee can accumulate in his hour bank can be found in Section 1(e)(2) of this Article.

3. **Special Rules for Small Man Shop.** As established by the Board of Trustees, the Minimum Contribution required by an owner working with tools (also known as a small man shop) is **143 hours**. If more hours are worked, those actual hours worked must be reported.

In the event a small man shop remits contributions for any calendar month which are less than the then current level of Minimum Contributions as determined from time to time by the Board of Trustees, the contributions will not be accepted by the Benefit Fund and will not be credited toward eligibility for coverage or an Hour Bank for the owner working with the tools. In addition, owners working with the tools of the trade shall not have the ability to make a self-payment under the Self-Pay option permitted under the Plan, unless a Qualifying Event under COBRA has occurred. Failure to pay a Minimum Contribution by a small man shop shall not constitute a Qualifying Event under COBRA or the Plan's COBRA provisions.

In no event shall Minimum Contributions be accepted by the Benefit Fund or applied to give coverage under this Plan or credited to an Hour Bank on behalf of any individual who does not receive W-2 wages. If a small man shop fails to pay Minimum Contributions for any calendar month, the owner working with the tools whose coverage under this Plan is terminated shall not be eligible for coverage under the Plan for a period of twelve (12) consecutive months from the termination of coverage.

c. Initial Eligibility

1. A Bargaining Employee that meets the eligibility rules in Section 1(b) of this Article will become an Active Employee on the first day of the second calendar month next following the date on which sufficient contributions have been received from one (1) or more Contributing Employers to provide at least one (1) month of eligibility. Currently, the Minimum Contribution is **143 hours**.
2. In order that there will be sufficient time for Contributing Employer reports and contributions to be received and processed by the Administrative Office, a **lag month** will be used in determining a Bargaining Employee's monthly eligibility. The lag month is the month between the report period and the month of actual coverage.
3. Each Bargaining Employee must complete an Enrollment card and submit it to the Administrative Office prior to payment of any claims under the Plan.

d. Special Note on Effective Date. The effective date of coverage for an Active Employee will be the date on which the employee becomes eligible for benefits in accordance with the above rules. No benefits are payable for services rendered prior to that date.

e. Continuation of Eligibility

1. Contributions received from Contributing Employers for hours worked by an Active Employee will be credited to the Active Employee's Basic Plan hour bank account. The monthly charge-off will be deducted from the Bargaining Employee's hour bank account for each month of coverage. An Active Employee will continue to remain covered as long as their hour bank account contains at least one (1) month's charge-off amount required for coverage.
2. Whenever a Bargaining Employee is credited with more than one (1) month's charge-off amount (which is required to furnish one (1) month of coverage), the excess contributions will be added to the Bargaining Employee's hour bank accumulation not to exceed a maximum of three (3) months of coverage.

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

1. such employee commences work in employment in the electrical industry within the jurisdiction of the Eighth District with an employer who does not make contributions to the Plan; or
2. a Contributing Employer is delinquent in making required contributions to the Fund, except the Fund will allow a maximum of three (3) months of hours to be posted retroactively to the Employee's hour bank account when the delinquent Contributing Employer executes a payment agreement that is personally guaranteed; or
3. the date the Plan is discontinued.

An Active Employee whose coverage terminates under this section may be entitled to continue coverage under the Self-Payment Provisions for Continuation of Coverage if the termination of coverage constitutes a Qualifying Event. See the Self-Payment Provisions for COBRA Continuation of Coverage Article for more information.

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

h. Transfer from Basic Plan Participation to Regular Active Plan Participation

1. In the event that an Active Employee in the Basic Plan transitions to Covered Employment that requires contributions to be made to the Regular Plan, the Bargaining Employee may continue coverage in the Basic Plan for the month in which (s)he is waiting to gain eligibility in the Regular Plan. The self-pay rate for the Bargaining Employee for the lag month will be the COBRA rate for the Basic Plan, as is periodically set by the Board of Trustees.
2. An Active Employee, who has at least one (1) month of Minimum Contributions in their current Basic Plan hour bank and transfers to a non-bargaining status in the Regular Plan for a Contributing Employer, may elect to freeze their hour bank effective on the first (1st) day of the calendar month next following or coinciding with the effective date of such transfer. Such election shall be at the sole discretion of the Bargaining Employee and must be made within thirty (30) calendar days immediately following the date of transfer. Such request must be made in writing on a form as prescribed by the Board of Trustees. The hour bank may be frozen for a period not to exceed thirty (30) consecutive calendar months, after which time, the hour bank will be terminated.

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

j. Elected Public Officials. In the event a Bargaining Employee becomes an elected public official, the Bargaining Employee shall have the right annually to elect to participate in this Plan or such other County, City, State, or Federal plan for which the Bargaining Employee may be eligible. The Bargaining Employee shall inform the Plan, in writing, of his or her election on an annual basis.

In the event the Bargaining Employee elects coverage under the County, City, State or Federal Plan for themselves and their dependents, the Bargaining Employee's Hour Bank Account from this Plan will be frozen starting with the first day of the month following the effective date of the Bargaining Employee's coverage with the County, City, State or Federal Plan.

If the Elected Public Official continues to work under a Collective Bargaining Agreement that requires hourly contributions to the Plan, all hours worked will be added to their Hour Bank Account. The Elected Public Official's Hour Bank Account will be reinstated effective immediately upon such Bargaining Employee's election to be covered under this Plan. To re-elect such coverage from the Plan, the Bargaining Employee shall inform the Plan in writing.

Section 2: MINIMUM CONTRIBUTION LEVELS

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

Section 3: ELIGIBILITY FOR DEPENDENTS OF BARGAINING EMPLOYEES

a. Eligibility Date. The eligibility date with respect to any Dependent of an Active Employee shall be determined as follows:

1. **Initial Eligibility Enrollment:** If an Active Employee has any Eligible Dependents on the date the Employee becomes eligible for coverage under the eligibility rules, the Dependents can become eligible on the same date as the Active Employee if the Active Employee enrolls his Dependents within ninety (90) days after the Active Employee becomes eligible for Basic Plan Coverage. Please contact the Administrative Office for more information on how to enroll Dependents. If the Active Employee does not enroll his Dependents within ninety (90) days of the Active Employee's Initial Eligibility, his Dependent(s) will have to meet one of Special Enrollment rules in Section 5 of this Article to obtain coverage after the ninety (90) days. If no Special Enrollment rule applies, the Active Employee can enroll his Dependent(s) at the next annual Open Enrollment opportunity.
2. **Contribution Required for Dependent Coverage:** While coverage for an Active Employee is a negotiated benefit, Employees who elect coverage for their **Eligible Dependents must pay for that Dependent coverage by making monthly post-tax premium payments to the Administrative Office.** Payments are due by the first of the month covering the upcoming month's coverage. Failure to make required premium payments in a timely manner (within 10 calendar days from the first day of the month) will cause termination of coverage. Note that the Active Employee must be covered in order for an Eligible Dependent to be eligible for benefits under the Plan, except as may be permitted under COBRA. Contribution amounts are determined by the Board of Trustees and changes in contribution amounts are generally announced annually. Contact the Administrative Office to request enrollment for a Dependent.

b. Termination of Eligibility of a Dependent of an Active Employee. The eligibility with respect to a Dependent (Spouse or Dependent Child) of an Active Employee shall automatically terminate upon the occurrence of the first of the following events:

1. at the end of the month in which the Dependent ceases to be eligible as a Dependent as set forth under the definition of Dependent;
2. when the Dependent Spouse enters full-time military service;

3. expiration of the period of coverage stated in the QMCSO;
 4. the date the Plan is discontinued;
 5. at the end of the month in which the Eligible Employee's eligibility terminates; or
 6. at the beginning of the month in which the required contributions for Dependent coverage fails to be submitted to the Plan in a timely manner.
- c. **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 (1) month's charge-off amount remaining in the deceased Bargaining Employee's hour bank account;
 2. the date the Dependent meets any of the provisions for Termination of a Dependent of a Bargaining Employee as noted in the sub-section above; or
 3. at the beginning of the month in which the required contributions fail to be submitted to the Plan in a timely manner.

For purposes of COBRA continuation coverage, the Dependent(s)' Qualifying Event (i.e., losing coverage due to the death of the Covered Employee) occurs when the Dependent's coverage terminates under this section. Coverage is not available under this provision for any dependent of a Surviving Spouse who was not a Dependent of the Covered Employee on the date of his death. However, if the Surviving Spouse was pregnant at the time of the Covered Employee's death, the child born to the Surviving Spouse will be treated as if he/she was a Dependent of the Covered Employee at the time of his death.

WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE (RESCISSION): In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when contributions and self-payments are not timely paid in full, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled under the Plan (for example, an ex-spouse, overage or ineligible dependent child, etc.) is considered fraud.

Section 4: LEAVE FOR MILITARY SERVICE

(Under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994)

- a. If an Active Employee enters service in the Uniformed Services (as defined by USERRA) **for up to thirty (30) days**, the Employee's coverage will continue and the Employee will only be required to pay the same share, if any, they would pay as an Active Employee for that period.
- b. If an Active Employee enters service in the Uniformed Services (as defined by USERRA) **for more than thirty (30) days**, the Employee may elect to use the remaining balance of his or her hour bank to maintain coverage in the Plan during his Military Service or freeze his or her hour bank and self-pay to continue Plan coverage during his Military Service. If the Employee declines USERRA continuation coverage or elects to self-pay for USERRA continuation coverage, the former Active Employee's hour bank will be frozen effective the end of the month the Active Employee enters service in the uniformed services.

If the Employee elects USERRA continuation coverage the maximum period for this coverage is **up to 24 months** from the day the Employee leaves for military service. The USERRA continuation coverage election procedures, self-pay rates, and payment procedures will be the same as those governing the Plan's COBRA Continuation Coverage as set forth in the Self-Payment Provisions for Continuation of Coverage Including COBRA Article of this Plan.

When an Employee's coverage under this Plan terminates because of the reduction in hours due to their military service, the Employee and their Eligible Dependents may also be eligible to continue coverage under COBRA. See also the self-payment provisions for COBRA described in this Plan Document.

The Plan's Board of Trustees has established a written USERRA Policy that describes the Plan's procedures with respect to an Employee's service in the Uniformed Services. Questions regarding entitlement to USERRA leave and to the continuation of health care coverage should be referred the Administrative Office.

- c. If a former Active Employee is discharged (not less than honorably from Uniformed Services) the Employee will be reinstated in the Plan on the day they return to work with a Contributing Employer provided such former Active Employee notifies a Contributing Employer or the Local Union of their intent to return to employment within:
 1. fourteen (14) days from the date of discharge if the period of service was more than thirty (30) but less than one hundred eighty-one (181) days; or
 2. ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days.

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

If an Employee returns to work for a Contributing Employer within the time frames identified above, the employee's hour bank will be reinstated on the day he or she returns to Covered Employment. If the balance of an Employee's hour bank does not contain at least one (1) month's charge-off amount required for Plan coverage, the Employee may self-pay for Plan coverage until (s)he has sufficient hours in the hour bank for one (1) month of coverage.

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

- d. In the event of conflict between this Plan and the provisions of USERRA, the provisions of USERRA will control.

Section 5: SPECIAL ENROLLMENT

- a. This Plan complies with the Federal law regarding Special Enrollment by virtue of the fact that all Active Employees are automatically enrolled in this Plan as soon as the Eligibility requirements of the Plan are met. There is no option for Active Employees to decline coverage.

- b. **Newly Acquired Spouse and/or Dependent Child(ren).** If after the Active Employee is enrolled for coverage under this Plan, that Employee acquires a Spouse by marriage, or if the Employee acquires any Dependent Child(ren) by birth, adoption or placement for adoption, the Employee may request enrollment for their newly acquired Spouse and/or any Dependent Child(ren) **no later than 90 days** after the date of marriage, birth, adoption or placement for adoption.

If after the Active Employee is enrolled for coverage under this Plan and that Employee did not **enroll their Spouse for coverage within 90 days of the date on which he or she became eligible for coverage under this Plan**, and if the Employee subsequently acquires a Dependent Child(ren) by birth, adoption or placement for adoption, that Employee may request enrollment for their Spouse and/or newly acquired Dependent Child(ren) and/or any Eligible Dependent Child(ren) **no later 90 days** after the date of the Employee newly acquires a Dependent Child(ren) on account of birth, adoption or placement for adoption.

- c. To request Special Enrollment or for questions about this enrollment, contact the Administrative Office at their phone number listed on the Quick Reference Chart in the front of this Plan Document. The Active Employee will also be requested to complete an enrollment form, pay any required contributions for Dependent coverage and may need to provide proof of Dependent status.
- d. **Loss of Other Coverage.**

If the Active Employee did not request enrollment under this Plan for their Spouse and/or any Dependent Child(ren) within 90 days after the date on which coverage under the Plan was previously offered because their Spouse and/or any Dependent Child(ren) had health care coverage under another group health plan or health insurance policy including COBRA Continuation Coverage, certain types of individual insurance, Medicare, or other public program; **and** that Spouse and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; the Active Employee may request enrollment for their Spouse and/or any Dependent Child(ren) within 90 days after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was **"exhausted;"** or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of Dependent status under the other plan's terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered.

Proof of loss of other coverage is required by this Plan.

COBRA Continuation Coverage is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;

- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
 - because the 18-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.
- e. You and your Dependents may also enroll in this Plan if you or the Eligible Dependents:
- have coverage through **Medicaid or a State Children’s Health Insurance Program (CHIP)** and lose eligibility for that coverage. However, you must request enrollment in this Plan within **90 days** after the Medicaid or CHIP coverage ends; or
 - become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **90 days** after you or the Dependents are determined to be eligible for such premium assistance.
- f. **Start of Coverage Following Special Enrollment.**
- **Coverage of an individual enrolling because of loss of other coverage or because of marriage:** If the individual requests Special Enrollment within 90 days of the date of the event that created the Special Enrollment opportunity, (except for newborn and newly adopted child, or on account of Medicaid or a State Children’s Health Insurance Program (CHIP), discussed below) generally coverage will become effective on either the first day of the month following the date the Plan receives the request for special enrollment, or the date of the event that created the Special Enrollment opportunity (e.g. the marriage), whichever date the employee requests.
 - If the individual requests Special Enrollment **within 90 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children’s Health Insurance Program (CHIP)**, generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.
 - **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 90 days after birth will generally become effective as of the date of the child’s birth.
 - **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 30 days after birth, but within 90 days after the child is adopted or Placed for Adoption, will generally become effective as of the date of the child’s adoption or placement for adoption, whichever occurs first.
 - Individuals enrolled during Special Enrollment have the same opportunity to select Plan Benefit options (when such options exist) at the same costs and the same enrollment requirements, including any limitations the Plan may require, as are available to similarly-situated Employees at Initial Enrollment.
- g. **Failure to Enroll During Special Enrollment (Very Important Information):** If an Employee fails to request enrollment for their Eligible Dependents within 90 days after the date on which those Dependents first became eligible for Special Enrollment, the Employee will not be able to enroll them until the next annual Open Enrollment period.

Section 6: QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) (Special Rule for Enrollment)

- a. This Plan will provide benefits in accordance with a National Medical Support Notice. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice.
- b. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state’s administrative proceeding) that creates or recognizes the rights of a child, also called the “alternate recipient,” to receive benefits under a group health plan, typically the non-custodial parent’s plan. The QMCSO typically requires that the Plan recognize the child as a Dependent even though the child may not meet the Plan’s definition of Dependent. A QMCSO usually results from a divorce or legal separation and typically:
- Designates one parent to pay for a child’s health plan coverage;
 - Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
 - Contains a reasonable description of the type of coverage to be provided under the designated parent’s health care plan or the manner in which such type of coverage is to be determined;
 - States the period for which the QMCSO applies; and
 - Identifies each health care plan to which the QMCSO applies.
- c. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a dependent child, except as required by a state’s Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

- d. If a court or state administrative agency has issued an order with respect to health care coverage for any dependent child of the Employee, the Administrative Office will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. The Administrative Office will notify the parents and each child if an order is determined to be a QMCSO, and if the Employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).
- e. No coverage will be provided for any Dependent Child under a QMCSO unless the applicable Employee contributions for that Dependent Child's coverage are paid, and all of the Plan's requirements for coverage of that Dependent Child have been satisfied.
- f. Coverage of a Dependent Child under a QMCSO will terminate when coverage of the Employee-parent terminates for any reason, including failure to pay any required contributions, subject to the Dependent Child's right to elect COBRA Continuation Coverage if that right applies. For additional information (free of charge) regarding the **procedures for administration of QMCSOs**, contact the Administrative Office and see also the Claim Filing and Appeal Information Article of this document for payment of claims under QMCSOs.

Section 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 any of the following:

- a. **Marriage:** copy of recorded Marriage Certificate or Common Law Marriage Affidavits/Documentation. Proof Spouse resides with Participant (i.e., utility bill).
- b. **Birth:** copy of the certified birth certificate.
- c. **Adoption or placement for adoption:** copy of recorded adoption papers issued by the court; copy of placement papers issued by a placement agency or recorded copy of judgment, decree, or other order of any court of competent jurisdiction
- d. **Stepchild:** the certified birth certificate, divorce decree and marriage certificate.
- e. **Legal Guardianship:** a copy of the Employee's court-appointed permanent legal guardianship documents and a copy of the certified birth certificate.
- f. **Disabled Adult 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 the Employee and/or the Employee's Spouse for support and maintenance. The Plan may require that the Employee 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.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such Dependents are currently enrolled in Medicare or have dis-enrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a Dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: <http://www.socialsecurity.gov/online/ss-5.pdf>. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form means that claims for the affected individuals will not be considered a payable claim.

Section 9: FAMILY AND MEDICAL LEAVE ACT (FMLA)

- a. Coverage under the Fund will continue while an Active Employee is on an approved leave of absence under the Family and Medical Leave Act of 1993.
- b. It is the responsibility of the Employee's last Employer to make any required contributions to the Fund during a period of leave taken under FMLA.

Section 10: NOTICE TO THE PLAN

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); 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 mentally disabled).

Failure to give this Plan a timely notice will cause your Spouse, 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.

ARTICLE IV: SELF-PAYMENT PROVISIONS FOR COBRA CONTINUATION COVERAGE

Section 1: OVERVIEW

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

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

Section 2: CONTINUATION OF COVERAGE UNDER COBRA

- a. **Eligibility.**

A Qualified Beneficiary may temporarily continue health care coverage under COBRA for the maximum periods specified below, by making an election to do so with the Administrative Office and submitting the applicable COBRA self-payment contribution. The amount of the monthly self-payment contribution will be established by the Board of Trustees.

Other Health Coverage Alternatives to COBRA. 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.

- b. **Compliance with COBRA.**

Active Employees whose hour bank is forfeited are not entitled to the COBRA continuation coverage under this section unless they incur a Qualifying Event prior to or coinciding with the date of withdrawal of the Contributing Employer. The cessation of contributions to the Fund by a Contributing Employer is not itself a Qualifying Event.

Furthermore, continuation of coverage under this section shall be terminated under this Fund for all Qualified Beneficiaries of a Contributing Employer on the date of termination of participation in the Fund by the Contributing Employer if such Employer provides other group health coverage to a class of its employees formerly covered by the Fund.

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

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

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

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

IMPORTANT:

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

Section 3: COBRA ADMINISTRATOR

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

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

- a. Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other Covered Individuals including Special Enrollment.
- b. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an Employee 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 Employee during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
 - A child of the covered Employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Employee'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 Qualified Beneficiary Employee during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing Qualified Beneficiary Employee but such Spouse is not a "Qualified Beneficiary." This means that if the existing Qualified Beneficiary Employee dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.
- e. **"Qualifying Event"**: Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the Participant LOSES health care coverage under this Plan.** If a Participant has a Qualifying Event but does not lose their health care coverage under this Plan, then COBRA is not yet offered.

Section 5: SPECIAL ENROLLMENT RIGHTS

You have special enrollment rights under federal law that allow 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.

Section 6: MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE

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

Section 7: MEDICARE ENTITLEMENT

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

Section 8: SELF-PAYMENT WHEN WORKING FOR A DELINQUENT CONTRIBUTING EMPLOYER

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

Section 9: COBRA QUALIFYING EVENTS

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

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

¹ When a covered Employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the Employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and Dependent Children who are Qualified Beneficiaries (but not the Employee) may become entitled to COBRA coverage for a maximum period that ends on the later of: 1) 36 months after the Medicare entitlement; or 2) 18 months (or 29 months, if there is a disability extension) after the date of the Employee's termination of employment or reduction in hours.

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

- a. In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "Dependent Child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs.**
- b. That written notice should be sent to the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

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

- c. Officials of the Contributing Employer should notify the COBRA Administrator of an Employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Section 11: NOTICES RELATED TO COBRA CONTINUATION COVERAGE

When:

- a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to coverage under the Plan, you died, have become entitled to Medicare, or
- b. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

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

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

Section 12: THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See Section 13 of this Article for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated Active Employees and their families, that same change will apply to your COBRA Continuation Coverage.

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

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated Active Employees and families (including both the Fund's and Employee's share), plus an additional 2% (i.e., 102% of the applicable premium). If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (i.e., 150% of the applicable premium), but only if the disabled person is covered during the 11-month additional COBRA period.

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

Section 14: RESERVED

Section 15: GRACE PERIODS

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

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

Section 16: FOR MONTHLY PAYMENTS, WHAT IF THE FULL COBRA PREMIUM PAYMENT IS NOT MADE WHEN DUE?

If the COBRA Administrator receives a COBRA premium payment that is not for the full amount due, the COBRA Administrator will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of \$50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall. If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred. If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the end of the month in which the last full COBRA premium payment was made.

Section 17: 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.

Section 18: ADDITION OF NEWLY ACQUIRED DEPENDENTS

If, while you (the Employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 90 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.

Section 19: LOSS OF OTHER GROUP HEALTH PLAN COVERAGE

If, while you (the Employee) 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 90 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.

Section 20: NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

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

Section 21: EXTENDED COBRA COVERAGE WHEN A SECOND QUALIFYING EVENT OCCURS DURING AN 18-MONTH COBRA CONTINUATION PERIOD

- a. 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).
- b. **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.
- c. **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.
- d. **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) during the 18-month period of COBRA Continuation Coverage.
- e. 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.
- f. In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Section 22: EXTENDED COBRA COVERAGE IN CERTAIN CASES OF DISABILITY DURING AN 18-MONTH COBRA CONTINUATION PERIOD

- a. If, at any time before or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).
 1. This extension is available only if:
 - a. the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; **and**
 - b. the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

Notifying the Plan: you or another family member follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.

2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be higher than the cost for that coverage during the 18-month period. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (i.e., 150% of the applicable premium), but only if the disabled person is covered during the 11-month additional COBRA period.
3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Section 23: EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

- a. Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:
 1. The date on which the Employee's Contributing Employer no longer provides group health coverage to any of its employees;
 2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
 3. The date, after the date of the COBRA election, on which the covered person first becomes entitled to Medicare;
 4. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan;
 5. The date the Plan has determined that the covered person must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA Participants under the Plan);
 6. The date the Plan is terminated;
 7. During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled.

Section 24: NOTICE OF EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

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

Section 25: NO ENTITLEMENT TO CONVERT TO AN INDIVIDUAL HEALTH PLAN AFTER COBRA ENDS

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

Section 26: COBRA QUESTIONS OR TO GIVE NOTICE OF CHANGES IN YOUR CIRCUMSTANCES

- a. 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.
- b. 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.
- c. **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)**; 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**.

ARTICLE V: PERSONAL CARE ACCOUNTS (PCA)

Section 1: ESTABLISHMENT OF PERSONAL CARE ACCOUNT(S)

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

- a. The Personal Care Account benefits described in this document are available **if** the Collective Bargaining Agreement under which the Active Employee works requires contributions to the PCA Account. However, in the case of an Active Employee working under a Reciprocal Agreement, when the required contributions exceed the Minimum Contribution levels required by this Plan, the overage may establish a PCA for such individual, regardless whether the contribution has been negotiated in two instances:
 1. An Active Employee may establish a Personal Care Account in instances where the Active Employee is working under the geographic jurisdiction of the Eighth District Electrical Benefit Fund as a traveler and the contribution rate of the home local health and welfare fund for which health and welfare contributions are directed to be reciprocated is an hourly rate less than the contribution rate established under the collective bargaining agreement in which the Active Employee is working. In such event, the excess contribution not subject to reciprocity will be used to establish a Personal Care Account for the Active Employee.
 2. An Active Employee who is working as a traveler in a geographic jurisdiction outside of the Eighth District Electrical Benefit Fund may establish a Personal Care Account with regard to any excess funds received by the Eighth District Electrical Benefit Fund through reciprocity if the hourly contribution rate remitted to the Eighth District Electrical Benefit Fund exceeds the hourly contribution rate for health and welfare contributions established by the Active Employee's home local collective bargaining agreement. In such event, the excess contribution received by the Benefit Fund via reciprocity will be used to establish a Personal Care Account for the Active Employee.

b. Legal Status

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses, COBRA premiums reimbursed under the Plan are intended to be eligible for exclusion from participating employees' gross income under Code §105(b). The Plan is intended to comply with the requirements of IRS Notice 2013-54 and IRS Notice 2015-87 and shall be interpreted to accomplish that objective. The PCA is not a benefit for any "self-employed individual" as that term is defined under Internal Revenue Code (IRC) Section 401(c). The following individuals are deemed to be "self-employed individuals" under IRC Section 401(c)(1)(B) and are legally prohibited from participating in the PCA: sole proprietors, partners, LLC members (unless the LLC has elected to be taxed as a C-Corporation), and greater-than 2% S-Corporation shareholders.

c. Definitions

1. "Code" means the Internal Revenue Code of 1986, as amended.
2. "Health FSA" means a health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125-2, Q/A-7(a).
3. "Highly Compensated Individual" means an individual defined under Code §105(h), as amended, as a "highly compensated individual" or "highly compensated employee."
4. "PCA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.
5. "PCA Account" means the personal care (health reimbursement arrangement) account described later in this Article under "Establishment of Account."
6. "Medical Care Expenses" has the meaning described later in this Article under "Eligible Medical Care Expenses."
7. "PCA Participant" means a person who is an Active Employee for whom the required contributions have been negotiated and paid, and who is participating in the PCA portion of this Plan.
8. "Period of Coverage" means the Plan Year, with the following exceptions:
 - (a) for Active Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences; and
 - (b) for Active Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, unless there is an account balance in which case claims can be reimbursed from the PCA account after the date of termination until the account balance is depleted. The Period of Coverage also includes any COBRA extension period, in which PCA funds can be used to pay COBRA premiums.

d. Eligibility

1. **Coverage under a Group Health Plan.** An Active Employee may not participate in the PCA account unless the Active Employee is actually enrolled in a group health plan that provides minimum value. Pursuant to Internal Revenue Code §36B(c)(2)(C)(ii), regardless of whether the group health plan is sponsored by this health and welfare fund. A group health plan provides minimum value if the coverage is at least 60 percent (60%) of the actuarial value of a standard plan as determined by the IRS.
2. **Proof of Coverage.** Proof of other group health plan coverage in a manner to be determined by the Trustees. If proof is not required, benefits will be restricted, as defined below.
3. **PCA Account Balance Run Out.** Notwithstanding the above, an Active Employee and his/her Dependents that meet the eligibility requirements of Sub-Section 1-d(5) of this Article will be allowed to utilize any remaining PCA account balance after loss of eligibility under the Eighth District Electrical Benefit Fund. This account balance run out provision does not require coverage under a group health plan. This account balance run out only applies to PCA contributions accumulated as an Active PCA Participant.
4. **Opt-Out.** An Active Employee is permitted to permanently opt-out of and waive future reimbursements from the PCA at least annually, in a time and manner determined by the Trustees. An Active Employee also has the ability to opt-out upon termination of coverage under the Plan. This means that the Active Employee is permitted to forfeit the balance of his PCA upon termination of coverage from the Plan.
5. **Dependents.** Dependents of an Active Employee are eligible for payment of Medical Care Expenses from an Active Employee's PCA only if the Dependents are enrolled in the Basic Plan.

e. Benefits Offered and Method of Funding

1. **Benefits Offered.** When an Active Employee becomes a PCA Participant, an account will be established for such PCA Participant to receive benefits in the form of reimbursements for Medical Care Expenses and COBRA premiums, as described later in the section titled "Health Reimbursement Benefits." In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses. In no event are premiums for individual health insurance payable, whether purchased in the individual insurance market or in a Health Insurance Marketplace.
2. **Plan and PCA Participant Contributions.**
 - a) **Plan Contributions.** When the required contributions have been negotiated the Contributing Employer will submit the contributions in the appropriate manner. In addition, Plan Contributions will be received and a PCA established for each Active Employee described in Section 1(a)(1) and 1(a)(2) above.
 - b) **PCA Participant Contributions.** There are no PCA Participant contributions for benefits under the Plan.
3. **No Funding Under Cafeteria Plan.** Under no circumstances will the benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

Section 2: HEALTH REIMBURSEMENT BENEFITS

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

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

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

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

To use the Prepaid Benefits card, simply swipe the card each time you incur an Eligible Medical Care Expense and the amount of the purchase will automatically be deducted from the PCA. It is also possible to fill in the Card number on bills received

from Providers to pay the amount owed. Using the Prepaid Benefits card means that there are generally no claim forms to complete and no wait to get a PCA reimbursement check in the mail. PCA account balances and account details can be checked online or questions can be directed to the Administrative Office.

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

- c. **Eligible Medical Care Expenses.** Under the PCA, a PCA Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage, provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees.
- d. **Incurred.** A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a PCA Participant first becomes covered by the Plan are not eligible. See also the section on Carryover of Accounts, below.
- e. **Medical Care Expenses Generally.** “Medical Care Expenses” means expenses incurred by a PCA Participant or his/her Eligible Dependents for medical care, as defined in Code §105 and 213(d) (including, for example, amounts for certain bills for Hospital care, doctors, dental care, vision care and prescription drugs), but shall not include expenses that are described in the section of this Article titled “Exclusions to the PCA Account.” Reimbursements due for Medical Care Expenses incurred by the PCA Participant or the PCA Participant’s Dependents shall be charged against the PCA Participant’s account.
- f. **Medical Care Expenses Exclusions.** “Medical Care Expenses” shall not include:
 - 1. health insurance premiums for individual policies, whether purchased in the individual insurance market or on a state or federal Health Insurance Marketplace;
 - 2. health insurance premiums for any other group health plan (including a plan sponsored by a Contributing Employer). However, the PCA may reimburse COBRA premiums or self-payment premiums for coverage under this Plan; and
 - 3. the expenses listed as Exclusions under the section of this Article titled “Exclusions to the PCA Account.”
- g. **Cannot Be Reimbursed or Reimbursable from Another Source.** Medical Care Expenses can only be reimbursed to the extent that the PCA Participant or his Eligible Dependent incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Plan, other insurance, or any other accident or health plan (if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Plan imposes copayment or Deductible limitations), the PCA can reimburse the remaining portion of such expense if it otherwise meets the requirements herein.
- h. **Maximum Benefits.** There will not be a maximum dollar amount that may be credited to a PCA Account for an Active Employee. Unused amounts may be carried over to the next Period of Coverage, as provided hereafter.
- i. **Nondiscrimination.** Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Board of Trustees in its sole discretion.
- j. **Establishment of Account.** The Administrative Office will establish and maintain a PCA Account with respect to each PCA Participant but will not create a separate fund or otherwise segregate assets for this purpose. The PCA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.
- k. **Crediting of Accounts.** A PCA Participant’s account will be credited at the beginning of each month with an amount equal to the contributions received based on the hours worked, increased by any carryover of unused account balance from prior Periods of Coverage.
- l. **Debiting of Accounts.** A PCA Participant’s account will be debited during each Period of Coverage for any reimbursement of Eligible Medical Care Expenses, including COBRA premiums incurred during the Period of Coverage.
- m. **Available Amount.** The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant’s PCA as described above reduced by prior reimbursements debited as described above.
- n. **Carryover of Accounts.** If any balance remains in the PCA Participant’s account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the PCA Participant for Medical Care Expenses incurred during a subsequent Period of Coverage.
- o. **Inactivation of the PCA Account.** An Active Employee is permitted to permanently opt-out and waive future reimbursements from the PCA at least annually, in a time and manner determined by the Trustees. In addition, an Active Employee also has

the ability to opt-out upon termination of coverage from the Plan. This means that the Active Employee is permitted to forfeit the balance of his PCA upon termination of coverage from the Plan.

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

- a. **Timing.** Within thirty (30) days after receipt by the Administrative Office of a reimbursement claim from a PCA Participant, the Administrative Office will reimburse the PCA Participant for appropriate Medical Care Expenses, or the Administrative Office will notify the PCA Participant that his/her claim has been denied.
 - 1. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Administrative Office, including in cases where a reimbursement claim is incomplete.
 - 2. The Administrative Office will provide written notice of any extension, including the reasons for the extension, and will allow the PCA Participant forty-five (45) days in which to complete an incomplete reimbursement claim.
- b. **Claims Substantiation.** A PCA Participant who seeks benefits may apply for reimbursement of claims that were incurred during a Period of Coverage by submitting an application in writing to the Administrative Office in such form as the Board of Trustees may prescribe, setting forth:
 - 1. the person or persons on whose behalf Medical Care Expenses have been incurred;
 - 2. the nature and date of the Medical Care Expenses so incurred;
 - 3. the amount of the requested reimbursement; and
 - 4. a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted. The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Administrative Office may request. Except for the final reimbursement claim for a Period of Coverage, **no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least \$25 (manual claim) or \$50 for the Prepaid Benefits card.**
- c. **Claims Denied.** For reimbursement PCA claims that are denied, see the Post-Service Appeals procedure in the Claim Filing and Appeal Information Article in this document.

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

- a. When a PCA Participant ceases to be a PCA Participant hereunder, the PCA Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his/her participation terminates, unless there is an account balance in which case claims can be reimbursed from the PCA account after the date of termination until the account balance is depleted.
- b. Notwithstanding any other provisions herein to the contrary, the PCA Participant's coverage and eligibility will terminate on the last day of the calendar month in which:
 - 1. such employee commences work in employment in the electrical industry within the Eighth District with an employer who does not make contributions to the Plan;
 - 2. the contributions made by a Contributing Employer on behalf of such employee are less than the Minimum Contribution established by the Board of Trustees; or
 - 3. the Participant exercises an annual or post-termination opt-out right, as described above.
- c. A PCA Participant whose coverage terminates under this PCA provision shall not be entitled to continue coverage under the Self-Payment Provisions for Continuation of Coverage unless such termination of coverage constitutes a COBRA Qualifying Event.
- d. Unless the PCA Participant has opted out of the PCA, PCA Participant claims are reimbursable after PCA participation terminates as long as there is an account balance.

Section 5: RECORDKEEPING AND ADMINISTRATION

- a. **Inability to Locate Payee.** If the Administrative Office is unable to make payment to any PCA Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such PCA Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such PCA Participant or other person shall be subject to the provisions set forth in the "Account Forfeiture" section described later in this Article.
- b. **Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Active Employee or his/her Dependents, or the allocations made to the account of any PCA Participant, or the amount of benefits paid or to be paid to a PCA Participant or other person, the Administrative Office shall, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or

accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such PCA Participant or other person the credits to the PCA or distributions to which he/she is properly entitled under the Plan. Such action by the Administrative Office may include withholding of any amounts due to the Plan from any future benefits.

c. Termination and Rehire.

1. If a PCA Participant terminates his/her employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, the PCA Participant will be allowed to utilize any remaining PCA account balance after loss of eligibility under the Eighth District Electrical Benefit Fund. This account balance run out only applies to PCA contributions the PCA Participant accumulated as an Active PCA Participant. A PCA Participant also has the ability to opt-out upon termination of coverage under the Plan. This means that the PCA Participant is permitted to forfeit the balance of his PCA upon termination of coverage from the Plan.
2. A PCA Participant who terminates employment with a balance in their PCA Account may voluntarily waive the remaining balance. The waiver must be in writing, signed by the PCA Participant, and filed with the Administrative Office. The waiver shall have the effect of permanently and irrevocably forfeiting any remaining account balance. The waiver shall be effective on the first of the month following the date it was received by the Administrative Office. Anyone who waives his or her PCA Account balance and who later returns to employment and reestablishes PCA eligibility shall be treated as a new PCA Participant with no accrued PCA Account balance.

d. Death of a Participant

1. If PCA Participant is married and/or has one or more Dependents and dies with a balance in a PCA Account, the surviving Spouse and Dependents, who met the eligibility requirements of Section 1(e)(5) of this Article at the time of the PCA Participant's death, may use the remaining balance in the PCA Account in the manner provided in Section 1(e)(3) of this Article. This provision only applies to PCA contributions accumulated during the life of the deceased PCA Participant. The surviving Spouse and Dependents need not continue coverage under the group health plan sponsored by this health and welfare fund in order to continue using a deceased PCA Participant's PCA Account balance. The surviving Spouse and Dependents may voluntarily waive the remaining balance according to Section 5(c)(2) of this Article. If the surviving Spouse and all Dependents voluntarily waive their right to use the remaining balance of a deceased PCA Participant, such balance shall be immediately and permanently forfeited. Otherwise, PCA accounts subject to this provision shall be subject to the inactive account and forfeiture rules set forth in Section 5(e)(1) of this Article.
2. If a PCA Participant is not married and has no Dependents, the remaining balance in the PCA Account is immediately forfeited upon the death of the PCA Participant without regard to the inactive account and forfeiture rules set forth in Section 5-e(1) of this Article.

e. Account Forfeiture.

1. Inactive accounts (no money coming in or going out) will be charged \$25 each year. After three years of inactivity, all remaining funds in the inactive account will be automatically and permanently forfeited.
2. **In the event an account balance is \$25 or less, the money will be forfeited and the account will be closed.**
3. Note however that an account balance will be forfeited if the PCA Participant works in **non-covered employment**. For purposes of this forfeiture rule, non-covered employment means any employment in the electrical industry for an employer who is not signatory to an agreement which requires contributions either to this Plan or another IBEW-affiliated health and welfare trust fund.

f. No Guarantee of Tax Consequences.

1. Neither the Administrative Office nor the Board of Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of a PCA Participant under this portion of the Plan will be excludable from the PCA Participant's gross income for federal, state or local income tax purposes.
2. It shall be the obligation of each PCA Participant to determine whether each payment under this portion of the Plan is excludable from the PCA Participant's gross income for federal, state and local income tax purposes, and to notify the Administrative Office if the PCA Participant has any reason to believe that such payment is not so excludable.
3. With respect to a PCA Participant who has separated from employment but remains covered under the PCA benefit, neither the Administrative Office nor the Board of Trustees offers any commitment, guarantee, or opinion with respect to the PCA Participant's eligibility for insurance premium tax credits. It shall be the sole responsibility of each terminated PCA Participant to determine his or her eligibility for insurance premium tax credits.

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

Medical Care Expenses eligible for reimbursement under the PCA are all expenses incurred by the PCA Participant, the PCA Participant's Spouse and/or the PCA Participant's dependents for medical care as that term is defined in Section 213(d) of the Internal Revenue Code. For a complete listing of all covered expenses, refer to IRS Publication 502. The Publication can be found on the Internet at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. If you do not have Internet access, contact the Fund Office for a copy of Publication 502. Expenses that are not reimbursable as defined in Section 213(d) of the Internal Revenue Code and are otherwise not covered by the Plan will not be reimbursed through the PCA Account.

ARTICLE VI: MEDICAL PLAN

Section 1: ELIGIBLE MEDICAL EXPENSES (Covered Charges)

- a. You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called “Eligible Medical Expenses” or “covered charges” and they are limited to those that are:
 1. determined by the Plan Administrator or its designee to be “**Medically Necessary**,” but only to the extent that the charges are “**Allowed Charges**” (as those terms are defined in the Definitions Article); and
 2. not services or supplies that are **excluded from coverage** (as provided in the Exclusions Article); and
 3. not services or supplies **in excess of a Maximum Plan Benefit** shown in the Schedule of Medical Benefits; and
 4. for the **diagnosis or treatment of an Injury or Illness** (except where certain wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits).
- b. Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have incurred an Out-of-Pocket Maximum cost each Calendar Year, for Providers used In-Network and Out of Area, and for Out-of-Network Services provided at In-Network Facilities or in an Emergency, no further cost-sharing will be applied for that Calendar Year.

Section 2: NON-ELIGIBLE MEDICAL EXPENSES

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

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

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

In-Network refers to Health Care Providers who are contracted with the PPO Network and who are located within the service area of the PPO Network. The Plan’s Preferred Provider Organizations (PPOs) are networks of Hospitals, Physicians, laboratories and other Health Care Providers who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to Plan Participants. **If you receive Medically Necessary services or supplies from an In-Network Provider you generally pay less than if you received those Medically Necessary services or supplies from a Health Care Provider who is Out-of-Network.** The In-Network Provider who is under a contract with the Plan has agreed to accept the Plan’s payment, plus any applicable Deductible, Coinsurance or Copayment that you are responsible for paying as payment in full, except with respect to certain claims involving a third party payer.

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

Out-of-Network refers to Providers who are not contracted with the PPO Network but who are located within the service area of the PPO Network. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount for any balance that may be due in addition to** the Allowed Amount payable by the Plan, also called Balance Billing. However, under certain circumstances, Plan Participants may be protected from Balance Billing. See the Medical Networks Article for more information.

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

- c. **Out of Area Benefit:**

Out of Area Benefit refers to when a Participant receives services from an Out-of-Network Provider because there are fewer than two In-Network Providers in the same specialty for a particular service within a 30-mile radius of their zip code. If this occurs, the Plan will pay benefits at the same rate as an In-Network Provider as explained in Section 3(a) of this Article and as listed in the Schedule of Medical Plan Benefits. If you use an Out-of-Network Provider when there are at least two In-Network Providers in the same specialty for a particular service within a 30-mile radius of your zip code, the Provider **will not be covered as an Out of Area Provider**. Instead, the Plan will pay benefits as an Out-of-Network Provider as explained in Section 3(b) of this Article and as listed in the Schedule of Medical Plan Benefits. An Out of Area Provider **may bill a Plan Participant a non-discounted amount for any balance that may be due in addition to** the Allowed Amount payable by the Plan, also called Balance Billing. However, under certain circumstances, Plan Participants may be protected from Balance Billing. For more information, see the Medical Networks Article.

d. **Network Providers**

Physicians and Health Care Providers who participate in the Plan's network are added and deleted during the year. At any time, you can find out (at no cost) if any Health Care Provider is a member of the Network by contacting the PPO at their telephone number or on their website shown on the Quick Reference Chart in the front of this document.

Section 4: PRECERTIFICATION

- a. Precertification may be required for certain services and for certain classes of drugs. See the Precertification Article for more information.

Section 5: DEDUCTIBLES

- a. The Deductible is the amount of expenses incurred for covered charges each Calendar Year before medical benefits are payable by the Plan. Each Calendar Year, you and your Dependent(s), if applicable, (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits.
- b. Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. The amount applied to the Deductible is the "Allowed Charge" amount as defined in this document (i.e., the amounts over the Allowed Charge are not subject to the Deductible).
- c. Deductibles under this Plan are accumulated on a Calendar Year basis.
- d. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles.
- e. Copayments, non-covered expenses, and any penalty for failure to obtain Precertification, do not count toward the Deductible.
- f. The **Individual Deductible** is the maximum amount each Participant has to pay toward Eligible Medical Expenses before Plan Benefits begin. The amount of the annual Deductible is listed on the Schedule of Medical Benefits.
- g. **Expenses Not Subject to Deductibles:** Certain Eligible Medical Expenses (such as covered preventive care and outpatient retail/mail order drugs) are not subject to Medical Plan Deductibles. These expenses may be covered 100% by the Plan, or they may be subject to Copayments or Coinsurance (explained below). See the Schedule of Medical Benefits to determine when Eligible Medical Expenses are not subject to Deductibles or Coinsurance.

Section 6: COINSURANCE

- a. Once you've met your annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. If you use the services of a Health Care Provider who is an In-Network Provider, you will generally be responsible for paying less money out of your pocket. This feature is described in more detail in the Medical Network Article of this document.
- b. **Coinsurance When You Don't Comply with Precertification Requirements of this Plan:** If you fail to follow the Plan's Precertification Requirements (as described in the Precertification Article of this document) the Plan may pay nothing and the additional amount you'll have to pay will not be subject to the Plan's Deductibles or Out-of-Pocket Maximum described below.

Section 7: COPAYMENT

- a. A Copayment (or copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur an Eligible Medical Expense. The Plan's Copayments are indicated in the Schedule of Medical Benefits. Copayments are not used to satisfy (and do not apply to meet) the Deductible.

Section 8: OUT-OF-POCKET LIMIT (ANNUAL LIMIT ON IN-NETWORK COST SHARING)

- a. The Medical Plan has an Out-of-Pocket Limit (also referred to as an Out-of-Pocket Maximum) which limits your annual cost-sharing (meaning Deductibles, Copayment and Coinsurance) for covered Essential Health Benefits received from In-Network Providers and in certain circumstances, Out-of-Network Providers or Facilities. There are different Out-of-Pocket limits for Medical Plan and Prescription Drug services. For more information regarding the Prescription Drug Out-of-Pocket Limit, please see the Schedule of Prescription Drug Benefits Article.
 - 1. The Out-of-Pocket Limit is accumulated on a Calendar Year basis.
 - 2. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
 - 3. The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.
 - 4. Covered Out of Area services along with covered Emergency Services performed in an Out-of-Network Emergency Room will apply to meet the In-Network Out-of-Pocket Limit on cost-sharing.

5. Covered services performed in an In-Network Facility provided by an Out-of-Network Provider are generally included in the Out-of-Pocket Limit, except in instances where the Participant consents to being Balance Billed.
6. The family Out-of-Pocket Limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual Out-of-Pocket Limit.
7. Expenses for mental health and substance use disorder benefits count toward the Out-of-Pocket Limit in the same manner as those for medical expenses.

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

Annual Limit on Cost Sharing is:	*Out-of-Pocket Limit Applies to:
\$3,000 per individual \$6,000 per family	Deductibles, Copayments and Coinsurance related to In-Network Essential Health Benefits for Medical Plan expenses and certain Out-of-Network expenses pursuant to the No Surprises Act accumulate to a separate Medical Plan Out-of-Pocket Limit.
\$3,600 per individual \$7,200 per family	Deductibles, Copayments and Coinsurance related to In-Network Essential Health Benefits for Outpatient Prescription Drug expenses accumulate to a separate Outpatient Drug Out-of-Pocket Limit. Please see the Schedule of Prescription Drug Benefits Article for further information regarding the Plan's Outpatient Drug Out-of-Pocket Limit.

c. *The Out-of-Pocket Limit **does not include or accumulate:**

1. Premiums,
2. Expenses for medical services or supplies that are not covered by the Plan,
3. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for Non-Network Providers in which the Participant has consented,
4. Penalties for non-compliance with Utilization Management programs,
5. Expenses for the use of Out-of-Network Providers, except Out-of-Network Emergency Services performed in an Emergency Room, or non-emergency services provided by an Out-of-Network Provider at an In-Network facility without the Participant knowingly electing that Provider or giving consent to be billed,
6. Charges in excess of the Medical Plan's Maximum Benefits, and
7. Expenses that are not considered to be Essential Health Benefits.

Section 9: MAXIMUM PLAN BENEFITS

- a. **Types of Maximum Plan Benefits:** There are two types of maximum amounts of benefits payable by the Plan on account of medical expenses incurred by any covered Plan Participant under this Plan. They are described in detail in the following sections, and they include the Limited Overall Maximum Plan Benefit and Annual Maximum Plan Benefit.
- b. **Limited Overall Maximum Plan Benefits:** Certain Plan Benefits are subject to limitations that are not considered Annual maximums. These other types of maximums are referred to under this Plan as Limited Overall Maximums. Examples include: Morbid Obesity and Respite Care services.

The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of these maximums are identified in the Schedule of Medical Benefits. Once the Plan has paid the Limited Overall Maximum Plan Benefit for any of those services or supplies on behalf of any Participant, it will not pay any further Plan Benefits for those services or supplies on account of the Participant.
- c. **Annual Maximum Plan Benefits:** Plan Benefits for certain Eligible Medical Expenses are subject to Annual Maximums per Participant during each Calendar Year (e.g., outpatient rehabilitation services). Once the Plan has paid the Annual Maximum Plan Benefit for any of those services or supplies on behalf of any Participant, it will not pay any further Plan Benefits for those services or supplies on account of that Participant for the balance of the Calendar Year. The services or supplies that are subject to Annual Maximum Plan Benefit are identified in the Schedule of Medical Benefits.

Section 10: INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR PEOPLE WITH MEDICARE

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

- b. Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (October 15th through December 7th of each year).
- c. You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If, however, you keep this Plan coverage and also enroll in a Medicare Part D prescription drug plan you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefit Article for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.
- d. Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:
 - when they first become eligible for Medicare; or
 - during Medicare's annual election period (from October 15th through December 7th); or
 - for beneficiaries leaving employer/union coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare prescription drug plan
- e. If you do not have creditable prescription drug coverage and you do not enroll in a Medicare prescription drug plan you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.
- f. For more information about creditable coverage or Medicare Part D coverage see the Plan's Notice of Creditable Coverage (a copy is available from the Administrative Office. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).
- g. If we find out that you have tried to enroll in a Medicare Prescription Drug Plan, we will contact you to see if that is your final decision or just an error.

Section 11: NONDISCRIMINATION IN HEALTH CARE

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

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

Section 12. PAYMENT FOR ROUTINE PREVENTIVE CARE BENEFITS

Certain Drugs and services are payable at no charge (i.e. the Plan pays 100%) when prescribed by a Physician/Health Care Practitioner in compliance with the ACA.

Please visit <https://www.healthcare.gov/coverage/preventive-care-benefits> for a list of Preventive Care Prescription Drugs and services covered by the Plan as required under the ACA. Please note, the list of Preventive Drugs covered by the Plan is subject to change. This non-grandfathered Medical Plan complies with the Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of Preventive Care Prescription Drugs, this Plan will comply with the new requirements on the date required.

Section 13: PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The Medical Plan in this document does not require the selection or designation of a **Primary Care Provider (PCP)**. You have the ability to visit any In-Network or Out-of-Network Health Care Provider; however, payment by the Plan may be less for the use of an Out-of-Network Provider.

You also do not need prior authorization from the Plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a Health Care Professional who specializes in obstetrics or gynecology. The Health Care Professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating Health Care Professionals who specialize in obstetrics or gynecology, contact the Medical Plan PPO Network at their website listed on the Quick Reference Chart.

Section 14: SCHEDULE OF MEDICAL BENEFITS

A schedule of the Basic Plan's Medical Benefits appears in Article VII which describes the Plan's Medical benefits; explanations and limitations that apply to each of the benefits; and the specific differences in the benefits when they are provided In-Network (when you use PPO Network Providers) and Out-of-Network (when you use Non-PPO, Non-Network Providers).

Deductibles and Annual Out-of-Pocket Maximums are listed first. Unless there is a specific statement in the Schedule of Medical Benefits, all benefits shown are subject to the Plan's Deductibles.

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

Section 15: TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All Post-Service Claims must be submitted to the Plan's Claims Administrator by July 1st of the year following the year in which the claims were incurred.

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

Introduction. This Article VII explains the medical benefits payable by the Plan. All benefits are subject to the Deductible except where noted. See also the Exclusions and Definitions Articles of this document. A summary chart follows the final section of this Article with a summary of coverage.

IMPORTANT NOTE

Out-of-Network and Out of Area Providers are paid according to Allowed Charges as defined in the Definitions Article and *could* result in Balance Billing to you.

Section 1: Definitions

- a. “In-Network” means Providers within the PPO Network. Refer to Article VI for a more in-depth definition.
- b. “Out-of-Network” means Providers not within the PPO Network. Refer to Article VI for a more in-depth definition.
- c. “Out of Area” means an Out-of-Network Provider if there are fewer than two In-Network Providers in the same specialty within a 30-mile radius of your zip code. Refer to Article VI for a more in-depth definition.

Section 2: Deductibles

- a. Deductibles are the amount you must pay each Calendar Year before the Plan pays benefits. Note that expenses incurred In-Network, Out-of-Network, and Out of Area are combined to meet your annual Deductible amount. See also the information on Deductibles in Article VI of this document for further explanations and limitations on Deductibles. Certain expenses are payable without having to meet the annual Deductible, such as preventive (wellness) care and outpatient Prescription Drugs.
- b. For all In-Network, Out-of-Network, and Out of Area Providers, the following Deductible applies: \$1,500 per person, per Calendar Year.

Section 3: Annual Out-of-Pocket Limit on In-Network Cost-Sharing

Please refer to Article VI for more information on the Plan’s Annual Out-of-Pocket Limit on In-Network Cost-Sharing. The Plan intends to comply with the No Surprises Act.

Section 4: Allergy Services

- a. The Plan covers the following Allergy Services:
 1. Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast,
 2. Desensitization and hyposensitization (allergy shots given at periodic intervals), and
 3. Allergy antigen solution
- b. Limitations: Allergy services are covered only when ordered by a Physician.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 5: Ambulance Services

- a. The Plan covers the following Ambulance Services:
 1. **Ground vehicle transportation** to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency, acute illness or inter-Health Care Facility transfer.
 2. **Air/sea transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient’s health status.
- b. Limitations: Expenses for Ambulance Services are covered only when those services are for an **Emergency** as that term is defined in the Definitions Article or for Medically Necessary inter-facility transport.
- c. For all service areas (In-Network, Out-of-Network, and Out of Area), the Percentage of Coverage is 70% after the Deductible is met.
 1. However, the Plan only covers non-emergency, ground vehicle transportation from Hospital to Hospital at 50%. Example: If a Participant or Beneficiary is being transferred from an Out-of-Network Hospital to an In-Network Hospital, the Plan provides 50% coverage after the Deductible is met.

Section 6: Ambulatory Surgery

Please refer to the section regarding Outpatient Surgery under this Article for further information on the Plan's coverage of Ambulatory Surgery.

Section 7: Behavioral Health (Mental Health and Substance Abuse Treatment)

- a. The Plan covers the following Behavioral Health (Mental Health and Substance Abuse Treatment):
 1. Inpatient Admission including acute Hospital admission and residential treatment program.
 2. Outpatient Visits including necessary Psychological (Psychiatric) Testing and other Outpatient Services such as Intensive Outpatient Program and Partial Hospitalization.
 3. Behavioral Health residential treatment program is covered, from In-Network Providers only, for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A Residential Treatment Facility must be properly licensed in the state in which the facility operates.
- b. **NOTE: The EAP Program offers free counseling visits.** See the Quick Reference Chart for the phone number to the EAP Program. The EAP benefits of this Plan may be used for smoking/tobacco cessation counseling.
- c. Explanations and Limitations:
 1. **Inpatient admissions and residential treatment program admission requires Precertification** by calling the Utilization Management Company whose phone number is listed on the Quick Reference Chart in the front of this document. No coverage for services not authorized by the Utilization Management Company. See the Precertification and Medical Review Article for more information.
 2. Partial Hospitalization means treatment of mental, nervous, or emotional disorders and substance abuse for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period.
 3. Expenses for Applied Behavioral Analysis (ABA) Therapy (as defined in the Definitions Article of this document) and related services are not covered by the Plan. **The Plan does not provide any benefits for the treatment of autism.**
- d. Percentage of Coverage:
 1. In-Network:
 - i. Inpatient services: 70% after the Deductible is met, plus a \$200 copayment per admission.
 - ii. Outpatient services: 70% after the Deductible is met.
 - iii. **The Plan completely covers the cost of EAP Counseling for In-Network Providers only.**
 2. Out-of-Network:
 - i. Residential Treatment Program Admission: **Not covered.**
 - ii. All other Inpatient services: 50% after the Deductible is met, plus a \$200 copayment per admission.
 - iii. Outpatient services: 50% after the Deductible is met.
 3. Out of Area:
 - i. Inpatient services: 70% after the Deductible is met, plus a \$200 copayment per admission.
 - ii. Outpatient services: 70% after the Deductible is met.

Section 8: Blood Transfusions

- a. The Plan covers blood transfusions and blood products and equipment for its administration.
- b. Limitations:
 1. Covered only when ordered by a Physician.
 2. Expenses related to autologous blood donation (patient's own blood) are covered.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 9: Cardiac Rehabilitation

Please refer to the Section regarding Rehabilitation Services (Cardiac) under this Article for further information regarding the Plan's coverage of Cardiac Rehabilitation.

Section 10: Chemotherapy

- a. The Plan covers chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.
- b. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 11: Colonoscopy, Screening Benefit

- a. A screening colonoscopy is payable once every five years for individuals age 45 and older, and more frequently than every five years or starting earlier than age 45 if the individual is at high risk of colon cancer, such as having a family history of colon cancer. The Fund will comply with recommendations for provided services as stated by the U.S. Preventive Services Task Force.
- b. See also the section regarding Wellness under this Article for further information.
- c. For a screening colonoscopy, no charge for a specialist pre-procedure consultation, bowel prep medication used prior to a screen colonoscopy, anesthesia services or the lab charges for analysis of polyps removed during a screening colonoscopy.
- d. Percentage of Coverage:
 1. In-Network and Out of Area: 100% - no Deductible applies
 2. Out-of-Network: Not Covered

Section 12: Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental)

- a. The Plan covers the following under this section:
 1. Corrective appliances includes prosthetics devices and Orthotics devices such as casts, splints, braces and crutches as follows:
 - i. rental for the first 90 days will be used as an offset against the purchase price (but only up to the allowed purchase price of the device).
 - ii. purchase of standard model.
 - iii. adjustment or servicing of the device
 - iv. repair or replacement of the device is limited to once in any five Calendar Year period or if the device cannot be satisfactorily repaired
 2. Colostomy or ostomy (orthotic) supplies
- b. Explanations and Limitations:
 1. **Orthotic devices over \$500 per item and Prosthetic devices require Precertification** by calling the Utilization Management Company, whose phone number is listed on the Quick Reference Chart. See the Precertification and Medical Review Article for more information.
 2. See the Exclusions related to Corrective Appliances in the Medical Exclusions Article. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions Article.
 3. Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner.
 4. **Prosthetic Appliances** are payable including the temporary and definitive (permanent) appliance, and necessary supplies.
 5. **Foot Orthotics** (including orthopedic or corrective shoes and other supportive devices for the feet), when prescribed by a Physician, are payable **for one pair of foot Orthotics per person per Calendar Year**.
 6. **Post-mastectomy bras** are payable to a maximum of two bras per Calendar Year.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 13: Dialysis

- a. The Plan covers hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.

- b. Explanations and Limitations:
 - 1. Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient.
 - 2. **It is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age.**
 - 3. See also the Coordination of Benefits Article that discusses what this Plan pays when you are also Medicare eligible.
- c. Percentage of Coverage:
 - 1. In-Network: 70% after the Deductible is met
 - 2. Out-of-Network: 50% after the Deductible is met
 - 3. Out of Area: 70% after the Deductible is met

Section 14: Diabetes Education

- a. The Plan covers educational services for a Plan Participant diagnosed with diabetes mellitus.
- b. Percentage of Coverage:
 - 1. In-Network: 70% after the Deductible is met
 - 2. Out-of-Network: 50% after the Deductible is met
 - 3. Out of Area: 70% after the Deductible is met

Section 15: Durable Medical Equipment (DME)

- a. The Plan provides the following services for DME:
 - 1. Coverage is provided for:
 - i. rental for the first 90 days will be used as an offset against the purchase price (but only up to the allowed purchase price of the device).
 - ii. purchase of standard model;
 - iii. adjustment or servicing;
 - iv. repair/replacement is limited to once in any 5 Calendar Year period unless due to pathological changes or normal growth or if the equipment cannot be satisfactorily repaired
 - 2. Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.
- b. Explanations and Limitations:
 - 1. **Durable Medical Equipment requires Precertification** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See the Precertification and Medical Review Article for more information.
 - 2. See the Exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions Article.
 - 3. To help determine what Durable Medical Equipment is covered, see the definition of “Durable Medical Equipment” in the Definitions Article.
 - 4. Durable Medical Equipment is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner.
 - 5. A Continuous Positive Airway Pressure (CPAP) humidifier is payable once every 5 years, based on Allowed Charges.
 - 6. For females who are breastfeeding, coverage is provided for a standard manual or standard electric breast pump, plus supplies necessary to operate the breast pump. Rental versus purchase is at the option of the Plan. Repair is payable when Medically Necessary. A Hospital grade breast pump is payable if the Plan determines it to be Medically Necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Coverage is available at no cost from In-Network Providers only.
- c. Percentage of Coverage:
 - 1. In-Network: 70% after the Deductible is met
 - 2. Out-of-Network: 50% after the Deductible is met
 - 3. Out of Area: 70% after the Deductible is met

Section 16: Emergency Room & Urgent Care Services (facility fees)

- a. The Plan covers the following coverage for Emergency Room & Urgent Care Services, specifically related to facility fees:
 1. Hospital emergency room (ER) for Emergency Services (as that term is defined in the Plan).
 2. Use of an Urgent Care facility.
 3. Ancillary charges (such as lab or x-ray) performed **during** the ER or Urgent care visit.
 4. See also the Section under this Article regarding Ambulance Services for further information.
- b. Explanations and Limitations:
 1. The Emergency Room Copayment will be waived if the Covered Individual is admitted to the Hospital or provides documentation of a referral to the Emergency Room from a Physician or Healthcare Practitioner, including a Telehealth Provider.
 2. Expenses for Emergency Room services are covered only when those services are for **Emergency Services** as that term is defined in the Definitions Article.
 3. There is no requirement to precertify the use of a Hospital-based emergency room visit.
 4. The plan will pay the In-Network cost-sharing rate for Hospital-based Emergency Services performed Out-of-Network, in compliance with the No Surprises Act. See the definition of Allowed Charge or contact the Administrative Office for more details on what the Plan allows as payment to Out-of-Network Emergency Service Providers.
- c. Percentage of Coverage:
 1. Urgent Care Services
 - i. In-Network: 70% after the Deductible is met
 - ii. Out-of-Network: 50% after the Deductible is met
 - iii. Out of Area: 70% after the Deductible is met
 2. Emergency Room Services
 - i. For all service areas, after a \$500 copay per ER visit and after the Deductible is met, the Plan pays 70%. Copayment waived if admitted or if documentation is provided of a referral to the Emergency Room from a Physician or Health Care Practitioner, including a Telehealth Provider.

Section 17: Endoscopy Facility (Outpatient)

- a. Endoscopy is a procedure to evaluate the interior surfaces of an organ by inserting a device such as an endoscope into the body, including but not limited to the lungs, intestines, bladder, sinus, etc.
- b. Limitations:
 1. For more information about Plan coverage of Outpatient Services at Endoscopy Facilities, please refer to the sections regarding Colonoscopy (Screening) or Wellness under this Article.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 18: Family Planning and Contraceptive Services

- a. The Plan provides the following coverage for Family Planning and Contraceptive Services:
 1. Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure). There is no cost-sharing for female sterilization procedures and these benefits will be paid at 100% no Deductible.
 2. FDA-approved contraceptives and counseling such as oral birth control pills/patch, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD), cervical cap, contraceptive ring, diaphragm, implantable birth control device/service.
- b. Explanations and Limitations:
 1. Certain FDA approved prescription drug contraceptives are to be obtained from the Prescription Drug Program and are payable under the Drugs (Medicines) row in this Schedule. There is no cost-sharing for generic FDA approved female contraceptives and these benefits will be paid at 100% no Deductible for services received from In-Network Providers.
 2. See the specific Exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Exclusions Article.

3. No coverage for the treatment of Fertility and Infertility.
 4. No coverage for the treatment of erectile dysfunction (impotency) including medical (e.g., Prescription Drugs such as Viagra, Cialis) and medical or surgical services.
- c. Percentage of Coverage:
1. For In-Network and Out of Area Providers, FDA approved contraceptive services and female sterilization will be paid at 100% with no Deductible. The Plan will not provide coverage for any FDA approved contraceptive services and female sterilization conducted by Out-of-Network Providers.
 2. Otherwise, the following coverage is provided by the Plan:
 - i. In-Network: 70% after the Deductible is met
 - ii. Out-of-Network: 50% after the Deductible is met
 - iii. Out of Area: 70% after the Deductible is met

Section 19: Gene Therapy

- a. Gene Therapy is a category of pharmaceutical products approved by the US Food and Drug Administration (FDA) to treat or cure a disease by:
1. replacing a disease-causing gene with a healthy copy of the gene.
 2. inactivating a disease-causing gene that may not be functioning properly.
 3. introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner.

- b. Explanations and Limitations:
1. **Gene Therapy Product** - Coverage includes the cost of the gene therapy product; medical, surgical and facility services directly related to administration of the gene therapy product; and professional services.
 2. **Inpatient Facility & Professional Services** - Gene therapy products and their administration are covered when preauthorized to be received at participating in-network facilities specifically contracted with Cigna for the specific gene therapy service.
 3. **Outpatient Facility & Professional Services** - Gene therapy products and their administration received at other facilities are not covered.

For In-Network service providers, the Plan covers 70% after the Deductible is met. The Plan does not cover services under this section for Out-of-Network or Out of Area service providers.

Section 20: Genetic Testing and Counseling

- a. The Plan covers the following coverage for Genetic Testing and Counseling:
1. The only genetic testing payable under this Plan is for fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee. Genetic Counseling only when provided before and/or after payable genetic testing.
 2. Certain Genetic Testing (e.g. BRCA) and Genetic Counseling may be covered as a Preventive service, in accordance with Health Reform regulations (see the Wellness row in this Schedule).

- b. Explanations and Limitations:
1. Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided in conjunction with a genetic test that is payable by this Plan.
 2. See the definitions of Genetic Counseling and Genetic Testing in the Definitions Article.
 3. See the Exclusions Article for Exclusions relating to Genetic Testing and Counseling, other than those indicated here as covered.
 4. No coverage for Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents. No coverage of genetic testing of Plan Participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan.

- c. Percentage of Coverage:
1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 21: Hearing Services

- a. The Plan provides coverage for hearing testing (audiology examinations).
- b. **Hearing aids are not payable.** See the Hearing Exclusions in the Exclusions Article.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 22: Home Health Care and Home Infusion Services

- a. The Plan provides the following coverage for Home Health Care and Home Infusion Services:
 1. Part-time, intermittent **Skilled Nursing Care** services and Medically Necessary supplies to provide Home Health Care or home infusion services.
 2. Certified Nurse Aide services under the supervision of a Registered Nurse.
- b. **Limitations:**
 1. **Home Health Care and Home Infusion Therapy services require Precertification** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See the Precertification and Medical Review Article for more information.
 2. Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner and provided by a licensed Home Health Care Agency.
 3. Home Hospice coverage is payable under Hospice benefits.
 4. Home Physical Therapy services coverage is payable under the Rehabilitation Services benefits.
 - i. See also the Exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Exclusions Article of this document.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 23: Hospice

- a. The Plan provides coverage for Hospice Services including inpatient Hospice Care and outpatient home hospice when the patient meets the definition of Hospice in the Definitions Article of this document.
- b. **Limitations:**
 1. Bereavement counseling beyond that included as part of the Hospice Provider's normal services is payable under the Behavioral Health benefits of this Plan.
 2. Inpatient Respite Care is payable to a maximum of 8 days per person per lifetime.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 24: Hospital Services (Inpatient)

- a. The Plan covers the following coverage for Hospital Services (Inpatient):
 1. Daily average room & board facility fees in a semiprivate room with general nursing services.
 2. Specialty care units (e.g., Intensive Care Unit, Cardiac/Coronary Care Unit).
 3. Lab/x-ray/diagnostic services.
 4. Related Medically Necessary Ancillary Services (e.g., prescriptions, Anesthesia, blood, supplies).
 5. Routine nursery care of a newborn child and newborn circumcision.

This section also includes Hospital Services at a licensed Birthing Center.

b. Explanations and Limitations:

1. **Inpatient Hospital admission requires Precertification** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See the Precertification and Medical Review Article for more information.
2. Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms.
3. A stay in a Health Care Facility after outpatient surgery for more than 24 hours is considered to be an inpatient Hospital service.
4. For a Hospital admission, in addition to the Deductible and Coinsurance, there is a **\$200 copay per admission**.

c. Percentage of Coverage:

1. In-Network: 70% after the Deductible is met, plus a \$200 copay per Hospital admission
2. Out-of-Network: 50% after the Deductible is met, plus a \$200 copay per Hospital admission
3. Out of Area: 70% after the Deductible is met, plus a \$200 copay per Hospital admission

Section 25: Laboratory Services (Outpatient)

a. The Plan provides the following coverage for Laboratory Services (Outpatient):

1. Technical and professional fees.
2. Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits.
3. Some laboratory services are payable under the Wellness benefits in this Schedule.

b. Limitations:

1. Covered only when ordered by a Physician or Health Care Practitioner.
2. **Transplantation-related laboratory services (pre-transplant work-up) and sleep management services require Precertification** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See the Precertification and Medical Review Article for more information.

c. Percentage of Coverage:

1. In-Network: 70% after the Deductible is met
2. Out-of-Network: 50% after the Deductible is met
3. Out of Area: 70% after the Deductible is met

Section 26: Maternity Services

a. The Plan covers the following coverage for Maternity Services:

1. Hospital and Birth (Birthing) Center charges and Physician and Licensed Nurse Midwife fees for Medically Necessary maternity services.
2. Plan Benefits are payable for charges incurred by a Participant as a result of pregnancy, childbirth or a related medical condition.
3. See the Eligibility Article on **how to enroll a Newborn Dependent Child(ren)**.
4. Elective induced abortion.
5. See Genetic Testing for additional information.
6. For females who are breastfeeding, the Plan pays for lactation support /counseling (including breastfeeding classes) at 100%, no Deductible, when provided by an In-Network Provider acting within the scope of license. In-Network Providers are listed on the network directory described on the Quick Reference Chart.
7. Under this Plan, there is no requirement to select a Primary Care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN Provider.

b. Limitations:

1. See the Exclusions related to Maternity Services in the Exclusions Article.
2. Pregnancy-related care is covered for a female Participant. No coverage is provided for the baby of a Dependent Child.
3. For all females, prenatal and postnatal visits obtained from an In-Network provider are payable at no cost to you. Normal plan cost-sharing still applies to all other maternity related services including ultrasounds and delivery fees. When a provider submits a bill to the plan with a global CPT code for the combination of prenatal/postnatal visits and delivery expenses, the Plan's Claims Administrator will process the claim applying no cost-sharing to

40% of the charges representing the prenatal/postnatal visit expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses.

4. Certain prenatal care/maternity related preventive care expenses are payable for all females (as listed on the government websites at <http://www.hrsa.gov/womensguidelines/> or <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>, including but not limited to screening for gestational diabetes, breastfeeding equipment and supplies to operate the equipment, and comprehensive lactation support and counseling while breastfeeding. These services are covered under the Wellness/Preventive Services category without cost sharing for a female when obtained from In-Network Providers.
 5. For females who are breastfeeding, coverage is provided for a standard manual or standard electric breast pump, plus supplies necessary to operate the breast pump. Rental versus purchase is at the option of the Plan. Repair is payable when Medically Necessary. A Hospital grade breast pump is payable if the Plan determines it to be Medically Necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Coverage is available at no cost from In-Network Providers only
 6. **Hospital Length of Stay for Childbirth:** Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, if applicable).
 7. **Inpatient admissions require Precertification ONLY IF the length of stay for delivery exceeds 48 hours for vaginal birth or 96 hours for C-section,** by calling the Utilization Management Company whose phone number is listed on the Quick Reference Chart. See the Precertification and Medical Review Article for more information.
- c. Percentage of Coverage:
1. For In-Network and Out of Area service providers only, prenatal visits and breast pumps, supplies, and counseling are available at no charge.
 2. Otherwise, the following coverage is provided by the Plan:
 - i. In-Network: 70% after the Deductible is met, plus a \$200 copayment per admission
 - ii. Out-of-Network: 50% after the Deductible is met, plus a \$200 copayment per admission
 - iii. Out of Area: 70% after the Deductible is met, plus a \$200 copayment per admission

Section 27: Nondurable Supplies

- a. The Plan covers the following coverage under this Section for up to a 31-day supply of the following:
 1. Sterile surgical supplies used immediately after surgery.
 2. Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances.
 3. Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
 4. Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under this benefit or under the Prescription Drug Program
- b. To determine what Nondurable Medical Supplies are covered, please see the definition of "Nondurable Supplies" in the Definitions Article.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 28: Obesity Services

Please refer to the section regarding Weight Management under this Article for further information on the Plan's coverage of Obesity Services.

Section 29: Oral, Craniofacial, and TMJ Services

- a. The Plan provides the following coverage for Oral, Craniofacial, and TMJ Services:
 1. Accidental Injury to Teeth/Jaw

2. Temporomandibular Joint (TMJ) dysfunction or syndrome.
 3. Oral and/or Craniofacial Surgery.
- b. Explanations and Limitations:
1. **Certain services and all elective Inpatient Services require Precertification** by calling the Utilization Management Company whose contact information is listed on the Quick Reference Chart in the front of this document. See the Precertification and Medical Review Article for more information.
 2. See the Exclusions related to Dental Services in the Exclusions Article.
 3. Treatment of Accidental Injuries to the Teeth/Jaw: This medical Plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met:
 - i. The accidental Injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and
 - ii. The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and
 - iii. The dental treatment will return the person's teeth to their pre-Injury level of health and function. See also the definition of Injury to Teeth in the Definitions Article of this document.
 4. Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess, acute Injury and for reconstructive but not cosmetic purposes.
 5. No coverage for dental services such as removal of wisdom teeth, root canal, gingivectomy, or dental abscess treatment.
- c. Percentage of Coverage:
1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 30: Outpatient (Ambulatory) Surgery Facility

- a. The Plan provides the following coverage for Outpatient (Ambulatory) Surgery Facility benefits:
1. Outpatient (Ambulatory) Surgical Facility (e.g., surgicenter, same day surgery).
 2. Physician fees payable under the Physician services section of this Schedule of Medical Benefits.
- b. Explanations and Limitations:
1. **Certain Outpatient Services including injectable drugs administered in an outpatient facility require Precertification** by calling the Utilization Management Company whose phone number is listed on the Quick Reference Chart. See the Precertification and Medical Review Article for more information.
 2. A stay in a Health Care Facility after outpatient surgery for more than 24 hours is considered to be an inpatient Hospital service.
- c. Percentage of Coverage:
1. In-Network: 70% after the Deductible is met
 - i. This cost-sharing applies even if a Participant gets covered non-emergency care from an Out-of-Network provider as part of a visit to an In-Network Health Care Facility without knowingly electing that provider or giving consent to be billed.
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 31: Physician and Other Health Care Practitioner Services

- a. The Plan provides the following coverage for Physician and Other Health Care Practitioner Services:
1. Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, Hospital, urgent care facility, retail medical clinic, telemedicine (virtual), or other covered Health Care Facility location.
 2. Payable Physicians and Health Care Practitioner professional fees include:
 - i. Surgeon;
 - ii. Assistant Surgeon (if Medically Necessary);
 - iii. Anesthesia by Physicians and Certified Registered Nurse Anesthetists;

- iv. Pathologist;
 - v. Radiologist;
 - vi. Physician Assistant;
 - vii. Nurse Practitioner;
 - viii. Nurse Midwife.
3. See also the Family Planning, Maternity and Wellness rows where certain women’s preventive services are payable without cost-sharing when obtained from In-Network Providers.
 4. See also the Emergency Services Section of this Article for payment of Providers in an emergency room.
- b. Explanations and Limitations:
1. **Certain outpatient and Inpatient Services require Precertification** by calling the Utilization Management Company, whose contact information is listed on the Quick Reference Chart. See the Precertification and Medical Review Article for more information.
 2. **Assistant Surgeon fees** will be reimbursed for Medically Necessary services to a **maximum** of 20% of the eligible expenses payable to the primary surgeon.
 - i. If the Assistant Surgeon is a Certified Surgical Assistant the reimbursement will be 10% of the eligible expenses allowed as payable to the primary surgeon.
 3. See also the definition of Physician, Health Care Practitioner and Surgery in the Definitions Article.
 4. The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of “Surgery” in the Definitions Article.
 5. No coverage for Chiropractic and Acupuncture services.
 6. See the Wellness rows for information on covered preventive/wellness services.
 7. Medical treatment of the foot, by a podiatrist, is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
 8. The Plan does not require the selection of a primary care Physician (PCP) therefore you have the right to be seen by any primary care Provider who participates in the Plan’s medical PPO network and who is available to accept you or your eligible family members.
 9. You do not need prior authorization from the Plan or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the medical Plan network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Medical Plan PPO network at their website listed under PPO Network on the Quick Reference Chart in this document.
- c. Percentage of Coverage:
1. In-Network: 70% after the Deductible is met
 - i. This cost-sharing applies even if a Participant gets covered non-emergency care from an Out-of-Network ancillary Provider as part of a visit to an In-Network Health Care Facility.
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 32: Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient)

- a. The Plan provides coverage under this section for technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.
- b. Explanations and Limitations:
 1. **Certain Outpatient Services require Precertification** by calling the Utilization Management Company, whose phone number is listed on the Quick Reference Chart in the front of this document. See the Precertification and Medical Review Article for more information.
 2. Covered only when ordered by a Physician or Health Care Practitioner.
 3. Some Radiology procedures are covered under the Wellness Programs described in this Schedule.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met

2. Out-of-Network: 50% after the Deductible is met
3. Out of Area: 70% after the Deductible is met

Section 33: Reconstructive Services and Breast Reconstruction After Mastectomy

- a. This Plan complies with the **Women’s Health and Cancer Rights Act (WHCRA)** that indicates that for any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined with the attending Physician and the patient, including:
 1. reconstruction of the breast on which the mastectomy was performed;
 2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 3. prostheses and physical complications for all stages of mastectomy, including lymphedemas.
- b. The Plan provides coverage for Reconstructive Surgery only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital anomaly that causes a functional defect.
- c. Limitations and Explanation:
 1. **Certain surgery/services require Precertification** by calling the Utilization Management Company whose contact information is listed on the Quick Reference Chart in the front of this document. See the Precertification and Medical Review Article for more information.
 2. See the Exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions Article. Cosmetic and Dental (including Orthognathic) services are excluded from coverage.
 3. A Participant must obtain Precertification for breast reduction to be deemed Medically Necessary.
 4. Reconstructive services are payable if Medically Necessary because of congenital disease or anomaly of a dependent child that has resulted in a functional defect. Non-functional defects resulting from congenital malformations of a dependent child will be covered after review by the Board of Trustees or its designee, on a case by case basis.
 5. Reconstructive Surgery only if such procedures are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital anomaly causing functional defect.
- d. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 34: Rehabilitation Service (Cardiac)

- a. **Cardiac Rehabilitation** is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.).
- b. Explanations and Limitations:
 1. Cardiac Rehabilitation programs must be ordered by a Physician.
 2. See also the Definition of Cardiac Rehabilitation in the Definitions Article of this document.
- c. Percentage of Coverage:
 1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Hello Heart - Virtual Hypertension Solution: Each Covered Individual that is identified by Hello Heart with or at-risk for heart disease (with prehypertension or hypertension), is eligible for this program. The Plan will provide a digital coaching solution to each Covered Individual who is identified by Hello Heart with or at-risk for heart disease (with prehypertension or hypertension). This digital coaching solution is available at NO COST to the Covered Individual. This digital solution is provided through a connected device and mobile app that uses artificial intelligence, behavioral science, and personalized digital coaching to drive lifestyle changes to empower patients to embrace healthier behavior, which can reduce the risks of high blood pressure and heart disease. For more information, contact Hello Heart at the contact information listed in the Quick Reference Chart.

Section 35: Rehabilitation Services (Physical, Occupational & Speech Therapy)

- a. The Plan provides the following coverage under this section:
 1. Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician.

2. Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.**
- b. Explanations and Limitations:
1. **Inpatient rehabilitation admission and speech therapy services require Precertification** by calling the Utilization Management Company whose contact information is listed on the Quick Reference Chart in the front of this document. See the Precertification and Medical Review Article for more information.
 2. Rehabilitation services are covered only when ordered by a Physician.
 3. **Outpatient Rehabilitation Services (any combination of Physical, Occupational and Speech Therapy) are payable up to 50 visits per person per Calendar Year.**
 - i. Outpatient Physical Therapy or Occupational Therapy services prescribed by a Physician. When prescribed or provided by a Physician, the following types of therapy are covered:
 - ii. Physical Therapy performed by a Physician or a registered Physical Therapist.
 - iii. Occupational Therapy performed by a properly accredited Occupational Therapist (OT) or certified occupational therapy assistant (COTA).
 - iv. Speech Therapy performed by a certified speech therapist. **Speech therapy requires Precertification.** See the Precertification and Medical Review Article for more information.
 4. Benefits are not payable for Physical, Occupational or Speech Therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected.
 5. Physical Therapy and Occupational Therapy which are prescribed by a Physician in lieu of non-medical treatment (e.g., exercise) are not considered Medically Necessary and reasonable treatment and would not be payable by the Plan.
 6. Speech Therapy is covered if the services are provided by a licensed or duly qualified speech therapist for:
 - i. childhood developmental speech delays and disorders (habilitation services),
 - ii. adults to **restore** normal speech or to correct dysphagic or swallowing defects and disorders lost due to Illness, Injury or surgical procedure.
- c. Percentage of Coverage:
1. In-Network: 70% after the Deductible is met
 - i. Outpatient Services: 70% after the Deductible is met
 - ii. Inpatient Services: 70% after a \$200 copayment per admission and after the Deductible is met
 2. Out-of-Network:
 - i. Outpatient Services: 50% after the Deductible is met
 - ii. Inpatient Rehabilitation Admission: **Not covered**
 3. Out of Area: 70% after the Deductible is met
 - i. Outpatient Services: 70% after the Deductible is met
 - ii. Inpatient Services: 70% after a \$200 copayment per admission and after the Deductible is met

Section 36: Respite Care

Please refer to the section regarding Hospice under this Article for further information on the Plan's coverage of Respite Care.

Section 37: Routine Costs - Clinical Trials

- a. The Plan provides the following coverage for routine costs associated with participation in an "approved clinical trial" related to cancer or other life-threatening illnesses.
- b. Explanations and Limitations:
 1. **Routine costs associated with clinical trials require Precertification** by calling the Utilization Management Company, whose phone number is listed on the Quick Reference Chart. See the Precertification and Medical Review Article for more information.
 2. See the definition of "Experimental" for information on what routine clinical trial costs are payable by the Plan.

Section 38: Skilled Nursing Facility (SNF) or Subacute Facility

- a. The Plan provides the following coverage for certain admissions at a Skilled Nursing Facility (SNF) or Subacute Care Facility subject to the explanations and limitations listed below.

- b. Explanations and Limitations:
 - 1. **Skilled nursing facility and subacute care facility admission requires Precertification** by calling the Utilization Management (UM) Company whose phone number is listed on the Quick Reference Chart in the front of this document. **No coverage for services not authorized by the Utilization Management (UM) Company.**
 - 2. Services must be ordered by a Physician.
 - 3. To determine if a facility is a Skilled Nursing Facility or Subacute Care Facility see the Definitions Article of this document.
 - 4. **Skilled Nursing Facility confinement** or Subacute Care Facility confinement is payable to a maximum of **70 days per Calendar Year.**
- c. Percentage of Coverage:
 - 1. In-Network: 70% after a \$200 copayment and the Deductible is met
 - 2. Out-of-Network: **No coverage**
 - 3. Out of Area: 70% after the Deductible is met

Section 39: Smoking/Tobacco Cessation

- a. The Plan provides the following coverage for Smoking/Tobacco Cessation
 - 1. Coverage is provided for free counseling sessions through the EAP, and over-the-counter or retail prescription drug tobacco cessation products.
- b. Explanations and Limitations:
 - 1. Counseling sessions are covered under the Plan's EAP, up to the number of visits available from a particular EAP vendor. (Refer to the Quick Reference Chart for the EAP in your area and their phone number).
 - 2. Over-the-counter or retail prescription drug products used for smoking/tobacco cessation are payable by the Plan. (Refer to the Schedule of Prescription Benefits for a complete description of the outpatient prescription drug benefits.)
 - 3. Physician office visit for smoking/tobacco cessation is also covered at no charge if an In-Network Provider is used.
- c. Percentage of Coverage:
 - 1. For In-Network and Out of Area service providers, the Plan pays 100% of costs associated with counseling via the EAP or for an Office Visit with an In-Network Physician.
 - 2. Out-of-Network: **The Plan provides no coverage under this section for Out-of-Network service Providers.**

Section 40: Surgeon, Assistant Surgeon

Please refer to the section entitled "Physician" under this Article for further information on the Plan's coverage of Surgeon, Assistant Surgeon.

Section 41: Telehealth Provider

- a. The Plan provides coverage for Telehealth Provider via Doctor on Demand, which provides consults with a Physician regarding a medical or behavioral issue or obtain certain prescriptions for common ailments. Doctor on Demand is available 24 hours a day / 7 days a week.
- b. Explanations and Limitations:
 - 1. No cost sharing
 - 2. Can help you determine whether or not a medical situation is an emergency
 - 3. Can access online (through a webcam) or through a smartphone app
- c. Percentage of Coverage:
 - 1. In-Network: Paid at 100% with no Deductible, Coinsurance, or Copayment
 - 2. The Plan does not provide any coverage under this Section for Out-of-Network or Out of Area service Providers.

Section 42: Transplants (Organ and Tissue)

- a. The Plan covers the following coverage for Transplants (Organ and Tissue):
 - 1. Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue (specifically cornea, bone marrow, peripheral stem cells, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin) along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.

2. Organ or tissue testing, procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor.
 3. Medically Necessary expenses incurred by a donor who **is covered** by this Plan, without any Deductibles and Coinsurance applicable to those expenses.
 4. Medically Necessary expenses incurred by a donor who **is not covered** by this Plan, without any Deductibles and Coinsurance applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan.**
- b. Explanations and Limitations:
1. **Transplant-related Outpatient Services and admission to a Hospital for transplant requires Precertification** by contacting the Utilization Management Company (at their phone number on the Quick Reference Chart in the front of this document). See the Precertification and Medical Review Article for more information.
 2. Donor expenses are payable at 100%, no Deductible. Donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan.
 3. See the specific Exclusions related to Experimental and Investigational Services and Transplants in the Exclusions Article.
 4. The following expenses will not be reimbursed by the Plan: meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs and expenses for persons other than the patient and his/her designated family member/travel companion.
- c. Percentage of Coverage:
1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 43: Weight Management

- a. This section applies to the Plan's coverage related to surgical treatment of morbid obesity.
- b. Explanations and Limitations:
1. The Plan pays for one surgical procedure for the treatment of Morbid Obesity per person per lifetime.
 2. The Plan covers bariatric surgery for the treatment of morbid obesity for individuals age 18 years and older, when such treatment is considered Medically Necessary by the Utilization Management Company.
 3. **Surgery benefits will not be allowed unless written authorization (Precertification) is received by the Utilization Management Company in advance of the date of surgery, regardless of the Medical Necessity for the surgery.** See the Precertification and Medical Review Article for more information. The contact information for the Utilization Management Company is listed on the Quick Reference Chart.
- c. Percentage of Coverage:
1. In-Network: 70% after the Deductible is met
 2. Out-of-Network: 50% after the Deductible is met
 3. Out of Area: 70% after the Deductible is met

Section 44: Wellness (Preventive, Well Child Examinations and Immunizations to age 26 years)

- a. The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations as outlined below in "Explanations and Limitations." Routine immunizations are payable, in accordance with the Centers for Disease Control (CDC) recommendations, when they are obtained from an In-Network Provider or from an In-Network retail pharmacy location.
- b. Explanations and Limitations:
1. Coverage is provided for preventive services that are required to be covered under the federal law "Affordable Care Act," in accordance with the US Preventive Services Task Force and Health Resources and Services Administration (HRSA) and immunizations approved by the Centers for Disease Control (CDC). For a list of payable services, visit this website: <https://www.healthcare.gov/what-are-my-preventive-care-benefits>.
 - i. In addition to the wellness services listed on the website above, the Plan will pay for well child Office Visits.
 - ii. Certain additional preventive care expenses are payable for all covered females (as listed on the government websites at <http://www.hrsa.gov/womensguidelines/> or <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> including but not limited to screening for gestational diabetes, HPV

testing starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, plus annual screening and counseling for interpersonal and domestic violence). These services are covered as a Wellness benefit without cost sharing for a female when obtained from In-Network Providers.

- iii. When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply.
 - iv. Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the Providers).
 - v. The Plan will use reasonable medical management techniques - such as age, location for service and test frequency - for consideration of payable preventive services. Services not covered under the wellness benefit may be covered under another portion of the medical Plan.
 - vi. Certain Over-the-Counter (OTC) Drugs are payable at no charge when prescribed by a Physician/Health Care Practitioner in compliance with Health Reform law. See Article VI for more information.
 - vii. Coverage is provided in primary care clinician visits for fluoride varnish applied to the primary teeth of children through age 5 years.
 - viii. Preventative services are payable without regard to gender assigned at birth or current gender status.
 - ix. For children 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's In-Network pediatrician.
- c. Percentage of Coverage:
1. In-Network and Out of Area: The Plan provides the services outlined in this section at no charge to the Participant or Eligible Dependents.
 2. Out-of-Network: **No coverage.**

Section 45: Wellness (Preventive, Adult Health Maintenance Examinations and Immunizations)

- a. The Plan provides coverage as outlined below in "Explanations and Limitations."
- b. Explanations and Limitations:
 1. Preventative services are payable without regard to gender assigned at birth, or current gender status.
 2. Coverage is provided for preventive services that are required to be covered under the federal law "Affordable Care Act," in accordance with the US Preventive Services Task Force and Health Resources and Services Administration (HRSA) and immunizations approved by the Centers for Disease Control (CDC). For a list of payable services, visit this website: <https://www.healthcare.gov/what-are-my-preventive-care-benefits>.
 3. As a **preventive counseling benefit** in compliance with Health Reform, the Plan covers the following services: For adults (1) with a body mass index of 30 kg/m² or higher, OR (2) who are overweight (defined as a BMI of 25 to 29.9 kg/m²) or obese (defined as a BMI of 30 kg/m² or higher) AND have additional cardiovascular disease (CVD) risk factors, the Plan covers Physician prescribed **intensive behavioral counseling interventions**. Intensive behavioral counseling interventions means the Plan will consider as Medically Necessary preventive services, up to a combined limit of 26 individual or group visits per 12-month period by an In-Network Provider.
 4. The Plan permits payment (or member reimbursement) of certain preventive services performed at a health fair or wellness gathering. The payable preventive services include only those preventive services that are required to be covered under the Affordable Care Act ("ACA"), including but not limited to immunizations, blood pressure screening, cholesterol and diabetes screening tests. Refer to this website for the list of ACA-mandated preventive services: <https://www.healthcare.gov/coverage/preventive-care-benefits/>. Age and frequency guidelines apply to ACA covered preventive services provided at a health fair or wellness gathering. The Plan will pay up to 100% of the Plan's Allowed Charge for ACA required preventive services provided at a health fair or wellness gathering by Non-Network Providers. For questions about payable preventive services contact the Administrative Office.

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

This chart summarizes the benefits payable by the Plan. For more information regarding each benefit, including explanations and limitations, please reference the benefits' corresponding section above.

NOTE: * denotes that Precertification is required

Benefit	In-Network	Out-of-Network	Out of Area
<u>Deductibles</u>	\$1,500/person		
<u>Annual Out-of-Pocket Limit on In-Network Cost-Sharing</u>	\$3,000 per individual; \$6,000 per family	Not applicable	Accumulates to the In-Network Out-of-Pocket Limit
<u>Allergy Services</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Ambulance Services</u>	70% after Deductible is met	70% after Deductible is met	70% after Deductible is met
<u>Ambulatory Surgery*</u>	<i>See "Outpatient Surgery" in this Schedule</i>		
<u>Behavioral Health Services: Mental Health and Substance Abuse Treatment*</u>	EAP Counseling: No Charge Outpatient Services: 70% after Deductible is met. Inpatient Services (including Residential Treatment Program): \$200 copayment per admission and then Plan pays 70% after Deductible is met.	Outpatient Services: 50% Coinsurance after Deductible is met (unless otherwise required by No Surprises Act) Residential Treatment program admission: Not covered Any other Inpatient Services: \$200 copayment per admission and then 50% Coinsurance after Deductible is met (unless otherwise required by No Surprises Act).	70% after Deductible is met Inpatient Services: \$200 copayment per admission and Deductible is met, the Plan pays 70%
<u>Blood Transfusions</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Cardiac Rehabilitation</u>	<i>See "Rehabilitation Services: Cardiac" in this Schedule</i>		
<u>Chemotherapy</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Colonoscopy, Screening Benefit</u>	100%, no Deductible applies	No coverage	100%, no Deductible applies
<u>Corrective Appliances: (Prosthetic & Orthotic Devices, other than Dental)*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Dialysis</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Diabetes Education</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Durable Medical Equipment (DME)*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

This chart summarizes the benefits payable by the Plan. For more information regarding each benefit, including explanations and limitations, please reference the benefits' corresponding section above.

NOTE: * denotes that Precertification is required

Benefit	In-Network	Out-of-Network	Out of Area
<u>Emergency Room & Urgent Care Services</u>	<p>Urgent Care Services: 70% after Deductible is met</p> <p>Emergency Room Services: After a \$500 copay per ER visit and after the Deductible is met, the Plan pays 70%. Copayment waived if admitted or with documentation of a referral to the ER from a Physician or Health Care Practitioner, including a Telehealth Provider.</p>	<p>Urgent Care Services: 50% after Deductible is met</p> <p>Emergency Room Services: After a \$500 copay per ER visit and after the Deductible is met, the Plan pays 70%. Copayment waived if admitted or with documentation of a referral to the ER from a Physician or Health Care Practitioner, including a Telehealth Provider.</p>	<p>Urgent Care Services: 70% after Deductible is met</p> <p>Emergency Room Services: After a \$500 copay per ER visit and after the Deductible is met, the Plan pays 70%. Copayment waived if admitted or with documentation of a referral to the ER from a Physician or Health Care Practitioner, including a Telehealth Provider.</p>
<u>Endoscopy Facility (Outpatient)</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Family Planning and Contraceptive Services</u>	<p>FDA Approved contraceptive services and female sterilization: 100%, no Deductible</p> <p>All other services: 70% after Deductible is met</p>	50% after Deductible is met	<p>FDA Approved contraceptive services and female sterilization: 100%, no Deductible</p> <p>All other services: 70% after Deductible is met</p>
<u>Gene Therapy*</u>	70% after Deductible is met	Not covered	Not covered
<u>Genetic Testing and Counseling</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Hearing Services</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Home Health Care and Home Infusion Services*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Hospice</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Hospital Services (Inpatient)*</u> (including licensed Birthing Center)	After a \$200 copay per Admission and Deductible is met, Plan pays 70%	After a \$200 copay per Admission and Deductible is met, Plan pays 50%	After a \$200 copay per Admission and Deductible is met, Plan pays 70%
<u>Laboratory Services (Outpatient)*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

This chart summarizes the benefits payable by the Plan. For more information regarding each benefit, including explanations and limitations, please reference the benefits' corresponding section above.

NOTE: * denotes that Precertification is required

Benefit	In-Network	Out-of-Network	Out of Area
<u>Maternity Services*</u>	<p>Prenatal Visits and breast pumps, supplies and counseling: No charge.</p> <p>Inpatient Admission: After a \$200 Copay per Admission and Deductible is met, Plan pays 70%</p> <p>All Other Maternity Services 70% after Deductible is met</p> <p>For delivery, the Deductible applies separately to both the mother and the new baby(ies).</p>	<p><u>Inpatient Admission:</u> After a \$200 Copay per Admission and Deductible is met, Plan pays 50%</p> <p>All Other Maternity Services: 50% after Deductible is met.</p> <p>For delivery, the Deductible applies separately to both the mother and the new baby(ies).</p>	<p>Prenatal Visits and breast pumps, supplies and counseling: No charge.</p> <p>Inpatient Admission: After a \$200 Copay per Admission and Deductible is met, Plan pays 70%</p> <p>All Other Maternity Services 70% after Deductible is met</p> <p>For delivery, the Deductible applies separately to both the mother and the new baby(ies).</p>
<u>Nondurable Supplies</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Obesity Services</u>	<i>See "Weight Management" in this Schedule</i>		
<u>Oral, Craniofacial, and TMJ Services*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Outpatient (Ambulatory) Surgery Facility*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Physician and Other Health Care Practitioner Services*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient)*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Reconstructive Services and Breast Reconstruction after Mastectomy*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Rehabilitation Services: Cardiac</u>	<p>70% after Deductible is met</p> <p>Hello Heart Virtual Hypertension Solution: Available at NO COST to Covered Individuals identified by Hello Heart with or at-risk for heart disease (with prehypertension or hypertension)</p>	50% after Deductible is met	70% after Deductible is met

ARTICLE VII: SCHEDULE OF MEDICAL PLAN BENEFITS

This chart summarizes the benefits payable by the Plan. For more information regarding each benefit, including explanations and limitations, please reference the benefits' corresponding section above.

NOTE: * denotes that Precertification is required

Benefit	In-Network	Out-of-Network	Out of Area
<u>Rehabilitation Services (Physical, Occupational & Speech Therapy)*</u>	Inpatient Rehabilitation: After a \$200 Copay per Admission and Deductible is met, Plan pays 70% Outpatient Rehabilitation Services: 70% after Deductible met Sword Health Virtual Physical Therapy: No Copay, Deductible or Coinsurance	Inpatient Rehabilitation: No coverage Other rehabilitation services: 50% after Deductible is met	Inpatient Rehabilitation: After a \$200 Copay per Admission and Deductible is met, Plan pays 70% Outpatient Rehabilitation Services: 70% after Deductible met
<u>Respite Care</u>	<i>See "Hospice" in this Schedule</i>		
<u>Routine Costs - Clinical Trial*</u>	<i>See the definition of "Experimental" for information on what routine costs are payable by the Plan.</i>		
<u>Skilled Nursing Facility (SNF) or Subacute Facility*</u>	After a \$200 Copay per Admission and Deductible is met, Plan pays 70%	No coverage	After a \$200 Copay per Admission and Deductible is met, Plan pays 70%
<u>Smoking/Tobacco Cessation</u>	Counseling: Plan pays 100% via the EAP or for an Office Visit with an In-Network Physician	No coverage	No Coverage
<u>Surgeon, Assistant Surgeon</u>	<i>See "Physician" in this Schedule</i>		
<u>Telehealth Provider</u>	Paid at 100%, no Deductible, Coinsurance, or Copayment	No Coverage	No Coverage
<u>Transplants, Organ and Tissue*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Weight Management*</u>	70% after Deductible is met	50% after Deductible is met	70% after Deductible is met
<u>Wellness (Preventive): Well Child Examinations and Immunizations to age 26 years</u>	No charge	No coverage	No charge
<u>Wellness (Preventive): Adult Maintenance Examinations and Immunizations</u>	<i>See detailed information in the relevant Section above this summary Schedule</i>		

ARTICLE VIII: SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits (Participant pays)

The Medical Plan Deductible does not apply to Prescription Benefits.

Copayments for drugs are not applied to meet the Medical Plan's Out-of-Pocket Maximum or Deductibles.

The Prescription Drug Out-of-Pocket Limit on outpatient drugs (\$3,600/Individual and \$7,200/family) is the most you will pay per Calendar Year for covered generic, preferred brand, non-preferred brand, and specialty drugs from In-Network Retail and Mail Order.

If the cost of a drug is less than the appropriate Copayment, you will only pay the drug cost.

The Prescription Drug Benefit of this Plan is creditable with Medicare Part D prescription drug coverage.

Certain over-the-counter drugs are covered under this outpatient Prescription Drug Benefit at no charge in compliance with Health Reform regulations. See Article VI for details.

Copayments:

In-Network Retail Pharmacy (up to 30 day supply)

Generic.....	10% of drug cost with a \$10 minimum and \$20 maximum
Preferred Brand*.....	25% of drug cost with a \$25 minimum and \$50 maximum
Non-Preferred Brand*.....	greater of 50% of drug cost or \$50 Copayment

Mail Order (Home Delivery) Service or Walgreens Retail (Smart 90) (up to a 90-day supply)

Generic	\$20 Copayment
Preferred Brand*.....	\$50 Copayment
Non-Preferred Brand*	50% of drug cost

Specialty Drugs (up to 30 day supply)** \$35 Copayment

Female Contraceptives (FDA Approved)

Generic.....	\$0 Copayment
Preferred Brand*.....	25% of drug cost with a \$25 minimum and \$50 maximum
Non-Preferred Brand*.....	greater of 50% of drug cost or \$50 Copayment

Certain CDC Recommended Vaccinations

In-Network Retail Pharmacy.....\$0 Copayment

* Brand Drug if Generic Drug is available (Mandatory Generic Program)

The Mandatory Generic Program is designed to help decrease prescription drug costs for both you and the Fund. The substitution applies to generic medications that are rated as equivalent to the brand name by the U.S. Food and Drug Administration (FDA). Under this program, Participants are encouraged to use a generic drug whenever it is available. If a patient or their physician requests a brand name drug instead of its generic equivalent, the patient will be charged the generic copayment PLUS the difference between the brand name drug and the generic alternative. However, if a letter of medical necessity is written by the prescribing physician indicating a medical reason for which the patient requires the brand name product, the patient will not be required to pay the difference in cost, only the applicable Brand copayment. Notwithstanding the foregoing, if a brand drug FDA-approved female contraceptive is determined to be Medically Necessary by your attending Provider, that brand name FDA-approved female contraceptive will be covered with a \$0 copayment.

** See Subsection D(7) of this Article for special Copayments that may apply to Specialty Drugs that are subject to the Specialty Drug Specialty Drug Coupon Program

Out-of-Network Retail Pharmacy (up to 30 day supply)

If you fill a prescription at an Out-of-Network/Non-Network pharmacy location, you will need to pay full price for the drug at the time of the purchase and then send your drug receipt to the Prescription Drug Program at the address listed on the Quick

Reference Chart. For Generic or Brand Drugs, the Plan reimburses 100% less any applicable Copay/Coinsurance. No reimbursement for Specialty Drugs, contraceptives or OTC drugs purchased from Non-Network retail pharmacy locations.

When a non-occupational Injury or Sickness causes an eligible person to need Prescription Drugs, the Plan will pay Benefits according to the Schedule of Benefits. Please use the Quick Reference Guide to find the name and contact information of the Plan's Prescription Drug Program.

A) Definitions

Definitions that apply to this Article - Schedule of Prescription Benefits are:

1. Retail Drugs

Retail drugs are medications up to a 30-day supply that are typically filled by retail pharmacies. To obtain up to a 30-day supply of medicine, present your ID card to any In-Network retail pharmacy. Contact the Prescription Drug Program (whose name is listed on the Quick Reference Chart) for the location of In-Network retail pharmacies.

2. Mail Order (Home Delivery) Drug Service

Mail Order drugs are maintenance medications up to a 90-day supply that are filled by the Prescription Drug Program's mail order facility. The mail order service is the easiest and least expensive way to obtain many medications plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" Prescription Drugs, such as for high blood pressure or diabetes. Not all medicines are available via mail order. Check with the Prescription Drug Program for further information. To use the mail order service:

- a. Have your Physician write the prescription for a 90-day supply, with the appropriate refills.
- b. Mail your prescription, Copay & mail order form to the Mail Order Services of the Prescription Drug Program whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the Prescription Drug Program. Allow up to 14 days to receive your order.

3. Walgreens Retail (Smart 90)

Walgreens Retail (Smart 90) allows you the quantity and cost savings of Mail Order, but you can pick up your prescriptions at a Walgreens Pharmacy. To use the Walgreens Retail (Smart 90) service:

- a. Have your Physician write the prescription for a 90-day supply, with the appropriate refills.
- b. Take your prescription and present your ID card at a local Walgreens Pharmacy.

4. Generic Drugs

Generic Drugs are medications that are created to be the same active ingredient as an existing approved brand-name medication in dosage, form, safety, strength, route of administration, quality, and performance. It may be given in place of the brand-name medication. FDA requires generic medications to have the same active ingredient, strength, dosage, form, and route of administration as the brand-name. The generic manufacturer must prove its medication is the same (bioequivalent) as the brand-name. All manufacturing, packaging, and testing sites must pass the same quality standards as those of brand-name. Many generic medications are made in the same manufacturing plants as the brand-name medications.

5. Brand Drugs

Brand Drugs means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that Brand Drug. A Brand Drug cannot have competition from a Generic Drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.

6. Preferred Brand Drugs

Preferred Brand Drugs are drugs listed on the Formulary maintained by the Prescription Drug Program. Preferred Brand Drugs are medications that cost less than and are therapeutically equal to Non-Preferred Brand Drugs. A therapeutically equal medication has essentially the same effect in the treatment of a disease or condition as one or more other drugs but may have a different active ingredient.

7. Non-Preferred Brand Drugs

Non-Preferred Brand Drugs are medications that cost more than Generic or Preferred Brand Drugs. Most Non-Preferred Brand Drugs require step therapy/prior authorization for approval. Please contact the Prescription Drug Program for more information on drugs that are classified as Non-Preferred Brand Drugs.

8. Specialty Drugs

Specialty Drugs are those injectable and non-injectable drugs on the Prescription Drug Program's Specialty Product List, which must have a cost exceeding \$600 per thirty days' supply and have one or more of several key characteristics, including:

- a. The requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes
 - b. The need for intensive patient training and compliance assistance to facilitate therapeutic goals
 - c. Limited or exclusive specialty pharmacy distribution*
 - d. Specialized product handling and/or administration requirements
- If a medication is only available through limited specialty pharmacy distribution it is considered a Specialty Drug, even if it doesn't have other Specialty Drug characteristics. Specialty Drugs require Precertification through the Prescription Drug Program. See Section B(5) of this Article for more information on how the Plan covers Specialty Drugs.

9. Investigational Drugs

Investigational Drugs are substances that have been tested in a laboratory and been approved by the FDA for testing in people. Clinical trials test how well Investigational Drugs work and whether they are safe to use. An Investigational Drug may be approved by the FDA for use in one disease or condition but still be considered investigational in other diseases or conditions. Also called Experimental drug, IND, investigational agent, and investigational new drug. These drugs are not covered by the Plan.

B) Covered Expenses

Prescription Benefits include:

1. Pharmaceuticals (drugs and medicines) approved by the Federal Drug Administration (FDA) as requiring a prescription.
2. Pharmaceuticals (drugs and medicines) approved by the FDA for treatment of the condition, dose, route duration and frequency prescribed.
3. Pharmaceuticals (drugs and medicines) prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.
4. Insulin, insulin syringes, diabetic supplies and contraceptives.
5. Specialty Drugs are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty Drugs require Precertification. Specialty Drugs are managed by the Prescription Drug Program because they often require special handling, are date sensitive and are available only in a 30-day quantity.
6. Over-the-counter or prescription tobacco cessation products (such as nicotine gum or patches) intended to assist an individual to stop smoking or using tobacco products. You must present a written prescription from a Physician for over-the-counter or prescription tobacco cessation products to the retail Pharmacist. You may also submit a prescription order through the mail order program. See also the Smoking/Tobacco Cessation section in the Schedule of Medical Plan Benefits regarding payment for smoking/tobacco cessation counseling.

C) Exclusions

Prescription Benefits are not payable for drugs not yet approved by the FDA and drugs used for treatment for erectile dysfunction, fertility/infertility, or weight control. Prescription Drug Benefits are also subject to the limitations in the Prescription Drug Program Clinical Programs as described in subsection (D) of this Article. See further Exclusions under Drugs, Medicines and Nutrition Exclusions section in the Medical Plan Exclusions Article.

D) Prescription Drug Program Clinical Programs

Participants are subject to the Prescription Drug Program Clinical Programs that are described in this Subsection D. Contact the Prescription Drug Program (whose phone number is listed on the Quick Reference Chart in the front of this document) with any questions or more information on the clinical programs.

1. Mandatory Generic Program

If you are currently taking a brand name drug that has a Generic Drug equivalent available or if you are newly prescribed a drug and a Generic Drug equivalent is available, and you choose to take a brand name drug, your Copayment will be the Generic Drug Copayment plus the difference in cost between the Generic Drug and the brand drug. However, if a letter of medical necessity is written by the prescribing physician indicating a medical reason for which you require the brand name product, you will not be required to pay the difference in cost, only the applicable Brand copayment. Notwithstanding the foregoing, if a Brand Drug FDA-approved female contraceptive

is determined to be Medically Necessary by your attending Provider, that Brand Drug FDA approved female contraceptive will be covered with a \$0 Copayment.

2. **Step Therapy**

Step Therapy is a program that applies to certain drug classifications to treat certain diseases. Step Therapy requires the use of a more cost-effective drug prior to the approval of a less cost-effective brand name medication. Drugs that qualify for Step Therapy are often high priced and largely advertised. The goal of this program is to use a sequential drug therapy, meaning that drugs for a given condition will be dispensed using the most cost-effective sequence - beginning with Step 1 drugs and moving to Step 2 drugs, based on accepted medical guidelines and standards.

If your Physician prescribes a higher cost medication that is a part of the Step Therapy program, the Plan will not cover the higher cost prescription until you have tried the lower cost medication alternative or your Physician provides documentation that the higher cost medication is Medically Necessary for you. The documentation will be reviewed by the Prescription Drug Program. The Prescription Drug Program will notify you and your Physician about any lower cost alternatives.

Medication classes that are subject to Step Therapy are listed on schedules maintained by the Prescription Drug Program, including but not limited to: cholesterol-lowering statins, ARB antihypertensives, SSRI/SNRI antidepressants, oral osteoporosis medications, migraine medications, Cox 2 and Non-Steroidal, Anti-Inflammatory Agents, steroid nasal sprays, Proton Pump Inhibitors, Beta and Calcium Channel Blockers, and Glaucoma Eye Drops. These schedules are subject to change.

You should contact the Prescription Drug Program for up-to-date information about drugs that are subject to Step Therapy. The phone number for the Prescription Drug Program is listed on the Quick Reference Chart in the front of this document. To find out if a drug is subject to Step Therapy, you may also log into the Prescription Drug Program's website listed in the Quick Reference Chart and search for the medication.

3. **Therapeutic Quantity Limits Program**

The Therapeutic Quantity Limits Program is a program which ensures the proper utilization of certain medications based on FDA guidelines. The program monitors prescription utilization and helps to identify potential overuse or abuse of medications. You or your Physician may contact the Prescription Drug Program with any questions regarding this program.

Drugs that are subject to the Therapeutic Quantity Limits Program are listed on schedules maintained by the Prescription Drug Program. The program places therapeutic limits on particular classes of medications including but not limited to: Narcotic Pain Relievers; Sedative Hypnotics; Migraine Medications; Respiratory and Asthma Medications; and Nasal Medications. These schedules are subject to change.

You should contact the Prescription Drug Program for up-to-date information about drugs that are subject to the Therapeutic Quantity Limits Program. The phone number for the Prescription Drug Program is listed on the Quick Reference Chart in the front of this document. To find out if a drug is subject to Quantity Limitation, you may also log into the Prescription Drug Program's website listed in the Quick Reference Chart and search for the medication.

4. **Prior Authorization**

If a Physician prescribes a medication that requires Prior Authorization, the Plan will not cover the prescription until the Prior Authorization process has been completed and the medication has been approved by the Prescription Drug Program. Prior Authorization helps to ensure that Participants are receiving the appropriate drugs for the treatment of specific conditions and in quantities as approved by the FDA. In these cases, clinical criteria based on the most current medical information must be met. The approval criteria are developed by the Prescription Drug Program's Pharmacy and Therapeutics Committee which is an established group of medical professionals including physicians and pharmacists whose primary concern is providing patients with the highest quality of care while supporting the integrity of the doctor-patient relationship.

Drugs that are subject to Prior Authorization are listed on schedules maintained by the Prescription Drug Program. These schedules are subject to change.

You should contact the Prescription Drug Program for up-to-date information about drugs that are subject to Prior Authorization. The phone number for the Prescription Drug Program is listed on the Quick Reference Chart in the front of this document. To find out if a drug is subject to Prior Authorization, you may also log into the Prescription Drug Program's website listed in the Quick Reference Chart and search for the medication.

5. **Opioid Management Program**

The Opioid Management Program is managed by the Prescription Drug Program. Under this program, the Prescription Drug Program ensures the proper utilization of opioid pain medications based upon new CDC guidelines

through clinical review. Enhanced evaluation of dosing is complete for all opioids to comply with CDC recommendations using morphine equivalent doses.

6. High Impact Advocacy Program

The Prescription Drug Program has developed a High Impact Advocacy Program, which moves carefully selected medications are moved to a separate copayment tier with a higher Participant cost share. The medications selected for this program are high-cost medications which have copayment coupons or other financial assistance. The purpose of this program is to decrease the financial burden to the Fund, without increasing the financial burden to the Participant; rather the cost share will be shifted to the coupon program. Further, the Participant's actual out-of-pocket payment after the coupon is processed is added to the Prescription Drug Out-of-Pocket Limit, rather than the copayment amount prior to coupon processing. In order for this process to work seamlessly, medications selected for the High Impact Advocacy Program will need to be processed at the Prescription Drug Program's Specialty Pharmacy. If you do not enroll in the Program, you will be responsible for the increased Copayment for that particular medication. Currently, the Prescription Drug Program is including Hepatitis C medications, certain oral oncology medications, TNF Inhibitors such as Enbrel and Humira and related medications such as Orencia and Cimzia, multiple sclerosis medications such as Copaxone and Rebif, as well as select oncology medications. Please note that the Specialty Drugs included in this program are subject to change.

7. Patient Assistance Program (PAP)

Through the Patient Assistance Program, the Prescription Drug Program will first attempt to find a more cost-effective alternative if a patient cannot afford their co-pay. If PAP is not available or appropriate, Sav-Rx will seek other options to reduce the patient's out-of-pocket expenses. Most drug manufacturers offer co-pay cards which eliminate or greatly reduce the out-of-pocket expenses for brand name medications. These co-pay cards are particularly beneficial for patients with a high co-insurance or high deductible and/or those using specialty medications. Financial assistance may also be offered through other non-profit or benevolence organizations. The Prescription Drug Program will assist patients in locating and signing up for these programs.

8. Compound Management

If you are prescribed a Compound Drug and seek to fill such a prescription on or after March 23, 2020, it will be subject to the Compound Management strategy. Every Compound Drug submitted over \$100 requires Prior Authorization by both the Prescription Drug Program's Clinical Department and Pricing Control Team. If the prescribed Compound Drug contains an ingredient that is on a list of excluded ingredients, coverage will be denied and the pharmacy will be notified the prescription is not covered. You will then receive a letter from the Prescription Drug Program, advising you that the Compound Drug was not covered and advising you to consult with your Physician for a different prescription that is not excluded. If you fill the excluded Compound Drug, you will be responsible for payment in full.

The Compound Management Strategy evaluates every ingredient within a Compound Drug claim against a list of ingredients that are targeted within this program because they represent a significant cost, are subject to significant or continuous price increases, lack clinical evidence within compounds, and have commercially available alternatives. The program excludes specific tablets and capsules based on a lack of clinical evidence to support their usage as well as an increased use of these oral dosage forms as a substitute for the previously excluded bulk powders. This program also excludes all Compound Drugs that include a non-hormonal topical cream.

Compound Drugs may be excluded under Compound Management for one or more of the following reasons:

- Represent a significant cost and/or within the top 200 most expensive compound ingredients
- Availability of commercially alternative medications
- Available as an OTC product
- Products lacking clinical evidence within compounds
- Products with significant and/or continuous price increases

If you were prescribed a Compound Drug on or after March 1, 2019, but before March 23, 2020, any refill of that prescription Compound Drug shall not be subject to the Compound Management Strategy provided that such refill is composed of the same ingredients, strength, and formulation as was originally prescribed.

ARTICLE IX: MEDICAL NETWORKS

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

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

a. IN-NETWORK SERVICES:

This Plan is a Preferred Provider Organization (PPO) health benefit plan. CIGNA Open Access Plus (CIGNA OAP) is the PPO Network for the Plan. In-Network Health Care Providers have agreements with the Plan's PPO under which they provide health care services and supplies for a favorable negotiated discount fee for Plan Participants. When a Plan Participant uses the services of an In-Network Health Care Provider, after satisfying any applicable Deductible, the Plan Participant is responsible for paying the applicable Coinsurance on the discounted fees and/or Copayment for any Medically Necessary services or supplies, subject to the Plan's limitations and Exclusions.

Because Providers are added to and dropped from the PPO network periodically throughout the year it is best if you ask your Health Care Provider IF they are still participating with the PPO each time BEFORE you seek services.

You may also verify if your Health Care Provider is an In-Network Provider by contacting the PPO at their phone number and website listed on the Quick Reference Chart in the front of this document. You may obtain a list of In-Network Health Care Providers automatically, without charge, from the website listed on the Quick Reference Chart in the front of this document.

If you contact the PPO Network whether a Provider is in the PPO Network, and the PPO Network fails to respond to your inquiry within one business day or incorrectly advises you that a Non-Preferred Provider is a Preferred Provider, the Plan will apply the Preferred Provider cost sharing rates for items and services you receive from the Non-Preferred Provider (i.e., you will generally pay a lower percentage of Covered Charges). The Plan will also apply the Preferred Provider cost sharing rates if you review the PPO Network's Provider directory to determine whether a Provider is a Preferred Provider and the directory incorrectly indicates that the Non-Preferred Provider is a Preferred Provider.

Your I.D. Card - A Passport to Health Care

All Plan Participants will be issued an identification ("I.D.") card. Always put your I.D. card in your wallet or purse, along with your driver's license, credits cards, and other essential items. With your I.D. card, U.S. Hospitals and Physicians can identify your coverage.

If you want extra cards for covered family members or need to replace a lost card, please contact the PPO at their phone number and website listed on the Quick Reference Chart in the front of this document.

b. OUT-OF-NETWORK SERVICES

Out-of-Network (also called Non-Network, Non-Contracted or Non-PPO) Health Care Providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan Participant for the Allowed Charge (as defined in this document) for any Medically Necessary services or supplies, subject to the Plan's Deductibles, Coinsurance, Copayments, limitations and Exclusions. Plan Participants must submit proof of claim before any such reimbursement will be made.

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

You can avoid Balance Billing by using In-Network Providers. (See the definitions of Allowed Charge and Balance Billing in the Definitions Article of this document.)

However, under certain circumstances, Plan Participants may be protected from Balance Billing. You are protected from Balance Billing for:

- (i) **Emergency services.** If you have an Emergency Medical Condition and get Emergency Services from an Out-of-Network Provider or Facility, the most the Provider or Facility may bill you is your Plan's In-Network cost-sharing amount (such as Copayments and Coinsurance). You **cannot** be Balance Billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be Balance Billed for these Post-Stabilization Services.
- (ii) **Certain services at an In-Network Hospital or Ambulatory Surgical Center.** When you get services from an In-Network Hospital or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers may bill you is your Plan's In-Network cost-sharing amount. This applies to emergency medicine, Anesthesia, pathology, radiology, laboratory, neonatology, Assistant Surgeon, Hospital, or intensivist services. These Providers **cannot** balance bill you and may **not** ask you to give up your protection

not to be balance billed. If you get other types of services at these In-Network Facilities, Out-of-Network Providers can't Balance Bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from Balance Billing. You are also not required to get care Out-of-Network. You can choose a Provider or Facility in your Plan's Network.

c. OUT OF AREA

Out of Area refers to when a Participant receives services from an Out-of-Network Provider because there are fewer than two In-Network Providers in the same specialty for a particular service within a 30 mile radius of their zip code. If this occurs, the Plan will pay benefits at the same rate as an In-Network Provider as explained in Section 3(a) of Article VI and as listed in the Schedule of Medical Plan Benefits. If you use an Out of Network Provider when there are at least two In-Network Providers in the same specialty for a particular service within a 30 mile radius of your zip code, the Provider **will not be covered as an Out of Area Provider**. Instead, the Plan will pay benefits as an Out-of-Network Provider as explained in Section 3(b) of Article VI and as listed in the Schedule of Medical Plan Benefits. An Out of Area Provider **may bill a Plan Participant a non-discounted amount for any balance that may be due in addition to** the Allowed Amount payable by the Plan, also called Balance Billing (unless the special protections against Balance Billing discussed above apply).

d. SPECIAL REIMBURSEMENT PROVISION

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

<p align="center">SPECIAL REIMBURSEMENT PROVISIONS</p> <p>This chart explains when the Plan's special reimbursement provisions apply if the services of certain Out-of-Network Providers are used.</p>	<p align="center">WHAT THE PLAN PAYS</p> <p>(Toward eligible claims submitted by an Out-of-Network Provider)</p>
<p>The Participant has an Emergency Medical Condition and receives Emergency Services from an Out-of-Network Provider or Facility.</p> <p>The Participant receives services from an In-Network Hospital or Ambulatory Surgical Center. This applies to emergency medicine, Anesthesia, pathology, radiology, laboratory, neonatology, Assistant Surgeon, Hospitalist, or intensivist services.</p> <p>Claims incurred for surgery to correct a Chiari malformation (a structural defect in the cerebellum of the brain) will be treated as In-Network regardless of whether the surgery is performed by an In-Network Provider or an Out-of-Network Provider.</p>	<p>As if the care was provided In-Network (including Deductible, Coinsurance, Copays, and Out-of-Pocket Maximum), based on the Allowed Charge for Out-of-Network Providers.</p> <p>The amount the Participant pays toward his or her Copayment, Coinsurance and/or Deductible will be applied to the Participant's annual Out-of-Pocket Maximum.</p> <p>The Plan reserves the right to have the billed amount of an Out-of-Network Provider's claim reviewed under the Plan's Out-of-Network Savings Program and/or negotiate a discount of the billed charges and/or review the billing/service by an independent Medical Review firm.</p> <p>See the definition of Allowed Charge in the Definitions Article of this document.</p>
<p>Use of an Out-of-Network Provider when an In-Network Provider was available to be used under circumstances not covered by the Plan's above-stated special reimbursement provisions or the No Surprises Act. For example, this provision applies if an In-Network Provider refers the individual to an Out-of-Network Provider or facility, including an Out-of-Network specialist or laboratory, under circumstances not covered by the No Surprises Act or the Plan's above-stated special reimbursement provisions.</p>	<p>As if the care was provided Out-of-Network (including Deductible, Coinsurance, Copays) based upon the Allowed Charge for Out-of-Network Providers.</p> <p>The Plan preserves the right to have the billed amount of an Out-of-Network Provider's claim reviewed under the Plan's Out-of-Network Savings Program and/or negotiate a discount of the billed charges and/or review the billing/service by an independent Medical Review firm.</p>

Section 2: PREFERRED PROVIDER ORGANIZATION (PPO)

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

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

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

Section 3: DIRECTORIES OF NETWORK PROVIDERS

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

ARTICLE X: PRECERTIFICATION AND MEDICAL REVIEW

Section 1: PURPOSE OF THE PRECERTIFICATION PROGRAM

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

If you follow the Plan's Precertification procedures, you may avoid some out-of-pocket costs. However, **if you do not follow these procedures, the Plan may not provide benefits, or the Plan may provide reduced benefits**, and you will be responsible for paying for services out of your own pocket.

Section 2: MEDICAL REVIEW PROGRAM

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

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

Section 3: ELEMENTS OF THE MEDICAL REVIEW PROGRAM

The Plan's Medical Review Program consists of:

- a. **Precertification (preservice) review:** review of proposed health care services (including Prescription Drugs) before the services are provided;
- b. **Concurrent (continued stay) review:** ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Health Care Facility or continued duration of healthcare services;
- c. **Retrospective (post-service) review:** review of health care services after they have been provided.
- d. **Case Management:** a process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the Fund work together under the guidance of the Plan's independent Medical Review firm to coordinate a quality, timely and cost-effective treatment plan.

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

- a. The fact that your Physician recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Medical Plan.
- b. The Medical Review Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan Benefits. The Medical Review firm's certification that a service is Medically Necessary does not mean that a benefit payment is guaranteed.
- c. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
- d. All treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if the Medical Review firm does not certify the proposed surgery/treatment/service or admission as Medically Necessary or as an Eligible Expense. However, the benefits payable by the Plan may be affected by the determination of the Medical Review firm.
- e. With respect to the administration of this Plan, the Fund, the Administrative Office and the Medical Review firms are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the Medical Review firm as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the Medical Review firm as Medically Necessary.
- f. Precertification of a service does not guarantee that the Plan will pay benefits for that service because other factors, such as ineligibility for coverage on the actual date of service, the information submitted during Precertification varies from the actual

services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

Section 5: PRECERTIFICATION (PRESERVICE) REVIEW

a. How Precertification Review Works:

Precertification Review is a procedure, administered by the Medical Review firms under contract to the Plan, including the Utilization Management firm and Prescription Drug Program, to assure that health care services meet or exceed accepted standards of care and that health care services are Medically Necessary.

Prior notification does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations. If you fail to get the requested services preauthorized before receiving such services, the Plan may still cover the service if it meets the Plan’s Medical Necessity criteria, subject to any benefit limitations.

You or your Physician must Precertify (pre-approve) the following services BEFORE the services are provided:

WHAT SERVICES MUST BE PRECERTIFIED:	MEDICAL REVIEW FIRM TO BE CONTACTED	PENALTY FOR FAILURE TO PRECERTIFY
<p>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 or Wise, 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 this document:</p> <ol style="list-style-type: none"> 1. All Elective Hospital admissions, including an admission for mental health and/or substance abuse. <i>(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).</i> 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/bariatric surgery, such as gastric bypass, lap band, etc.; Cord Blood Harvesting; Pharyngoplasty; Outpatient Vein therapy procedures; Spinal procedures; Brachytherapy; Sleep Management; Potential Experimental, Investigational or unproven treatments. 5. Home Health Care services and Home Infusion services 6. Outpatient injectable drugs administered in an outpatient facility 7. Speech therapy 8. Orthotic devices 9. Prosthetic devices including cochlear implants 10. Durable Medical Equipment 11. For individuals who will participate in a clinical trial, Precertification is required in order to notify the Plan that routine clinical trial costs, services and supplies may be incurred by the individual during their participation in the clinical trial. 12. Therapeutic Radiology 13. Genetic Testing 	<p style="text-align: center;">Utilization Management (UM) Company whose name and phone number are listed on the Quick Reference Chart in the front of this document.</p>	<p style="text-align: center;">If you fail to notify the Utilization Management Company (UM) before receiving any services requiring precertification (noted to the left), <u>benefits may NOT be paid for the related expenses.</u></p>

WHAT SERVICES MUST BE PRECERTIFIED:	MEDICAL REVIEW FIRM TO BE CONTACTED	PENALTY FOR FAILURE TO PRECERTIFY
14. Outpatient Procedures 15. Unlisted Procedures 16. Gene Therapy		
Specialty and certain other high-cost 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, <u>benefits may NOT be paid for the related expenses.</u>

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

If you use an In-Network Provider, your Health Care Provider will work with CIGNA to arrange Precertification. However, it is your responsibility to assure that Precertification occurs when it is required by this Plan. Any penalty for failure to Precertify is the responsibility of the Plan Participant, not the Health Care Provider.

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

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

Section 6: CASE MANAGEMENT

How Case Management Works:

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

Working with the Case Manager:

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

From time to time, the Case Manager may confer with your Physician or other Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

Contacting a Case Manager:

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

ARTICLE XI: MEDICAL PLAN EXCLUSIONS

Introduction. The following is a list of services and supplies or expenses **not covered (excluded) by the Medical Plan.** The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these Exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related Plan Exclusion. The below is not an all-inclusive listing of excluded services and supplies. It is only representative of the types of services and supplies for which no payment is made and of the types of situations in which loss may be sustained or in which expenses may be incurred for which no payment is made.

The list of services and supplies or expenses not covered by the Medical Plan do not apply to items or services rendered at a Hospital or facility for an Emergency Medical Condition to the extent required by the No Surprises Act.

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

1. **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
2. **Complications of a Non-Covered Service:** Any services, supplies or accommodations related to complications of non-covered services/treatment.
3. **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, interest charges, late fees, mileage costs, provider administration fees and/or photocopying fees, disabled person license plates/automotive forms, concierge/retainer agreement/membership/surcharge fees or provider's special plan charging fees to access added benefits.
4. **Educational Services:** Even if they are required because of an Injury, Illness or disability of a Covered Individual the following expenses are not payable by the Plan: expenses for learning deficiencies, behavioral problems or Special Education, educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, vision therapy, auditory aides, speech aids, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices. Certain educational services may be listed as a covered benefit in the Schedule of Medical Benefits in this document.
5. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by the Fund or a participating employer of the Fund, or if benefits are otherwise provided under this Plan or any other plan that the employer contributes to or otherwise sponsors.
6. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan Benefit limitation or Maximum Plan Benefit as described in the Medical Plan Article of this document.
7. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions Article of this document.
8. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party may be required to pay are not covered, except as provided for in the provisions relating to Third Party Liability in the Article on Coordination of Benefits. See the provisions relating to Third Party Liability in the Coordination of Benefits Article for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
9. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided the patient was covered by the medical program; or after the date the patient's coverage ends, except under those conditions described in the COBRA Article of this document.
10. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions Article of this document.
11. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.
12. **Military service-related Injury/Illness:** If a Covered Individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related Illness or Injury, benefits are not payable by the Plan.

13. **Illegal Act:** Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual unless such Injury or Illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this Exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.
14. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission.
15. **Medical Students or Interns or Residents:** Expenses for the services of a medical student or intern or resident.
16. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions Article, except for certain wellness benefits as outlined in the Schedule of Medical Benefits.
17. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an Injury, Illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.
18. **No-Cost Services:** Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
19. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by a Covered Individual arising out of or in the course of employment (including self-employment) if the Injury, Illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if the Covered Individual was not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified.
20. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, DVD/CD or similar device, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
21. **Physical Examinations, Tests for Employment, School, etc.:** Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party.
22. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or its designee.
23. **Relatives Providing Services:** Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee.
24. **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, Dentist, Midwife or Nurse Midwife, Nurse Practitioner, Physician Assistant or Podiatrist.
25. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in the Definitions Article of this document.
26. **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.
27. **Telephone Calls:** Expenses for any and all telephone calls between a Physician or other Health Care Provider and the patient, other Health Care Provider, Medical Review firm, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan or its Medical Review firm, for any purpose related to the care or treatment of a Covered Individual, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.

28. **Travel and Related Expenses:** Expenses for and related to travel or transportation (including lodging and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual, unless those expenses have been pre-approved by the Plan Administrator or its designee.
29. **Travel Contrary to Medical Advice:** Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.
30. **War or Similar Event:** Expenses incurred as a result of an Injury or Illness due to any act of war, either declared or undeclared, war-like act, release of nuclear energy, or active or passive participation or attempted participation in a riot, insurrection, rebellion, or invasion, except as required by law.
31. **Failure to Provide Required Information:** If the Plan requests information from a Participant in order to process a claim for benefits and that requested information is not provided within the timeframe allowed under the Plan, no payment will be extended for the questionable services. If the requested information is later received by the Plan in a timely manner according to the Claim Filing and Appeal Information Article of this document, the claim will be reviewed.
32. **Non-Routine Services:** Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the Investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

Section 2: EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

A. Alternative/Complementary Health Care Services Exclusions

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

B. Autism Treatment Exclusions

1. Expenses for and related to any treatment, including but not limited to medical (including prescriptions), behavioral and educational treatment of autism.

C. Behavioral Health Care Exclusions

1. Expenses for Out of Network Residential Treatment Programs for Behavioral Health Care.
2. Expenses for hypnosis, hypnotherapy and/or Biofeedback.
3. Expenses related to enuresis (bedwetting).
4. Expenses for **Applied Behavioral Analysis (ABA) Therapy** (as defined in the Definitions Article of this document) and related services. **The Plan does not provide any benefits for the treatment of autism.**
5. Expenses for Behavioral Health Care services related to:
 - dyslexia, learning disorders, educational delays, including tests and related expenses to determine the presence of or degree of a person's dyslexia or learning/reading disorder;
 - vocational disabilities;
 - court-ordered Behavioral Health Care services (unless determined to be Medically Necessary) or custody counseling;
 - family planning/pregnancy/adoption counseling;
 - marital or family counseling (except that such counseling is available from the Plan's Employee Assistance Program (EAP)).

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

1. Expenses for any items that are **not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions Article of this document, including but not limited to air purifiers, air conditioners, swimming pools, spa/whirlpools, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, and water beds.
2. Expenses for **replacement of lost, missing, or stolen, duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.
3. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.

4. Expenses for **occupational therapy adaptive supplies and devices** used to assist a person in performing Activities of Daily Living including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.
5. Expenses for **Nondurable Supplies**, except as payable under Nondurable Supplies in the Schedule of Medical Benefits.

E. Cosmetic Services Exclusions

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

F. Custodial Care Exclusions

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

G. Dental Services Exclusions

1. Expenses for Dental services or supplies of any kind, (even if they are necessary because of symptoms, congenital anomaly or Illness affecting the mouth or another part of the body) including but not limited to Dental prosthetics and Dental services for the care, filling, removal or replacement of teeth, or disease of the teeth, gums or structures directly supporting or attached to the teeth. No coverage for Dental services for removal of wisdom teeth, root canal, gingivectomy, or Dental abscess treatment.
2. Expenses for Dental services may be covered under the Medical Plan if they are incurred for the repair or replacement of Accidental Injury to Teeth or restoration of the jaw if damaged by an external object in an Accident. For the purposes of this coverage by the Plan, an Accident does not include any Injury caused by biting or chewing. See Oral, Craniofacial and TMJ Services in the Schedule of Medical Benefits to determine if those services are covered.
3. Expenses for Orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with Prognathism, Retrognathism, or other cosmetic reasons. See Oral, Craniofacial and TMJ Services in the Schedule of Medical Benefits for additional information.

H. Drugs, Medicines and Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (*i.e.* are used "off-label"). Off-label use of an FDA approved drug will only be considered for payment (as not being Experimental or Investigational), on a case by case basis considering the facts and circumstances of the clinical situation, if approved by the Board of Trustees with medical evidence to support the fact that the benefits of the use of the drug outweigh the risks, or the off label use of an FDA drug relates to treatment of cancer. The Board of Trustees reserves the right to seek independent Medical Review regarding the request for off label drug use.
2. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin and drugs mandated for coverage in accordance with Health Reform regulations and tobacco cessation products.
3. Foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, diets, dietary supplements, vitamins, herbs and minerals, enzymes (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered hospitalization or as mandated for coverage in accordance with Health Reform regulations. Nutritional support may be payable when it is determined by the Plan Administrator or its designee to be Medically Necessary, and is the sole means of adequate nutritional intake and is administered enterally (*i.e.*, by feeding tube) or parenterally (*i.e.*, by intravenous administration) and is not considered a food thickener, infant formula, donor breast milk, baby food, or other non-prescription product that can be mixed in a blender.

4. Naturopathic, naprapathic or homeopathic services and substances.
5. Drugs, medicines or devices for:
 - non-prescription contraceptives drugs and devices for males;
 - fertility and/or infertility drug products or agents;
 - hair removal or hair growth products (*e.g.*, Propecia, Rogaine, Minoxidil, Vaniqa);
 - growth hormone;
 - erectile dysfunction (*e.g.*, Viagra, Cialis, Muse, Caverject);
 - vitamin A derivatives (retinoids) for dermatologic use (*e.g.* Retin A, Renova) are excluded after age 26;
 - weight control, appetite suppressants or anorexiant (*e.g.* Xenical) except those anorexiant used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy.
6. Compound Drugs that do not meet the requirements of the Compound Management Strategy set forth in Article VIII, Subsection D(8).
7. Self-help devices such as a scale, pill crusher, magnifying glass/device, etc.

I. Durable Medical Equipment Exclusions

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

J. Fertility and Infertility Services Exclusions

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

K. Foot/Hand Care Exclusions

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

L. Genetic Testing and Counseling Exclusions

1. **Genetic Testing** - All genetic testing, except as specifically allowed in the Genetic Testing and Counseling section of Article VII, Schedule of Medical Plan Benefits.
2. **Genetic Counseling:** Expenses for Genetic Counseling are not covered, unless these three conditions are met: is ordered by a Physician, performed by a qualified genetic counselor and performed in conjunction with a genetic test that is payable by this Plan

M. Hair Exclusions

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

N. Hearing Care Exclusions

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

O. Home Health Care Exclusions

1. Expenses for any Home Health Care services other than part-time, intermittent **skilled nursing** services and supplies, except when the services of Home Health aides are payable under Home Health Care Services in the schedule of Medical Benefits.

2. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, Custodial Care, child care, adult care or personal care attendant, except as provided under the Plan's Hospice coverage, and when Custodial Care is provided by Home Health aides that are payable under Home Health Care Services in the Schedule of Medical Benefits.

P. Maternity/Family Planning/Contraceptive Exclusions

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

For Nondurable supplies (see Corrective Appliances).

Q. Nursing Care Exclusions

1. Expenses for services of private duty Nurses.

R. Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

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

S. Sexual/Erectile Dysfunction Services Exclusions

1. **Treatment of Erectile Dysfunction (Impotency):** Expenses for Prescription Drugs (e.g. Viagra) and/or medical or surgical treatment of erectile dysfunction or inadequacy.

T. Transplant (Organ and Tissue) Exclusions

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

U. Vision Care Exclusions

1. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK).
2. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies.
3. Vision therapy (orthoptics) and supplies.

V. Weight Management and Physical Fitness Exclusions

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

ARTICLE XII: CLAIM FILING AND APPEAL INFORMATION

Section 1: OVERVIEW

This Article describes the procedures for filing claims for certain benefits under this Plan and for appealing Adverse Benefit Determinations in connection with those claims in compliance with 29 C FR §2560.503-1. Claims covered by these procedures include those claims filed under the Medical Plan (including Prescription Drugs). See the Death Benefit and Accidental Death and Dismemberment Article for details on claim filing and appeal procedures for these benefits.

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

This Article also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is Experimental or Investigational).

Section 2: QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

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

Section 3: WHEN YOU MUST REPAY PLAN BENEFITS

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

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

then, the Plan will be entitled to

- a. a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan Benefits that should have been paid by the Plan for those expenses based on the actual facts;
- b. offset future benefits (that would otherwise be payable on behalf of you or your Dependents) if necessary in order to recover such expenses; and/or
- c. its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

Section 4: TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All Post-Service Claims must be submitted to the Plan's Claims Administrator by July 1st of the year following the year in which the claims were incurred.

Section 5: COORDINATION OF BENEFITS (COB) PROVISION

This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a person is covered so that the total benefits available will not exceed one hundred percent of Allowable Expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your eligible services. Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits Article for more information.

Section 6: ADDITIONAL INFORMATION NEEDED

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

Section 7: WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan Benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as Pre-Service Claims (also known as Precertification or preauthorization). See the definition of Pre-Service Claims in this Article. See also the Precertification and Medical Review Article for which services require Precertification. You are not required to obtain approval in advance for Emergency Care or Hospital admission for delivery of a baby.

Section 8: KEY DEFINITIONS

- a. **Days:** For the purpose of the claim and appeal procedures outlined in this Article, “days” refers to calendar days, not business days.
- b. **Adverse Benefit Determination:** For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination is defined as a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit including any such denial, reduction, termination or failure to provide or make a payment that is based on:
 - a determination of an individual’s eligibility to participate in this Plan; or
 - a determination that a benefit is not a covered benefit; or
 - a reduction in a benefit resulting from the application of any utilization review (Medical Review) decision, source of injury exclusion, network exclusion or other limitation on otherwise covered benefits, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate; or
 - compliance with the surprise billing and cost-sharing protections under the No Surprises Act; or
 - any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.
- c. **Claim:** For purposes of benefits covered by these procedures, a claim is a request for a Plan Benefit made by an individual (commonly called the “Claimant” but hereafter referred to as “you”) or that individual’s Authorized Representative (as defined later in this Article) in accordance with the Plan’s claims procedures, described in this Article.

There are **four types of claims** covered by the procedures in this Article: **Pre-service, Urgent, Concurrent, and Post-service**, described later in this Article. The type of claim is determined as of the time the claim or review of denial of the claim is being processed. For the **Death Benefits and Accidental Death & Dismemberment Benefits**, follow the claims and appeal procedures outlined in Article XV.

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

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

A claim is NOT:

1. a request made by **someone other than** the individual or his/her Authorized Representative;
2. a request made by a **person who will not identify him/herself** (anonymous);
3. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
4. a request for **prior approval of Plan Benefits where prior approval is not required** by the Plan;
5. an **eligibility inquiry that does not request Plan Benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an Adverse Benefit Determination and the individual will be notified of the decision and allowed to file an appeal;
6. a **request for services and claims for a work-related Injury/Illness**, unless the Workers’ Compensation program has provided a written confirmation that the Injury/Illness is not compensable as a work-related claim. A request is also not a claim if you or your covered Dependent were not covered by workers’ compensation insurance, or if the Covered

Individual's rights under workers' compensation or occupational disease or similar law have been declined/waived, not purchased or qualified; or

7. a **submission of a prescription** with a subsequent Adverse Benefit Determination at the point of sale at a retail pharmacy.

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

Appropriate Claims Administrator	Types of Claims Processed
Administrative Office	<ul style="list-style-type: none"> • Medical including behavioral health Post-Service Claims • PCA claims • Death benefit • Accidental death and dismemberment • Emergency or non-emergency services or items rendered by an Out-of-Network Provider or at an Out-of-Network facility
Utilization Management Company	<ul style="list-style-type: none"> • Pre-Service and Urgent Medical Plan services requiring Precertification and Concurrent Claims
MAP and EAP Program	<ul style="list-style-type: none"> • Preservice claims for MAP and/or EAP visits
Prescription Drug Program	<ul style="list-style-type: none"> • Drugs needing pre-service review • Post-service drug claims

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

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

f. **Urgent Care Claim:** An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for Precertification:

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

The services that require Precertification (also called prior authorization) are listed in the Precertification and Medical Review Article of this document.

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

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

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

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

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

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

Section 9: REVIEW OF ISSUES THAT ARE NOT A CLAIM AS DEFINED IN THIS ARTICLE

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

Section 10: AUTHORIZED REPRESENTATIVE

This Plan recognizes an Authorized Representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an Adverse Benefit Determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An Authorized Representative under this Plan also includes a Health Care Professional. The Plan requires a written statement from an individual that he/she has designated an Authorized Representative along with the representative’s name, address, phone number and duration of representation. (Except that under this Plan, a Health Care Professional does not require a written statement in order to appeal an Urgent Care, Pre-Service or Concurrent Care Claim for a Plan Participant, but does require a written authorization for a Health Care Provider to appeal a Post-Service Claim.) To designate an Authorized Representative, you must submit a completed Authorized Representative form (available from the Appropriate Claims Administrator).

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed Authorized Representative has the power of attorney for health care purposes (*e.g.* notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual’s legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an Authorized Representative form, future claims and appeals-related correspondence will be routed to the Authorized Representative and not the individual as specified on the Authorized Representative form. The Plan will honor the designated Authorized Representative until the designation is revoked, or as mandated by a court order. A Participant may revoke a designated Authorized Representative status by submitting a completed change of Authorized Representative form available from and to be returned to the Administrative Office.

The Plan reserves the right to withhold information from a person who claims to be your Authorized Representative if there is suspicion about the qualifications of that individual.

Section 11: HOW TO FILE A POST-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

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

1. Plan Benefits for Post-Service Claims are considered for payment on the receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim but sometimes additional information or records may be required.
2. Generally, Plan Benefits for a Hospital or Health Care Facility will be paid directly to the facility. Plan Benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services. For eligible claims, the Plan pays their portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the Provider.
3. If health care services are provided through the Preferred Provider Organization (PPO), the PPO Health Care Provider will usually submit the written proof of claim directly to the Appropriate Claims Administrator.
4. If you pay for non-PPO health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered Dependent paid some or all of those charges. Plan Benefits will be paid to you up to the amount allowed by the Plan for those eligible expenses. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.
5. **Claim Forms:** Occasionally a Health Care Provider will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this Article) to find out if they require you to complete a claim form. If a claim form is required, it may be obtained from the Appropriate Claims Administrator whose name and address are listed on the Quick Reference chart in the front of this document.
 - Complete the Employee part of the claim form in full. Answer every question, even if the answer is “none” or “not applicable (N/A).”
 - The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or Health Care Practitioner or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:
 - A description of the services or supplies provided.

- Details of the charges for those services or supplies, including CPT/CDT codes.
 - Diagnosis including ICD codes.
 - Date(s) the services or supplies were provided.
 - Patient's name, social security or ID number, address and date of birth.
 - Insured's name, social security or ID number, address and date of birth, if different from the patient.
 - Provider's name, address, phone number, professional degree or license, and federal tax identification number.
- Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Appropriate Claims Administrator.** This can reduce costs to you and the Plan.
 - Complete a **separate claim form** for each person for whom Plan Benefits are being requested.
 - If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.
 - Mail the claim form and a copy of the Provider's actual claim to the Appropriate Claims Administrator.
6. In all instances, when Deductibles, Coinsurance or Copayments apply, you are responsible for paying your share of the charges.
7. The Appropriate Claims Administrator will review your Post-Service Claim and notify you of its determination 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.*, Disabled Adult Child status 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.
8. The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a Claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the Claimant has had such an opportunity.

9. **If the Post-Service Claim is approved**, you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The Provider of service (or you when applicable) will be paid according to Plan Benefits.
10. **If the Post-Service Claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) on the Explanation of Benefits or EOB form. This notice of initial denial will:
- identify the claim involved (e.g. date of service, Health Care Provider, claim amount if applicable);
 - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
 - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
 - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - disclose the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and external review processes.
11. The Plan will provide, upon request, a notice in any applicable non-English language.
12. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
- SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
 - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (801) 973-1001 or toll free (800) 628-6562.
13. **If you disagree with a denial of a Post-Service Claim**, you or your Authorized Representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 12: APPEAL OF A DENIAL OF A POST-SERVICE CLAIM

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

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

with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a Claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the Claimant has had such an opportunity.

- a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
 - in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary will:
 - consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
1. The Plan will make an appeal determination according to the following timeframes:
 - **If an appeal is filed with the Plan more than thirty (30) days before the next Board meeting**, the review will occur at the next Board meeting date.
 - **If an appeal is filed with the Plan within thirty (30) days of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.
 - If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
 - After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.
 2. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
 3. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
 4. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
 - information that is sufficient to identify the claim involved (e.g., date of service, Health Care Provider, claim amount if applicable);
 - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for external review;
 - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;
 - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
 - an explanation of the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
 - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and (if applicable) your State insurance regulatory agency."; and

- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
5. The Plan will provide, upon request, a notice in any applicable non-English language.
 6. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
 - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (801) 973-1001 or toll free (800) 628-6562.
 7. This concludes the post-service appeal process under this Plan.

Section 13: HOW TO FILE AN URGENT CARE CLAIM FOR BENEFITS UNDER THIS PLAN

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

1. Urgent Care Claims (as defined previously in this Article) may be requested by you orally or by writing to the Appropriate Claims Administrator whose phone number and mailing address are listed on the Quick Reference chart in the front of this document.
2. In the case of an Urgent Care Claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the Health Care Professional will be considered by this Plan to be the Authorized Representative bypassing the need for completion of the Plan's written Authorized Representative form.
3. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a Claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the Claimant has had such an opportunity.
4. You will be notified of the Plan's benefit determination as soon as possible but **no later than 72 hours** after receipt of an urgent care claim by the Appropriate Claims Administrator. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.
5. **If you fail to provide sufficient information to decide an Urgent Care Claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the Urgent Care Claim by the Appropriate Claims Administrator, of the specific information necessary to complete the Urgent Care Claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.
6. **If the Urgent Care Claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
7. **If the Urgent Care Claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial Urgent Care Claim denial will:
 - identify the claim involved (e.g. date of service, Health Care Provider, claim amount if applicable);
 - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
 - give the specific reason(s) for the denial; including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;

- reference the specific Plan provision(s) on which the determination is based;
 - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of the Plan's internal appeal procedure and external review process along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process and external review process for Urgent Care Claims
 - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
 - you will be provided a description of the expedited appeal review process for Urgent Care Claims.
 - The Plan will disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
8. The Plan will provide, upon request, a notice in any applicable non-English language.
9. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
- SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
 - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (801) 973-1001 or toll free (800) 628-6562.
10. **If you disagree with a denial of an Urgent Care Claim**, you or your Authorized Representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 14: APPEAL OF A DENIAL OF AN URGENT CARE CLAIM

1. You may request an appeal review of an Urgent Care Claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, at their phone number or address listed on the Quick Reference chart in the front of this document.
2. All necessary information including the Plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious methods.
3. You will be provided with:
 - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a Claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the Claimant has had such an opportunity;

- a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
 - in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or not appropriate, the Plan will:
 - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
4. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than 72 hours after receipt of the appeal.
 5. The notice of appeal review of an Urgent Care Claim will be provided orally with written confirmation (or electronic, as appropriate). If that determination is adverse, it will include:
 - information that is sufficient to identify the claim involved (e.g. date of service, Health Care Provider, claim amount if applicable);
 - a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal (if any) or external review;
 - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents, records, and other information relevant to your claim;
 - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
 - an explanation of the Plan's 2nd level appeal (if any) and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
 - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and (if applicable) your State insurance regulatory agency."; and
 - disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is relevant).
 6. The Plan will provide, upon request, a notice in any applicable non-English language.
 7. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
 - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (801) 973-1001 or toll free (800) 628-6562.
 8. This concludes the urgent care claim appeal process under this Plan.

Section 15: HOW TO FILE A CONCURRENT CLAIM FOR BENEFITS UNDER THIS PLAN

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

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.
2. Any request to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, and the Plan Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
3. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a Claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the Claimant has had such an opportunity.
4. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this Article.
5. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Preservice or Post-Service Claim sections of this Article.
6. **If the Concurrent Care Claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
7. **If the Concurrent Care Claim is denied**, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
 - identify the claim involved (e.g., date of service, Health Care Provider, claim amount if applicable);
 - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
 - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of the Plan's internal appeal procedure and external review process along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process and external review process for urgent care claims;
 - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
 - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
7. The Plan will provide, upon request, a notice in any applicable non-English language.
8. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.

- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (801) 973-1001 or toll free (800) 628-6562.
9. **If you disagree with a denial of a concurrent claim**, you or your Authorized Representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 16: APPEAL OF A DENIAL OF A CONCURRENT CARE CLAIM

1. You may request an appeal review of a Concurrent Care Claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, at their phone number or address listed on the Quick Reference chart in the front of this document.
2. You will be provided with:
 - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a Claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the Claimant has had such an opportunity.
 - a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
 - in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary will:
 - consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
3. A determination will be made on the appeal (without the opportunity for extension) as soon as possible before the benefit is reduced or treatment is terminated.
4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with follow-up written (or electronic, as appropriate) notice. If that determination is adverse, it will include:
 - information that is sufficient to identify the claim involved (e.g. date of service, Health Care Provider, claim amount if applicable);
 - a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal (if any) or external review;
 - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents, records, and other information relevant to your claim;

- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
 - an explanation of the Plan's 2nd level appeal (if any) and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and (if applicable) your State insurance regulatory agency."
 - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
5. The Plan will provide, upon request, a notice in any applicable non-English language.
 6. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
 - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (801) 973-1001 or toll free (800) 628-6562.
 7. This concludes the concurrent claim appeal process under this Plan.

Section 17: HOW TO FILE A PRE-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

1. A claim for pre-service (as defined in this Article) must be made by a Claimant or the Claimant's Authorized Representative (as described in this Article) in accordance with this Plan's claims procedures outlined in this Article.
2. A Pre-Service Claim (claim which requires Precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Precertification Article of this document) to the Appropriate Claims Administrator (as defined in this Article).
3. The Pre-Service Claim will be reviewed and the Plan will notify you of its determination no later than 15 calendar days from the date the Pre-Service Claim is received by the Appropriate Claims Administrator. If you do not follow the Pre-Service Claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.
4. The 15 calendar day review period may be extended one time for up to fifteen (15) additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial fifteen (15) day period by using a written Notice of Extension.
5. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or sixty (60) days has elapsed since the Notice was sent to you.
6. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
7. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
8. A claim determination will be made no later than fifteen (15) calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension if no additional information is received.
9. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date

on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a Claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the Claimant has had such an opportunity.

10. **If the Pre-Service Claim is approved** you will be notified orally and in writing (or electronic, as applicable).
11. **If the Pre-Service Claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
 - identify the claim involved (e.g., date of service, Health Care Provider, claim amount if applicable);
 - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
 - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of the Plan's internal appeal procedure and external review process along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process and external review process for Urgent Care Claims;
 - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeals procedures have been exhausted;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
12. The Plan will provide, upon request, a notice in any applicable non-English language.
13. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
 - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (801) 973-1001 or toll free (800) 628-6562.
14. **If you disagree with a denial of a Pre-Service Claim**, you or your Authorized Representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 18: APPEAL OF A DENIAL OF A PRE-SERVICE CLAIM

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

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and

sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a Claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the Claimant has had such an opportunity.

- a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
 - in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary will:
 - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
1. Under this Plan's 2 level appeal process, the Plan subcontracts the first level of review to the Appropriate Claims Administrator who will make the first level determination on the pre-service appeal no later than 15 calendar days from receipt of the appeal.
 2. There is **no extension permitted** to the Plan in the first or second level of the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
 3. If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Board of Trustees whose address is listed on the Quick Reference chart in the front of this document.
 4. A second level determination will be made no later than 15 calendar days from receipt of the second level appeal.
 5. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
 6. If the claim was denied due to Medical Necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
 7. You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:
 - information that is sufficient to identify the claim involved (e.g., date of service, Health Care Provider, claim amount if applicable);
 - a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal (if any) or external review;
 - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
 - a statement that you have the right to bring civil action under ERISA section 502(a) following the exhaustion of the appeals procedures;
 - an explanation of the Plan's 2nd level appeal (if any) and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
 - the statement that “You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and (if applicable) your State insurance regulatory agency”; and
 - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review process.
8. The Plan will provide, upon request, a notice in any applicable non-English language.
9. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
- SPANISH (Español): Para obtener asistencia en Español, llame al (801) 973-1001 or toll free (800) 628-6562.
 - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (801) 973-1001 or toll free (800) 628-6562.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (801) 973-1001 or toll free (800) 628-6562.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' (801) 973-1001 or toll free (800) 628-6562.
10. This concludes the pre-service appeal process under this Plan.

Section 19: OUTLINE OF THE TIMEFRAMES FOR THE CLAIM FILING AND CLAIM APPEAL PROCESS

OVERVIEW OF CLAIMS AND APPEALS TIMEFRAMES				
	Urgent	Concurrent	Pre-service	Post-service
Plan must make Initial Claim Benefit Determination as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated	15 days	30 days
Extension permitted during initial benefit determination?	No ¹	No	Yes, one 15-day extension.	Yes, one 15-day extension
First (initial) Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days
Plan must make Appeal Claim Benefit Determination as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated	15 days	within the timeframe for Board meetings, outlined below
Second Appeal Review must be submitted to the Plan within:	NA	NA	180 days of receipt of the first level appeal determination	NA
Plan must make Second Appeal Claim Benefit Determination as soon as possible but no later than:	NA	NA	15 days	NA
Extension permitted during appeal review?	No	No	No	No

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

Post-Service Timeframes for Multiemployer Plan with Committee or Boards of Trustees that meet at least Quarterly		
Appeal filed within 30 days of the next Board meeting:	Board review occurs no later than the second meeting following receipt of the appeal	If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal.
Appeal filed more than 30 days before next Board meeting:	Board review occurs at the next Board meeting date.	If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal.
Board's decision on the appeal to be provided to Claimant as soon as possible after the Board decision but no later than 5 days after the Board's decision date.		

Section 20: LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You or any other Claimant may not start a lawsuit or other legal action to obtain Plan Benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal

review procedures described in this document) **for every issue deemed relevant by the Claimant**, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly. No lawsuit may be started more than two (2) years after the Board of Trustees renders a final decision on appeal.

Section 21: DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

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

SECTION 22: ELIMINATION OF CONFLICT OF INTEREST

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

SECTION 23: EXTERNAL REVIEW OF CLAIMS

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

You may seek further external review, by an Independent Review Organization (IRO), only in the situation where your appeal of a health care claim, whether Urgent, Concurrent, Pre-Service or Post-Service claim is denied and it fits within the following parameters:

- The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment;
- The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time; and/or
- The denial relates to compliance with the surprise billing and cost-sharing protections under the No Surprises Act. A denial relates to the surprise billing and cost-sharing protections under the No Surprises Act if the claim involves at least one of the following:
 - (1) items or services related to an Emergency Medical Condition rendered by an Out-of-Network Provider;
 - (2) items or services that do not relate to an Emergency Medical Condition rendered by an Out-of-Network Provider at an In-Network Hospital or Facility; this applies to Anesthesia, pathology, radiology, laboratory, neonatology, Assistant Surgeon, hospitalist, or intensivist services; or
 - (3) air ambulance services rendered by an Out-of-Network Provider.

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

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

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

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

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

A. Preliminary Review of Standard Claims

- 1) Within five (5) business days of the Plan's receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:
 - a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
 - b. The Adverse Determination satisfies the above-stated requirements for external review and does not relate to your failure to meet the requirements for eligibility under the terms of the Plan or to a denial that is based on a contractual or legal determination or to a failure to pay premiums causing a retroactive cancellation of coverage;
 - c. You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations you are not required to do so); and
 - d. You have provided all of the information and forms required to process an external review.
- 2) Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:
 - a. If your request is complete and eligible for external review; or
 - b. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll free number 866-444-EBSA (3272)).
 - c. If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

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

- 1) If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:
 - a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days)
 - b. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.
 - c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. **Reconsideration** by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
 - d. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) Health Care Providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
 - e. The assigned IRO will provide written notice of its final external review decision to you and the Plan **within 45 days** after the IRO receives the request for the external review.

- i. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
 - ii. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).
- f. The assigned IRO's decision notice will contain:
- i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, Health Care Provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);
 - ii. The date that the IRO received the request to conduct the external review and the date of the IRO decision;
 - iii. References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
 - iv. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
 - v. A statement that the IRO's determination is binding on the Plan and you (unless other remedies may be available to you or the Plan under applicable State or Federal law);
 - vi. A statement that judicial review may be available to you; and
 - vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.
- g. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

2) External Review of Expedited Urgent Care Claims

A. You may request an expedited external review if:

- 1) you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- 2) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but you have not yet been discharged from a facility.

B. Preliminary Review for an Expedited Claim

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

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

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

under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

- 3) The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- 4) The IRO will provide notice of their final expedited external review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.
 - a. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
 - b. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a), subject to the Plan's limitation on when a lawsuit may be started under Section 20 of this Article.

3. Overview of the Timeframes During the Federal External Review Process.

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (<i>generally after internal claim appeals procedures have been exhausted</i>)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan performs preliminary review	Within 5 business days following receipt of an external review request	Immediately
<ul style="list-style-type: none"> • Plan's notice to Claimant regarding the results of the preliminary review 	Within 1 business day after Plan's completion of the preliminary review	Immediately
<ul style="list-style-type: none"> • When appropriate, Claimant's timeframe for perfecting an incomplete external review request 	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan assigns case to IRO	In a timely manner	Expeditiously
Notice by IRO to Claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the Plan to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the Claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously
IRO forwards to the Plan any additional information submitted by the Claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously
If (on account of the new information) the Plan reverses its denial and provides coverage, a Notice is provided to Claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
External Review decision by IRO to Claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the Claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to Claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's Adverse Benefit Determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

ARTICLE XIII: COORDINATION OF BENEFITS (COB)

Section 1: HOW DUPLICATE COVERAGE OCCURS

This Article describes the circumstances when a Participant may be entitled to health care benefits (including medical) under this Plan and may also be entitled to recover all or part of his health care expenses from some other source. In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if the Participant is also covered by:

1. Another group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA continuation coverage);
2. Medicare;
3. Other government program, such as Medicaid, Tricare, or a program of the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical/dental/vision expenses, or any coverage provided by a federal, state or local government or agency;
4. Workers' compensation;
5. Coverage resulting from a judgment at law or settlement;
6. Any responsible third party, its insurer, or any other source on behalf of that party;
7. Any first party insurance (e.g., medical, personal injury, no-fault, underinsured motorist or uninsured motorist coverage);
8. Any policy from any insurance company or guarantor of a third party; or
9. Any other source (e.g., crime victim restitution, medical, disability, school insurance).

The Plan's benefit coverage is excess to other responsible parties' coverage sources such as coverage from a judgment, settlement, or any responsible party.

Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

This Article describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, this Plan will not provide coverage if the Participant can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when the Participant actually recovers some or all of his losses from a third party (see also the subrogation provisions in this Article). Duplicate recovery of health care expenses may also occur if a third party caused the Injury or Illness by negligent or intentionally wrongful action.

Section 2: COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits Article, the word "plan" refers to any group medical policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical services incurred by the Covered Individual or that provides health care services to the Covered Individual. A "group plan" provides its benefits or services to employees, or members of a group who are eligible for and have elected coverage (including but not limited to a plan that provides the Covered Individual with COBRA continuation coverage).
2. Many families that have more than one family member working outside the home are covered by more than one medical plan. If this is the case with your family, **you must let this Plan and its Claims Administrators or its insurers know about all your coverages when you submit a claim.**
3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Section 3: WHICH PLAN PAYS FIRST: ORDER OF BENEFIT DETERMINATION RULES

The Overriding Rules

1. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

2. When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The COB rules for this Plan are:

Rule 1: Non-Dependent/Dependent

- A. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.
- B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee); then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

- A. The plan that covers the parent whose Birthday falls earlier in the Calendar Year pays first; and the plan that covers the parent whose Birthday falls later in the Calendar Year pays second, if:
1. the parents are married;
 2. the parents are not separated (whether or not they ever have been married); or
 3. a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.
- B. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.
- C. The word "Birthday" refers only to the month and day in a Calendar Year; not the year in which the person was born.
- D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, that plan pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree. If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose Birthday falls earlier in the Calendar Year pays first, and the plan that covers the parent whose Birthday falls later in the Calendar Year pays second.
- E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their Spouses (if any) is:
1. The plan of the custodial parent pays first; and
 2. The plan of the non-custodial parent pays second; and
 3. The plan of the Spouse of the custodial parent pays third; and
 4. The plan of the Spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off Employee

- A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.
- B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

- A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.
- B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- C. If a person is covered other than as a dependent (that is, as an employee, former employee, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

- A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.
- B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
- C. The start of a new plan does not include a change:
 1. in the amount or scope of a plan's benefits;
 2. in the entity that pays, provides or administers the plan; or
 3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).
- D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Section 4: HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY

- a. **Secondary Liability of this Plan For Active Employee Plan Participants:** When this Plan pays second, it will pay, 100% of "Allowable Expenses" less whatever payments were actually made by the plan (or plans) that paid first. It will reduce its benefits so that the total benefits paid or provided by all coordinating plans is not more than 100% of total Allowable Expenses and in no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first.
- b. **"Allowable Expense"** means the **lowest** of the health care service or expense, including deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:
 - The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.
 - If the coordinating plans determine benefits on the basis of Usual and Customary Charges, any amount in excess of the lowest Usual and Customary Charge is not an Allowable Expense.
 - If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - If one coordinating plan determines benefits on the basis of Usual and Customary Charges and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the Allowable Expense for all plans.
 - When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Precertification/Medical Review in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays second.

Allowable Expenses **do not include** expenses for services received because of an occupational sickness or Injury, or expenses for services that are excluded or not covered under this Plan.

Section 5: ADMINISTRATION OF COB

- a. To administer COB, the Plan reserves the right to:
 - exchange information with other plans involved in paying claims;
 - require that you or your Health Care Provider furnish any necessary information;
 - reimburse any plan that made payments this Plan should have made; or
 - recover any overpayment from your Hospital, Physician, other Health Care Provider, other insurance company, you or your Dependent.
- b. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.
- c. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.
- d. This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits.

- e. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.
- f. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.
- g. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Section 6: COORDINATION WITH MEDICARE

- a. **Entitlement to Medicare Coverage:** Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (generally after a waiting period).
- b. **Medicare Participants May Retain or Cancel Coverage Under This Plan:** If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, the eligible individual may either retain or cancel coverage under this Plan. If the eligible individual 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 any of the Eligible Employee's Dependents are covered by Medicare and the employee **Cancels** that Dependent's coverage under this Plan, that Dependent will **not** be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the Employee. Neither this Plan nor the Employee's Employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

- c. **Coverage Under Medicare and This Plan When Totally Disabled:** If an Eligible Employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the Eligible Employee will no longer be considered to remain actively employed. As a result, once entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an Eligible Dependent of an Active Employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that Dependent and Medicare pays second. This Medicare secondary payer rule applies if any Contributing Employer has 100 or more employees.
- d. **Coverage Under Medicare and This Plan for End-Stage Renal Disease:** If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting with the first month the individual is eligible for Medicare based on ESRD, even if the individual has not enrolled in Medicare. Then, starting with the 31st month after the start of Medicare coverage/eligibility, Medicare pays first and this Plan pays second.
- e. **How Much This Plan Pays When It Is Secondary to Medicare**

1. **When Covered by this Plan and also by Medicare Parts A, and/or B:** When an eligible individual under this Plan is also covered by Medicare Parts A and/or B and this Plan is secondary to Medicare, this Plan pays as follows: the Plan's Deductible is taken on the balance after Medicare's payment or allowance, then the Plan pays the appropriate Coinsurance on the balance. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Billed Charges of the Health Care Provider.
2. **When Covered by this Plan and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) without prescription drug benefits:** If an individual is covered by both this Plan and a Medicare Advantage program, this Plan will NOT reimburse any applicable copayments and will NOT pay the same benefits provided for active.
3. **When Covered by this Plan and Eligible for but Not Covered by Medicare:** When the Covered individual is covered by this Plan and is also **eligible for, but is not enrolled in Medicare Parts A, B and/or D**, this Plan pays the same benefits provided for Active Employees less the amounts that would have been paid by Medicare had the individual been covered by Medicare Parts A, B and D and not on the Billed Charges of the Health Care Provider.
4. **When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract:** Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare) under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a

contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

5. **When Covered by this Plan and also by Medicare and the Veteran's Affairs benefits:** Either Medicare or Veteran's pays first, this Plan pays second. Under Medicare's COB rules, Veteran's (VA) claims will not be covered. If a claim is not filed with the VA, then Medicare will pay. VA and Medicare will not both reimburse on the same claim.
6. **When Covered by this Plan and also by a Medicare Part D Plan such as a Prescription Drug Plan:** Any Medicare-eligible person can elect coverage under a Medicare prescription drug plan in place of, or in addition to, this group health Plan's prescription drug coverage. Medicare must be notified of any duplicate prescription drug coverage that you maintain.
 - a. If you have dual coverage under both this Plan and Medicare, the following explains if and how this Plan and Medicare will coordinate that dual coverage:
 1. For Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary (subject to the 30-month coordination period for ESRD).
 - b. For more information on Medicare Part D refer to the "Medicare and You" handbook provided to you by Medicare or www.medicare.gov or contact the Administrative Office.

Section 7: COORDINATION WITH OTHER GOVERNMENT PROGRAMS

- a. **Medicaid:** If an individual is covered by both this Plan and Medicaid, or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or a or a State Children's Health Insurance Program (CHIP) pays second.
- b. **Tricare:** If a Covered Dependent is covered by both this Plan and Tricare Program, the program that provides health care services to dependents of active armed services personnel, this Plan pays first and Tricare pays second. For an employee called to active duty for more than 30 days, and who is covered by both Tricare and this Plan, Tricare is primary and this Plan is secondary.
- c. **Veterans Affairs Facility Services:** If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related Illness or Injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related Illness or Injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.
- d. **Motor Vehicle Coverage Required by Law:** If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage (or should have been covered because of state law), including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second.
- e. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.
- f. **Other Coverage Provided by State or Federal Law:** If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Section 8: WORKERS' COMPENSATION

- a. This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law (or should have been covered but such coverage was declined/not purchased). If the individual's employer contests the application of workers' compensation law for the Illness or Injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, the individual must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee.

Section 9: FIRST OR THIRD PARTY LIABILITY/SUBROGATION

Reimbursement for Expenses paid as a result of Acts of First or Third Parties. If a Participant or Beneficiary receives benefits from this Trust for an Injury or Illness sustained from the acts or omissions of any first or third party, the Trust shall have the right to be reimbursed in the event the Participant or Beneficiary recovers all or any portion of the benefits paid by the Trust by legal action, settlement, or otherwise, regardless of whether such benefits were paid by this Trust prior to or after the date of any such recovery. The Participant or Beneficiary will not be entitled to receive any benefits for such expenses under this Trust unless he executes a Subrogation Agreement and agrees in writing to the following conditions:

- a. **Reimbursement to Trust.** The Participant or Beneficiary authorizes reimbursement to the Trust upon obtaining any monetary recovery from any party or organization for such Injury or Illness, whether by action at law, settlement or otherwise by virtue of executing a Subrogation Agreement, with the understanding that any and all monies recovered as a result of the actions of a first or third party shall be reimbursed to the Trust in accordance with these provisions.

- b. **Assignment of Rights.** The Participant or Beneficiary irrevocably assigns to the Trust all rights to recover monetary compensation from the first or third party to the extent of all benefits paid by this Plan and to give notice of this assignment directly to such first or third parties, their agents or insurance carriers, or to any agent or attorney who may represent the Participant or Beneficiary. The assignment shall entitle the Trust to reimbursement from any sums to be held or received by the following first or third parties which are due to the Participant or Beneficiary prior to any distribution of funds to the Participant or Beneficiary, and shall provide that such parties shall specifically direct that any and all monies recovered from any first or third party are to be reimbursed to the Trust in accordance with these provisions. The parties who shall be bound by such assignment are:
- (1) Any party or its insurance carriers making payments to or on behalf of the Participant or Beneficiary, including pursuant to any uninsured or under-insured motorist provision of any insurance policy; or,
 - (2) Any agent or attorney receiving payments for or on behalf of the Participant or Beneficiary.
- c. **Notice.** The Participant or Beneficiary agrees to notify the Trust of any claim or legal action asserted against any first or third party or any insurance carrier(s) for such Injuries or Illnesses, as well as the name and address of such first or third parties, insurance carrier(s), any agent or attorney who is representing or acting on behalf of the Participant or Beneficiary or the estate of the Participant or Beneficiary, or any person claiming a right through such Participant or Beneficiary, on a form to be supplied by the Trust.
- Discretion of the Board of Trustees.** The Board of Trustees, within its sole discretion, shall determine which of this Plan's rights and remedies is within the best interests of the Plan to pursue. The Trustees may decide to recover less than the full amount of excess payments or to accept less than full reimbursement if:
- (1) This Plan has made, or caused to be made, such reasonable, diligent, and systematic collection efforts as are appropriate under the circumstances; and
 - (2) Such decision is reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.
- e. **Subrogation.** The Plan shall have the independent right to bring suit in the name of the Participant or Beneficiary. The Plan shall also have the right to intervene in any action brought by the Participant or Beneficiary against any third party, to and including the insurance carrier of the Participant or Beneficiary under any uninsured or under-insured motorist provision or policy. The Participant or Beneficiary further agrees to take no action inconsistent with the requirements of this provision.
- f. **Cooperation With Trust.** The Participant or Beneficiary agrees to cooperate fully with the Trustees in the exercise of any Assignment or right of Subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Trust.
- g. **Withholding Future Benefits.** The Participant or Beneficiary agrees to acknowledge that this Trust shall have the Right of Recovery against the Participant or Beneficiary, should the Participant or Beneficiary and/or their legal representative fail to execute an Assignment, Subrogation Agreement or any other documents required herein, or fail to reimburse the Trust in accordance with these provisions. In addition, in such event, the Trust may withhold future benefit payments to be made on behalf of the Participant or Beneficiary until such time as the Trust is fully reimbursed as provided for in this Section.
- h. **Disclaimer.** If there is any reasonable cause to believe that the Injuries or Illnesses sustained by a Participant or Beneficiary were in any way the result of the acts or omissions of a first or third party or parties, but the Participant or Beneficiary disclaims any first or third party involvement, the Trust shall have the right to require the Participant or Beneficiary to sign a declaration, under penalty of perjury, regarding such disclaimer as a pre-condition to the payment of any benefits.
- i. **Separate Rights.** Each of the provisions set forth above relating to the right of this Trust to receive reimbursement for eligible expenses paid to or on behalf of a Participant or Beneficiary because of injuries sustained relating to or resulting from the acts and omissions of any first or third party is separate and any illegality or invalidity of any one provision shall not affect the legality or validity of any other provision.
- j. **Medical Expenses Incurred After Settlement or Final Judgment in First or Third Party Claim.** In the event a Participant or Beneficiary incurs medical expenses relating to his or her injuries or disabilities which are the subject of a Subrogation Agreement following any settlement or final judgment received from the first or third party (ies) responsible for the injuries, the Plan shall have no further responsibility to pay for such medical expenses. The Participant or Beneficiary shall agree to release and hold the Trust harmless from any further obligations under the Subrogation Agreement for any future medical expenses incurred following any settlement or final judgment received from the first or third party(ies) responsible for the injuries, except as provided below. Provision can be made for the continued payment of such medical expenses under the following circumstances:
- (1) Payment by the responsible first or third party(ies) pursuant to a settlement agreement, which is approved by the Fund in writing prior to the execution thereof. In that event, the rights of the Participant or Beneficiary to the continued payment of medical expenses shall also be assigned to the Trust under the Subrogation Agreement and the Participant or Beneficiary shall be required to reimburse the Trust for 100% of all medical expenses paid by the Trust under this

provision following execution and payment by the responsible first or third party(ies) under the settlement agreement or final judgment.

- (2) At the discretion of the Trustees, payment by the Fund following settlement or final judgment a Participant or Beneficiary receives from the first or third party(ies) responsible for the injuries or responsible for reimbursement of the injuries, to the extent that there are no remaining net settlement proceeds to pay for further medical expenses and all first or third party insurance policy limits have been exhausted, and the Participant or Beneficiary certifies under penalty of perjury that there are no further sources of first or third party recovery to pursue.
- k. **This Plan does not recognize the Make-Whole Doctrine.** This Plan is entitled to obtain restitution of any amounts owed to it either from first or third-party funds received by the Participant or the Beneficiary, regardless of whether the Participant or the Beneficiary have been made whole for losses sustained as a result of the act of a first or third party.
- l. **This Plan expressly rejects the Common Fund Doctrine with respect to payment of attorney's fees.** A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise this Plan's equitable (or other) right to obtain full restitution.
- m. **Cooperation with Trust.** The Participant or Beneficiary, as well as their attorney or agent, shall cooperate fully with the Trustees in the exercise of any Assignment or right of Subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Trust.
- n. **Direction to Agent or Attorney.** The Participant or Beneficiary shall direct that the agent or attorney shall readily comply with the terms of the Subrogation Agreement to reimburse the Trust in accordance with the provisions set forth above.
- o. **Completed Subrogation Agreement.** A Participant or Beneficiary must provide a completed Subrogation Agreement and any requested supporting documents within ninety (90) days of the request being mailed to the Participant or Beneficiary. If a completed Subrogation Agreement and/or requested supporting documentation are not returned to the Trust within those ninety (90) days, any accident-related claims will be denied and not paid by the Trust.

ARTICLE XIV: DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT

Section 1: DEATH BENEFIT

Benefits will be payable upon the death of a Participant as soon as administratively feasible after the original death certificate is received by the Administrative Office. Benefits are only available to the Disabled or COBRA Employees who opt to self-pay the required amount.

DEATH BENEFIT AMOUNT	
For the death of an Active Employee or an employee who makes self-payments (Disabled or COBRA) and opts to self-pay the required amount to be eligible for the Death Benefit, the benefit is payable to the designated beneficiary.	
Death of	Death Benefit Amount Payable
Active Employee or Disabled or COBRA Employee (who opts to self-pay the required amount)	\$20,000

Eligibility for Death Benefits will end the earlier of:

1. If a Disabled or COBRA Employee (who opts to self-pay the required premium), the last day of the calendar month in which you reach age 65,
2. The last day of the calendar month in which your employment terminates, unless you are Disabled or a COBRA Employee and you elect to self-pay the required amount to be eligible for the Death Benefit, or
3. The date an Active Employee or a former employee who elects to self-pay premiums is no longer eligible for benefits from the Plan.

Section 2: ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Benefits will be payable to all Eligible Active, Disabled and COBRA Employees upon bodily Injury caused solely by an Accident if the loss occurs within one year of the accident. Benefits are only available to Disabled and COBRA Employees who opt to self-pay the required premium.

The amount of your full AD&D benefit is \$20,000; however, certain losses result in a benefit that is a lesser percentage of the full amount as detailed in the table below. The AD&D benefit is separate from and in addition to any death benefit that may also be payable.

AD&D TABLE OF LOSSES	
<ul style="list-style-type: none"> • No more than 100% of your AD&D Benefit will be paid for all losses resulting from one accident. • No AD&D Benefit will be paid for loss of thumb and index finger of the same hand if an AD&D Benefit is payable for the loss of the entire hand. • Maximum Benefit = \$20,000 	
Loss	Percentage of the AD&D Benefit Payable
a. Life	100%
b. One hand or one foot	50%
c. Sight in one eye, speech or hearing in both ears	50%
d. Two of more of the losses listed in b & c above	100%
e. Thumb and index finger of the same hand	25%
f. Quadriplegia	100%
g. Hemiplegia	50%
h. Paraplegia	50%

Accidental Death and Dismemberment Exclusions

No AD&D benefit is payable if the Accident or Loss is caused or contributed to by any of the following:

1. War or act of War. War means declared or undeclared war, whether civil or international and any substantial armed conflict between organized forces of a military nature.
2. Suicide or other intentionally self-inflicted Injury, while sane or insane.
3. Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.
4. The voluntary use or consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a Physician.

5. Sickness or Pregnancy existing at the time of the accident.
6. Heart attack or stroke.
7. Medical or surgical treatment for any of the above.

Accidental Death and Dismemberment Eligibility

Accidental Death and Dismemberment Benefits are payable to an Eligible Active, Disabled or COBRA Employee who incurs a loss listed in the AD&D Table of Losses, except that benefits for Accidental Death shall be payable to the designated beneficiary. Benefits are only available to the Disabled or COBRA Employees who opt to self-pay the required amount. To be considered a "loss," **all** of the following requirements must be met:

1. The loss must be caused solely and directly by an accident.
2. The loss must occur independently of all other causes.
3. The loss must occur within 365 days of the accident.
4. With respect to loss of life, the loss must be evidenced by a certified copy of the death certificate.
5. With respect to all other losses, the loss must be certified by a Physician in the appropriate specialty as determined by the Administrative Office.
6. With respect to loss of life, death will be presumed if you disappear and the disappearance:
 - a. is caused solely and directly by an Accident that reasonably could have caused loss of life.
 - b. occurs independently of all other causes, and
 - c. continued for a period of 365 days after the date of the accident, despite reasonable search efforts.
7. With respect to a hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint, whether or not surgically reattached.
8. With respect to sight, loss means entire, uncorrectable and irrecoverable loss of sight. With respect to speech, loss means entire, uncorrectable and irrecoverable loss of audible speech. With respect to hearing, loss means entire, uncorrectable and irrecoverable loss of hearing in both ears. With respect to thumb and index finger of the same hand, loss means actual and permanent severance from the body at or above the metacarpophalangeal joints.
9. With respect to quadriplegia, hemiplegia and paraplegia, loss must be permanent, complete and irreversible. Quadriplegia means total paralysis of both upper and lower limbs. Hemiplegia means total paralysis of the upper and lower limbs on the same side of the body. Paraplegia means total paralysis of both lower limbs.

Termination of Accidental Death and Dismemberment Benefits

Eligibility for Accidental Death and Dismemberment Benefits will end on the date an active, Disabled or COBRA Employee is no longer eligible for benefits from the Plan. Benefits are available to Disabled or COBRA Employees who opt to self-pay the required premium.

Section 3: BENEFICIARY(IES)

Beneficiary means a person you name to receive death benefits. You must name the same beneficiary(ies) to receive both the Death Benefit and the Accidental Death Benefit. You may name a primary beneficiary and a contingent beneficiary. If no primary beneficiaries survive, the Plan will pay the Death Benefit and Accidental Death Benefit to your contingent beneficiary(ies). You may also name one or more beneficiary in each class. If you name two or more beneficiaries in a class:

1. Two or more surviving beneficiaries will share equally, unless you provide for unequal shares.
2. If you provide for unequal shares in a class and two or more beneficiaries in that class survive, the Plan will pay each surviving beneficiary his designated share. If one or more beneficiaries are deceased at the time the Death Benefit and Accidental Death Benefit are payable, the Plan will split the benefit that is payable to the deceased beneficiary among the living beneficiaries in the same proportion that you designated.
3. If only one beneficiary in a class survives, the Plan will pay the total Death Benefit and Accidental Death Benefit to that beneficiary.

You can change a beneficiary at any time, in writing, on the beneficiary designation form provided by the Administrative Office, without the consent of the beneficiary as long as you have signed and dated the beneficiary designation form and it is received in the Administrative Office or by your Employer prior to your death. Any change in beneficiary that meets these requirements will be effective on the date it is received by the Administrative Office or by your Employer.

If you do not name a beneficiary prior to your death or if all your named beneficiaries pre-decease you, your Death Benefit will be paid in equal shares to the first surviving group of the following:

1. your spouse;
2. your children;
3. your parents;

4. your brothers and sisters;
5. your estate

Notwithstanding the foregoing, an Employee's designation of his/her Spouse as beneficiary shall be 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.

Section 4: BENEFIT PAYMENT

The designated beneficiary of an Active Employee or self-paying Disabled or COBRA Employee will be eligible for payment in the event of the death of the active or self-paying employee. Payment is made directly to the active or self-paying employee in the event of other specified losses incurred by such individuals. Benefits will be payable as soon as administratively feasible upon proof of accidental death or dismemberment, subject to the claims procedures described in Section 5 below.

Section 5: CLAIMS PROCEDURES

Filing a Claim: Claims should be filed on the appropriate forms available from the Administrative Office.

Proof of Loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible. If proof of loss is filed outside these time limits, the claim may be denied. These limits will not apply while the eligible person or beneficiary lacks legal capacity.

Proof of loss means written proof that a loss occurred. For a Death or Accidental Death claim, the proof of loss is the original death certificate. For an Accidental Dismemberment claim, the proof of loss includes a Physician's statement of the dismemberment along with any other documentation that may be requested.

Proof of loss includes any other information the Administrative Office may reasonably require in support of a claim. Proof of loss must be in writing and must be provided at the expense of the Claimant. No benefits will be provided until the Administrative Office receives proof of loss.

Investigation of Claim: The Trustees may have you examined at their own expense at reasonable intervals. Any such examination will be conducted by specialists of their choice. The Trustees may have an autopsy performed at their expense, except where prohibited by law.

Time of Payment: The Administrative Office will pay benefits within 90 days after proof of loss is satisfied.

Notice of Decision On Claim: The Administrative Office will evaluate a claim for benefits promptly after they receive it. With respect to all Death and AD&D claims, within 90 days after the Administrative Office receives the claim, they will send the Claimant: (a) a written decision on the claim; or (b) a notice that the Administrative Office is extending the period to decide the claim for an additional 90 days.

If the Administrative Office extends the period to decide the claim, they will notify the Claimant of the following: (a) the reasons for the extension; (b) when they expect to decide the claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information they need to resolve those issues.

If the Administrative Office requests additional information, the Claimant will have 45 days to provide the information. If the Claimant does not provide the requested information within the 45 days, the Administrative Office may decide the claim based on the information they have already received.

If the Administrative Office denies any part of the claim, they will send the Claimant a written notice of denial containing:

1. The specific reason or reasons for their decision.
2. Reference to the specific parts of the Plan on which their decision is based.
3. A description of any additional information needed to support the claim and an explanation of why such information is necessary.
4. A description of the Plan's appeal procedures and the time limits applicable to such procedures.
5. Information concerning the right to bring a civil action for benefits under Section 502(a) of ERISA if the claim is denied on review.

Review Procedure: If all or part of a claim is denied, the Claimant may appeal the decision to the Board of Trustees by submitting a request for review to the Administrative Office. The Claimant must request a review in writing within 60 days after receiving notice of the denial of the claim.

The Claimant may send written comments, documents, records, or other items to support the claim. The Claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. The review will consider any written comments, documents, records, or other items the Claimant submits to support the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The Board of Trustees will render a determination on your appeal no later than the date of the regularly scheduled quarterly meeting immediately following the Administrative Office's receipt of your request for review. If your request for review was received within 30 days of the date of the next regularly scheduled quarterly meeting, the Trustees' review and determination will be made no later than the second regularly scheduled quarterly meeting following the Administrative Office's receipt of your request for review. If special circumstances make an extension of time necessary, the Trustees will decide the appeal no later than the regularly scheduled quarterly meeting immediately following the one at which the appeal was originally scheduled to be decided. If an extension of time is necessary, the Administrative Office will send you a written notice before the extension commences. The written notice will explain the special circumstances requiring the extension of time and the date that the Trustees will render a determination on your appeal.

The Administrative Office will provide you a written notice of the decision on appeal as soon as possible but no later than five days after the decision is made. If any part of your appeal is denied, you will receive a written notice of denial containing:

1. The specific reason or reasons for the decision.
2. Reference to the specific parts of the Plan on which their decision is based.
3. Information concerning the Claimant's right to receive, upon request and free of charge, reasonable access to, and copies of, non-privileged documents and records relevant to the claim.
4. Information concerning the right to bring a civil action for benefits under Section 502(a) of ERISA.

Your right to bring a civil action for benefits under Section 502(a) of ERISA shall be subject to the requirements and time limitations set forth in the Claim Filing & Appeal Information Article, Section 20.

ARTICLE XV: GENERAL PROVISIONS AND ERISA INFORMATION

Section 1: NAME OF THE PLAN

Eighth District Electrical Benefit Fund BASIC Plan

Section 2: NAME AND ADDRESS OF PLAN SPONSOR/PLAN ADMINISTRATOR

Board of Trustees of the Eighth District Electrical Benefit Fund
P.O. Box 30751
Salt Lake City, Utah 84130
Phone: 844-989-2321

This Plan is administered exclusively by the Board of Trustees which consists of representatives appointed by the Union and by the Employers through their collective bargaining associations. The Trustees serve without compensation.

Section 3: EMPLOYER IDENTIFICATION NUMBER (EIN)

84-0730298

Section 4: TYPE OF PLAN AND PLAN NUMBER

Employee Group Health and Welfare Benefits Plan including:

1. Medical expense benefits (501);
2. Personal Care Account (501);
3. Death Benefit and AD&D Insurance (501)

Section 5: TYPE OF ADMINISTRATION

The Eighth District Electrical Benefit Fund is a group health plan and self-funds the eligible Basic Medical Plan Benefits (including Prescription Drugs), Personal Care Account (PCA), Death Benefit and Accidental Death and Dismemberment benefits under the Plan. Claims for these benefits are administered by an independent Claims Administrator (referred to as the Administrative Office) as listed on the Quick Reference Chart in the front of this document.

Section 6: CLAIMS ADMINISTRATORS

With respect to all matters regarding eligibility and adjudication of medical Claims, Personal Care Account Claims, Death Benefit and Accidental Death and Dismemberment Benefits, please contact the Administrative Office at their address listed on the Quick Reference Chart in the front of this document.

With respect to the outpatient drug benefits through retail and mail order pharmacies, please contact the Prescription Drug Program whose contact information is listed on the Quick Reference Chart in the front of this document.

Section 7: AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made on any Plan Trustee, the Plan Administrator, or on the Plan's General Counsel:

Blake & Uhlig, P.A.
6803 West 64th Street, Suite 300
Overland Park, Kansas 66202
(913) 321- 8884

BeneSys Administrators
5295 South Commerce Drive, Suite 220
Murray, Utah 84107

or

BeneSys Administrators
4704 Harlan Street, Suite 205
Denver CO, 80212

Section 8: COLLECTIVE BARGAINING AGREEMENT

This Plan is maintained according to Collective Bargaining Agreements between employers and the Union. A copy of such agreement may be obtained by Plan Participants upon written request to the Administrative Office, and is available for examination by Plan Participants. A complete list of the employers and employee organizations sponsoring the plan may be obtained by Participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by Participants and beneficiaries.

Section 9: FUNDING MEDIUM

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust of the Eighth District Electrical Benefit Fund for the purpose of providing benefits to eligible persons and defraying reasonable administrative expenses. All self-funded benefits are provided directly through the Trust Fund as set forth in the Plan Rules.

Section 10: CONTRIBUTION SOURCE

All contributions to the Plan are made by employers in accordance with Collective Bargaining Agreements between the Eighth District Electrical Benefit Fund and employers in the industry. The Collective Bargaining Agreement requires contributions to the Plan at a fixed rate per hour worked. The Administrative Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of eligible persons working under the Collective Bargaining Agreement, additional information about the Collective Bargaining Agreement, and the Fund's investment of assets and checking accounts.

Section 11: PLAN YEAR

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

Section 12: PLAN TRUSTEES (For current officer positions contact the Administrative Office)

Management Trustees

Rory Berumen
Rocky Mountain Chapter, NECA
495 Uinta Way, Suite 240
Denver, CO 80203

Patrick Carlson
Wyoming Chapter, NECA
158 South Fenway
Casper, WY 82601

Klaas DeBoer, Jr.
Intermountain Chapter, NECA
2125 West 2300 South
West Valley City, UT 84119

James Peterson
1535 Smoochers Circle
Colorado Springs, CO 80904

Jeremy Wheeler
Idaho Chapter, NECA
Wheeler Electric
469 W. 16th Street
Idaho Falls, ID 83402

Scott Wilson
Montana Chapter, NECA
Cascade Electric
903 10th Ave North
Great Falls, MT 59401

Susan King, *Alternate*
Southern Colorado, NECA
1070 S. Eighth St.
P.O. Box 61000
Colorado Springs, CO 80960

Union Trustees

Daniel Mondragon
IBEW Local #113
2150 Naegele Rd
Colorado Springs, CO 80904

George Bland
IBEW Local Union No. 768
P.O. 1095
Kalispell, MT 59903

Clay Hirning
IBEW Local #449
1537 Baldy Ave.
Pocatello, ID 83205-4949

Jerry Payne
IBEW Local #322
691 English Drive
Casper, WY 82601

Zachary Esquibel
IBEW Local #68
5660 Logan St
Denver, CO 80216

Steve Woodman
IBEW Local #354
3400 West 2100 South
Salt Lake City, UT 84119

Jeremy Redman, *Alternate*
IBEW Local #291
225 North 16th Street, Suite 110
Boise, ID 83702

Lee Stephens, *Alternate*
Sturgeon Electric
12150 E. 112th Avenue
Henderson, CO 80960

Tom Kelley, *Alternate*
IBEW Local #12
P.O. Box 12
Pueblo, CO 81002

Jeff Morrow, *Alternate*
IBEW Local Union #415
810 Fremont Ave
Cheyenne, WY 82001

Section 13: PLAN'S REQUIREMENTS FOR ELIGIBILITY AND BENEFITS

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of benefits are described in the Eligibility Article in this document. The benefits provided by the Plan are described in the remaining Articles of this SPD/Plan Rules document.

Section 14: STATEMENT OF ERISA RIGHTS

As a Participant in the **Eighth District Electrical Benefit Fund Basic Plan**, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits:

1. Examine, without charge, at the Administrative Office (whose address is listed on the Quick Reference Chart in the front of this document) and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

1. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the COBRA Article. You and/or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

1. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.
2. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

1. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules, as discussed in the Claims Filing and Appeals Information Article of this document.
2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
3. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the Plan's Claims Filing and Appeal information on the requirement to appeal a denied claim before filing a lawsuit.
4. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.

5. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

1. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.
2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

Section 15: PAYMENT OF CLAIMS

Benefits under the Plan and this Restated Plan Document will be paid only after receipt by the Administrative Office of written notice of claim filed by the Participant or someone on the Participant's behalf if they are unable to file such written notice of claim, properly completed covering the occurrence, character and extent of the event for which the claim is made and supported by proper documentation.

Section 16: ASSIGNMENT OF BENEFITS

Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, a Plan Participant may direct that benefits due him/her be paid to a Health Care Provider in consideration for medical and/or hospital services rendered, or to be rendered. A direction to pay a Provider is not an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding.

Section 17: FILING OF CLAIMS/APPEAL OF CLAIMS

Benefits will be paid by the Plan only if written notice of claim is filed in accordance with the Claim Filing and Claim Appeal Information Article of this document. Appeals may be made by following the appeals procedures discussed in the Claim Filing and Claim Appeal Information Article.

Section 18: AUTHORITY TO INTERPRET PLAN

The Board of Trustees, or where Board of Trustee responsibility has been delegated to others, such delegates shall have complete authority and discretion to determine the standard of proof required in any case, to determine eligibility and benefits, and to construe, apply and interpret this Restated Plan Document. The decisions of the Board of Trustees or its delegates shall be final and binding.

All questions or controversies, of whatsoever character, arising in any manner or between any parties or persons in connection with this Plan or its operation, whether as to any claim for benefits, or as to the construction of language or meaning of this Plan Document, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Board of Trustees or, where Board of Trustee responsibility has been delegated to others, to such delegates for decision. The decision of the Board of Trustees or its delegates shall be binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court having jurisdiction over such matters.

Section 19: PROOF OF CLAIM

The Board of Trustees, at its own expense, shall have the right and opportunity to examine the person of any Participant when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Notice of claim forms, as well as other forms and methods of administration and procedure, will be solely determined by the Trustees.

Section 20: WORKERS' COMPENSATION

The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance Laws or similar legislation.

Section 21: TRUST AGREEMENT

The provisions of this Restated Plan Document are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Restated Plan Document and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

Section 22: FACILITY OF PAYMENT

In the event the Plan determines that the Participant is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Participant has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Participant, pay any amount otherwise payable to the Participant to the husband or wife or relative by blood of the Participant, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Participant before all amounts payable under the Plan have been paid, the Plan may pay any such amount to any person or institution determined by the Plan to be equitably entitled thereto.

The remainder of such amount shall be paid to one (1) or more of the following surviving relatives of the Eligible Employee: lawful Spouse, child or children, mother, father, brothers or sisters, or to the Participant's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

Section 23: SUBROGATION

This Plan shall be subrogated and shall succeed to the Participant's rights of recovery from a third party or under any uninsured or underinsured automobile insurance coverage for incurred Hospital, medical and surgical expenses. The Participant shall pay over to the Plan all sums recovered by suit, settlement or otherwise in an amount equal to such services or benefits which the Plan provided, subject to the provisions of any Subrogation Assignment Agreement between the Participant and the Fund. The Participant shall, upon request, execute and deliver such instrument or papers including a written subrogation agreement with the Plan as may be required and do whatever else is necessary to carry out this provision. Refer also to the Coordination of Benefits Article.

Section 24: AMENDMENT AND TERMINATION

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all employees, the Board of Trustees expressly reserves the right, at any time and from time to time, but upon a non-discriminatory basis, to:

- a. terminate, change, or amend either the amount or the conditions with respect to any benefit;
- b. alter or postpone the method of payment of any benefit;
- c. amend, change, or rescind any provisions of this Restated Plan Document;
- d. determine the amount of the required contribution by Contributing Employers and Participants;
- e. change the Providers for any portion of the Plan of Benefits; or
- f. terminate the Plan of Benefits in its entirety or terminate portions of the Plan of Benefits.

Such amendment, termination or change shall be documented in written amendment form approved by action of the Board of Trustees.

Section 25: DISCLAIMER

The Benefits provided in this Restated Plan Document is not insured by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amounts in the Fund collected and available for such purpose.

Section 26: TITLES

Titles of provisions are for convenience of reference only and are not to be considered in interpreting this Plan. The headings of chapters/articles, sections, subchapters or subsections and text appearing in bold or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

Section 27: GENDER

Wherever any words are used in this Plan in masculine gender, they should be construed as though they were also used in the feminine gender in all situations where they would so apply; wherever any words are used in the Plan in the singular form, they should be construed as though they were also in the plural form in all situations where they would so apply, and vice versa.

Section 28: NON-REVERSION OF EMPLOYER REFUNDS

It is expressly understood that in no event shall any of the corpus or assets of the Plan revert to the Contributing Employers or Participants or be subject to any claims of any kind or nature by the Contributing Employers or Participants, except for employee benefits made available to Participants, under the Plan, provided, however, that contributions made by a Contributing Employer by mistake of fact or law (other than a mistake relating to whether the Plan is described in Section 401(a) of the Internal Revenue

Code of 1986 or the Trust which is part of such Plan is exempt from taxation under Section 501(a) of such Code) may, but are not required, to be returned to such Contributing Employer within six (6) months after the Fund determines that the contribution was made by such a mistake.

Section 29: NO VESTED RIGHTS

No Participant, or any other person shall have any vested right to any benefit(s) provided by the Plan or under this Restated Plan Document.

Section 30: SUBMISSION OF FALSIFIED OR FRAUDULENT CLAIMS (RESCISSION OF COVERAGE)

All claims or enrollment cards submitted to the Fund shall be honest, accurate and as complete as possible. If the Board of Trustees finds, at any time, that there has been an intentional falsification of any document submitted in support of a claim, either by use of forgery or intentionally inaccurate information or any other fraudulent means whatsoever, it shall have the right to terminate coverage (after giving at least a 30-day written notice). The coverage to be terminated, if the Board of Trustees so determines, shall be that of the Eligible Employee and Dependents 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 the Claim Filing and Appeal Information Article.

Section 31: NO LIABILITY FOR PRACTICE OF MEDICINE

Neither the Plan, the Board of Trustees nor any of their designees are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or Injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Section 32: WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) AND NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NEWBORNS' ACT)

This Plan complies with the Women's Health and Cancer Rights Act and the Newborns' and Mothers' Health Protection Act. See the information described under Reconstructive services and Maternity services in the Schedule of Medical Benefits chart in this document.

Section 33: HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Protected Health Information (PHI). The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH).

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor, to the extent necessary to review a benefit claim, appeal or for other reasons related to the administration of the Plan.

Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

- a. **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to Coordination of Benefits or management of health care by a Health Care Provider with a third party and consultations and referrals between one or more of your Health Care Providers.
- b. **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan Benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
 1. determination of eligibility, coverage and cost sharing amounts (including Coordination of Benefits or the determination of cost sharing amounts);
 2. adjudication of health benefit claims (including appeals and other payment disputes);
 3. subrogation of health benefit claims;
 4. establishing employee contributions;
 5. risk adjusting amounts due based on enrollee health status and demographic characteristics;

6. billing, collection activities, obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance) and related health care data processing;
 7. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
 8. review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
 9. Utilization Review/Medical Review, including Precertification, preauthorization, Concurrent Review and retrospective review;
 10. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social security number, payment history, account number and name and address of the provider and/or health plan); and
 11. reimbursement to the Plan.
- c. **Health Care Operations** include, but are not limited to, the following activities:
1. quality assessment;
 2. improvement activities, which include outcomes evaluation and development of clinical guidelines, provided that obtaining generalizable knowledge is not the primary purpose of any studies that result from such activities;
 3. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting Health Care Providers and patients with information about treatment alternatives and related functions;
 4. reviewing Provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
 5. underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding (surrendering), securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
 6. conducting or arranging for Medical Review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
 7. business planning and development, such as conducting cost-management and planning related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
 8. business management and general administrative activities of the Plan, including, but not limited to:
 - i. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements,
 - ii. customer service, including the provision of data analyses for Eighth District Electrical Benefit Fund, plan sponsors or other customers;
 - iii. resolution of internal grievances;
 - iv. the sale, transfer, merger, or consolidation of assets with another covered entity, or an entity that, following such activity will become a covered entity and due diligence related to such activity; and
 - v. creating de-identified health information or a limited data set.
- d. **The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary.** With a written authorization, the Plan will disclose PHI to another benefit plan for purposes related to administration of that plan.
- e. **For Purposes of This Section the Board of Trustees Is the Plan Sponsor.** The Plan shall disclose only the minimum necessary PHI to the Plan Sponsor for the purpose of deciding the administrative functions the Board performs for the Plan, as permitted by HIPAA. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.
- f. **With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions.** The Sponsor agrees to:
1. not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
 2. ensure that any agents or independent contractors, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
 3. not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
 4. not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;

5. report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
 6. make PHI available to an individual in accordance with HIPAA's access requirements;
 7. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
 8. make available the information required to provide an accounting of disclosures;
 9. make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
 10. if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
 11. if a breach of your unsecured PHI occurs, the Plan will notify you.
- g. **Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained.** In accordance with HIPAA, only the Board of Trustees, other Plan contracted Covered Entities and Business Associates may be given access to PHI.
- h. **Limitations of PHI Access and Disclosure.** The persons described in section g. may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons described in section g. do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.
- i. **HIPAA Security Rule Compliance.** The Plan Sponsor will:
1. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan,
 2. ensure that the adequate separation discussed in f. above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
 3. ensure that any agent or independent contractor, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
 4. report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Discrimination is Against the Law

The Eighth District Electrical Benefit Fund (the "Fund") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Administrative Office.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Rachel Mora, Plan Manager, P.O. Box 30751, Salt Lake City, UT 84130. Phone: (702) 415-2180; Email: Rachel.Mora@benesys.com; Fax: (702) 425-9471. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Rachel Mora, Plan Manager, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building Washington, D.C. 20201
 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you, or someone you're helping, has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (844) 989-2321.

Section 34: Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 - Quantitative Treatment Limitation (QTLs) and Non-Quantitative Treatment Limitations (NQTLs).

Federal MHPAEA generally provides that QTLs (financial requirements such as Coinsurance and Copays and treatment limitations such as visit limits) imposed on mental health or substance abuse disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification. In addition, MHPAEA regulations provide that a plan cannot impose a Non-Quantitative Treatment Limitation (NQTL) on mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the Plan.

A description of the Plan's NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available for review by contacting the Administrative Office.

ARTICLE XVI: DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions pertaining to a particular Article are found in that Article.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related. See also the term Injury to Teeth.

Active Employee: means any Bargaining Employee who meets the hour bank eligibility rules as set forth in Article III.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

Administrative Office: means the individual or entity designated and engaged by the Board of Trustees to administer the Plan and process benefit claims. See the Quick Reference Chart in the front of this document.

Adverse Benefit Determination: See the Claim Filing and Appeal Information Article for the definition.

Allowable Expense: A health care service or expense, including Deductibles, Coinsurance or Copayments, that is covered in full or in part by any of the plans covering a Plan Participant (see also the COB Article of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

Allowed Amount/Allowable Charge/Allowed Charge: means the amount this Plan allows as payment for eligible medically necessary services or supplies. If you have coverage from more than one health insurance plan, you should review the definition of Allowed Charge as found in the Coordination of Benefits Article of this Plan Document. Generally, the Allowed Charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

1. **With respect to a Network Provider** (PPO network Health Care Provider/Facility), the fee set forth in the agreement between the PPO network Health Care Provider/facility and the PPO Network or the Plan; **or**
2. **With respect to a Non-Network Provider**, Allowed Charge means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network Providers.

For either: (1) items or services furnished by a Non-Network Provider for a Medical Emergency; or (2) items or services furnished by Non-Network Provider at Network Hospital or Facility (unless the Covered Individual consented to be balance billed and the items or services are not Ancillary Benefits, as that term is defined above):

- The rate articulated in an All-Payer Model Agreement if the services are rendered in a state that has such an agreement;
- The rate specified by state law; or
- The Qualifying Payment Amount.

For air ambulance services, the lesser of the billed amount or the Qualifying Payment Amount.

For purposes of this definition, the "Qualifying Payment Amount" is the median of the contracted rates recognized by the Plan on January 31, 2019 for the same or similar item or service that is provided in a geographic region, increased for inflation.

For all other treatment received from Non-Network Providers, the usual and customary amount that must Health Care Providers within a geographic cost area charge for treatment.

The Plan reserves the right to have the billed amount of a claim reviewed by an independent Medical Review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this Article and the Special Reimbursement Provisions described in the Medical Networks Article; **or**

3. **For an In-Network Health Care Provider/Facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer**, including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed charge amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**
4. The Health Care Provider's/Facility's actual **billed charge**.

5. **With respect to a Non-Network Provider for services other than those described in paragraph 2 above,** 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 of 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.

The Plan will not always pay benefits equal to or based on the Health Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies. **Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket Maximums. Typically In-Network Providers do not charge for amounts that exceed the "Allowed Charge."** However, Participants may be responsible for amounts that exceed "Allowed Charge" amounts by this Plan. See also the Special Reimbursement Provisions described in the Medical Networks Article.

Ambulance: A vehicle, helicopter, airplane or boat that is licensed or certified for Emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located. An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this Article, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Ancillary Benefits/Ancillary Services: Includes one of the following: (1) items and services that relate to emergency medicine, anesthesiology, pathology, radiology, and neonatology; (2) diagnostic services, including radiology and laboratory services; (3) items and services provided by Assistant Surgeons, hospitalists, and intensivists; (4) items and services provided by Non-Network Providers when there is no Network Provider that can furnish it at the Network Provider's Hospital or Facility; and (5) items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general Anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local Anesthesia). Anesthetics are commonly administered by injection or inhalation.

Applied Behavior Analysis (ABA) Therapy: is the design, implementation, and evaluation of environmental modifications to attempt to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior. ABA strives to improve speech and social interaction skills and reduce disruptive behavior and includes instruction in a range of skills including speech, motor and socialization. ABA Therapy is a technique that some use for individuals diagnosed with Autism Spectrum Disorder (that refers to disorders defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) manual as autistic disorder, Asperger's syndrome or pervasive developmental disorder). Applied Behavior Analysis Therapy is not a covered benefit. **The Plan does not provide any benefits for the treatment of Autism Spectrum Disorder.**

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are Medically Necessary.

Assistant Surgeon: An Assistant Surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an Assistant Surgeon actively assists the Physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This Plan allows payment of an Assistant Surgeon under the following conditions:

- a. the individuals functioning as an Assistant Surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Registered Nurse First Assistant (RNFA) or Certified Surgical Assistant (CSA, SA-C), but not an employee of a hospital or surgical facility, or an intern, resident or other trainee; and
- b. the use of an Assistant Surgeon is determined by the Plan Administrator or its designee to be Medically Necessary; and
- c. the Assistant Surgeon actively participated in the surgical procedure (was not stand-by).

Authorized Representative: See the Claim Filing and Appeal Information Article for the definition.

Balance Billing: A bill from a Health Care Provider to a patient for the difference (or balance) between what this Plan pays and what the Provider actually charged. Generally, amounts for which Balance Billing is made are never covered by this Plan, even if the Plan's Out-of-Pocket Maximums are reached because they usually involve expenses that are not covered by the Plan. See the provisions related to the Plan's Out-of-Pocket Expenses for more details. See also the definition of Allowed Charge in this Article. Note that amounts over Allowed Charge do not count toward the Plan's Out-of-Pocket Maximums and may result in Balance Billing to you. Typically, In-Network Providers do not balance bill. **Out-of-Network Health Care Providers commonly engage**

in Balance Billing a Plan Participant for any balance that may be due in addition to the amount payable by the Plan. Generally, you can avoid Balance Billing by using In-Network Providers. However, you may not be Balance Billed in the scenarios described in the Medical Networks Article, pursuant to the No Surprises Act.

Bargaining Employee: “Bargaining Employee” means an employee on whose behalf a Contributing Employer makes hourly contributions to the Fund under a collective bargaining agreement.

Behavioral Health Disorder: A Behavioral Health Disorder is any Illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things, autism, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by Behavioral Health Practitioners as defined in this Article. **Certain Behavioral Health Disorders, conditions and diseases such as Autism Spectrum Disorder are specifically excluded from coverage as noted in the Medical Plan Exclusions Article of this document. See also the definitions of Chemical Dependency and Substance Abuse.**

Behavioral Health Practitioners: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a Master’s degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Behavioral Health Treatment: Behavioral Health Treatment includes all Inpatient Services, including room and board, given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health or Substance Abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code is considered a Behavioral Health Treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders and which is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Behavioral Health Treatment Facility that qualifies as a Hospital is covered by this Plan as a Hospital and not a Behavioral Health Treatment Facility.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the Allowed Charge, after calculation of all Deductibles, Coinsurance and Copayments, and after determination of the Plan’s Exclusions, limitations and maximums.

Biofeedback: Biofeedback is a technique an individual can learn in order to control certain of their bodily processes that normally happen involuntarily, such as heart rate, blood pressure, muscle tension, and skin temperature. With Biofeedback, an individual is connected to electrical sensors that help them receive information (feedback) about their body (bio). This feedback (often shown on a display monitor) helps the individual focus on making subtle changes in their body, such as relaxing certain muscles, to achieve the desired results, such as reducing pain. Biofeedback can give a person the power to use their thoughts to control certain aspects of their body, often to help control a health condition or reduce stress.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Birth (or Birthing) Center that is part of a Hospital, as defined in this Article, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Board of Trustees: “Board of Trustees” means the Board of Trustees of the Eighth District Electrical Benefit Fund established by the Trust Agreement.

Calendar Year: The 12-month period beginning January 1 and ending December 31. For the Medical Plan, all annual Deductibles, Out-of-Pocket Maximums and Annual Maximum Plan Benefits are determined during the Calendar Year.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home, the exercise and educational techniques they learn in this program. Cardiac Rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open heart surgery.

Certified Surgical Assistant (CSA, SA-C): A person who is at least a high school graduate and who has successfully passed a national surgical assistant program. A CSA does not typically hold a valid healthcare license as a RN, Nurse Practitioner (NP), Physician Assistant (PA), Midwife, Podiatrist, Dentist, MD or DO. A CSA is typically not a licensed health professional. A CSA assists the primary surgeon with a surgical procedure in the operating room and is not an employee of a Health Care Facility. Such individual may be payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA, SA-C),

Certified Surgical Technologist (CST), Certified First Assistant (CFA), Certified Surgical Technologist (CST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT), **only IF** the use of an Assistant Surgeon is Medically Necessary.

Chemical Dependency: This is another term for Substance Abuse. See also the definitions of Behavioral Health Disorders and Substance Abuse.

Child(ren): See the definition of Dependent Child(ren).

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of Scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings. Christian Science Practitioners **are not** payable under this Plan.

Claim, Claimant: See the Claim Filing and Appeal Information Article for the definition.

Claims Administrator: See the term "Appropriate Claims Administrator" in the Claim Filing and Appeal Information Article.

Coinsurance: That portion of Eligible Medical Expenses for which the covered person has financial responsibility. In most instances, the Covered Individual is responsible for paying a fixed percentage of Covered Medical Expenses in excess of the Plan's Deductible. In some instances, the Covered Individual may be responsible for paying a higher percentage of those expenses, and in other instances, no Coinsurance applies. Coinsurance amounts are listed on the Schedule of Medical Benefits.

Complications of Pregnancy: An added difficulty, complex state, disease or Accident superimposed on a pregnancy without being specifically related, yet affecting or modifying the prognosis of the pregnancy, as determined by the Plan Administrator or its designee. Complications of Pregnancy can include but are not limited to the following diagnoses: anemia, bleeding during pregnancy, cervical incompetence, ectopic or molar pregnancy, gestational diabetes, excessive vomiting, miscarriage, placental abruption or previa, preeclampsia, or preterm labor. Complications of Pregnancy does not include common symptoms/discomforts associated with pregnancy such as spotting, false labor, morning sickness, skin changes, backache, headache, leg cramps, indigestion, constipation/hemorrhoids, or the usual lab/ultrasound tests to monitor status and progression of the pregnancy.

Compound Drugs: See the definition of Prescription Drugs.

Concurrent Care Claim: See the Claim Filing and Appeal Information Article for the definition.

Concurrent Review: A Managed Care program designed to assure that Hospitalization and Health Care Facility admissions and length of stay, surgery and other health care services are Medically Necessary by having the Medical Review firm conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Health Care Facility. Also called Continued Stay Review.

Contributing Employer: "Contributing Employer" means any employer who is required by a collective bargaining agreement with the union, the Trust Agreement, or any other written agreement, to make contributions to the Basic Medical Plan for Active Employees.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan Benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits Article.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an Eligible Medical Expense for certain services. The services with a Copay are listed on the Schedule of Medical Benefits and Schedule of Prescription Drug Benefits in this document.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are Medically Necessary.

Covered Individual: Any Eligible Employee 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.

Covered Medical Expenses: See the definition of Eligible Medical Expenses.

Custodial Care: Care and services given mainly for personal hygiene or to perform the Activities of Daily Living. Some examples of Custodial Care include helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial Care may be payable by this Plan under certain circumstances such as when Custodial Care is provided during a covered hospitalization or during a covered period of Hospice Care or in conjunction with covered Home Health Services.

Customary Charge: See the definition of Allowed Charge. **Days (as relates to claim filing and appeals):** See the Claim Filing and Appeal Information Article for the definition.

Deductible: The amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of Deductibles for Covered Individuals is discussed in the Medical Plan Article of this document.

Dental: As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, Injury, decay, malformation, disease or infection. The only Dental services payable under this Medical Plan are described in the Schedule of Medical Plan Benefits Article.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse as those terms are defined in this definition. 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;
 1. b. **Dependent Child:** For the purposes of this Plan, a Dependent Child is any of the Eligible Employee's Children listed below who are under the age of 26, unless the Child meets the definition of Disabled Adult Child (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 (proof of adoption or placement for adoption and age may be required). **Placed for Adoption** means the assumption and retention by the Eligible Employee 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 is 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 Adult Child, **coverage will terminate for a Dependent Child** at the earlier of the end of the month in which the Child attains age 26, or when the guardianship ends.
 3. **Disabled Adult Child:** The Eligible Employee's unmarried Dependent Children who are incapable of self-sustaining employment by reasons of mental or physical disability will continue to be covered for benefits provided such incapacity commenced while the Child was an Eligible Dependent prior to the end of the month in which the Dependent attains age twenty-six (26) years, and provided the Child is dependent upon the Eligible Employee for support and maintenance. 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.
 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'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. Except as provided above with respect to a Disabled Adult Child, coverage will terminate for a Dependent Child at the end of the month in which the Child attains age 26.
7. **The following individuals are not Eligible Dependents under this Plan:** foster child, grandchild, son-in-law or daughter-in-law.

Disabled (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as intellectual disability, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, (as that term is defined in this Plan) provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Disabled Child: means a child who is intellectually disabled, hard of hearing, deaf, speech impaired, visually handicapped, determined by a qualified mental health practitioner as having a serious emotional disturbance, orthopedically impaired, other physical health impairment, blind, multi-handicapped, or having specific learning disabilities. **Durable Medical Equipment (DME):** means items which can withstand repeated use, are primarily used to serve a medical purpose, are generally not useful to a person in the absence of Illness, Injury or disease, and are appropriate for use in the patient's home and is not disposable or non-durable. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Eighth District Electrical Pension Fund: means either the Eighth District Electrical Pension Plan or the Eighth District Electrical Pension Fund Annuity Plan

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: Your lawful Spouse and/or 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.

Eligible Employee: means each Active Employee and each Self-pay Employee.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that the expenses meet all of the following qualification as determined by the Plan Administrator or its designee: are Medically Necessary; and the charges for them are an Allowed Charge; and coverage for the services or supplies is not excluded; the Maximum Plan Benefits for those services or supplies has not been reached; and are for the diagnosis or treatment of an Injury or Illness (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document).

Emergency Care/Emergency: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Emergency Care means medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

1. The patient's life or health would be placed in serious jeopardy.
2. There would be a serious dysfunction or impairment of a bodily organ or part.
3. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

However, for Emergency Services performed in a hospital Emergency Room, the following definition applies:

Emergency Services means with respect to an Emergency Medical Condition (defined below), an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished). For the purposes of the No Surprises Act, the definition of Emergency Services also includes Post-Stabilization Services. The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

The term "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably

expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or of her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an Illness or within 24 hours of an accidental Injury causing a life-threatening situation.

Employee: See the term Eligible Employee.

Enroll, Enrollment: The process of completing and submitting a written enrollment form indicating that coverage by the Plan is requested by the Employee. An Employee may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility Article for details regarding the mechanics of enrollment.

Essential Health Benefits: The Affordable Care Act defines essential health benefits as a set of health care service categories to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in this document for which the Plan does **not** provide Plan Benefits.

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility Article.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Precertification under the Plan's Medical Review program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts; classify the service or supply as Experimental and/or Investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is:
 - approved by the FDA as an “investigational new drug for treatment use”; or
 - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease” as that term is defined in FDA regulations; or
 - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.
6. Under this medical Plan, Experimental, Investigational or unproven does not include **routine clinical trial costs associated with a certain “approved clinical trial” related to cancer or other life-threatening illnesses.** The routine costs that are covered by this Plan are discussed below:

- a. **“Routine clinical trial costs”** means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a Participant or beneficiary who is not enrolled in a clinical trial. However, the Plan does not cover non-routine services and supplies, such as: (1) the Investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient’s particular diagnosis.
- b. An **“approved clinical trial”** means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial’s study or investigation must be (1) federally-funded; (2) conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from Investigational new drug application requirements. “Federally funded” clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRO), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRO, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual’s referring Physician is a participating Health Care Provider in the plan who has determined that the individual’s participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.
- d. The Plan may require that an eligible individual use an In-Network Provider as long as the Provider will accept the patient. This Plan is only required to cover Out-of-Network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient’s state of residence.
- e. The Plan may rely on its Utilization Management Company or other Medical Review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person’s routine costs are associated with an “approved clinical trial.” During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a Medical Review firm regarding the information collected during the review process. See the Claim Filing and Appeal Information Article for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered for Precertification under the Plan’s Medical Review program:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including, but not limited to “United States Pharmacopeia Dispensing Information”; and “American Hospital Formulary Service”;
5. The published opinions of: the American Medical Association (AMA); or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or clinical policy bulletins of major insurance companies in the US such as Aetna or CIGNA, or Milliman Care Guidelines; or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of “The Medicare National Coverage Determinations Manual.”

Extended Care Facility: See the definition of Skilled Nursing Facility.

Federal Legend Drugs: See the definition of Prescription Drugs.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Formulary: A list of outpatient prescription drug products, including strength and dosages, available for use by Plan Participants. A formulary is also called a Preferred drug list. **Genetic Counseling:** Counseling services provided before or in the absence of Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Habilitative/Habilitation: Health care services, such as Physical Therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services includes Physician-prescribed therapy for a child who is not walking at the expected age. Expenses for Habilitation services are not covered unless it is speech therapy for children for the treatment of delays in childhood speech.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include Outpatient Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities, as those terms are defined in this Definitions Article.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Nurse, Nurse Practitioner, Nurse Midwife, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider: A Health Care Practitioner, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility, as those terms are defined in this Definitions Article.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency.

Home Health Care Agency: An agency or organization that provides a program of Home Health Care and is approved by Medicare; and is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances will produce symptoms of an illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." **Homeopathy is not a covered Benefit under this Plan.**

Hospice Benefit Period: means the period that begins on the date the Physician certifies that the Participant is a Terminally Ill Patient and ends six (6) months after it began or on the death of the Participant, if sooner. If the Hospice Benefit Period ends before the death of the Participant, a new Hospice Benefit Period may begin if the Physician again certifies that the Participant is a Terminally Ill Patient.

Hospice Care: means palliative and supportive medical and health care and other services provided to Terminally Ill Patients to meet special physical and emotional needs as part of dying so that a Hospice patient may remain at home, to the maximum extent possible, with home-like inpatient care utilized only if and while it is necessary. A Hospice agency must be licensed by the state of its situs and meet the certification requirements of a Hospice agency as required by Medicare.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice Care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must be approved by Medicare; and be licensed as a

Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Hospice that is part of a Hospital, as defined in this Article, will be considered a Hospice for the purposes of this Plan.

Hospital: A public or private facility or institution, licensed and operating according to law, that:

1. is accredited by The Joint Commission; and
2. is approved by Medicare as a Hospital; and
3. provides care and treatment by Physicians and Nurses on a 24-hour basis for Illness or Injury through the medical, surgical and diagnostic facilities on its premises.

A Hospital may include facilities for Behavioral Health treatment that are licensed and operated according to law. Any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Subacute Care Facility, or other residential treatment facility or place for rest, Custodial Care, or the aged will **not** be regarded as a Hospital for any purpose related to this Plan. A stay in a Health Care Facility after outpatient surgery for more than 24 hours is considered to be an inpatient Hospital service.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited metabolic disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia and diabetes are not inherited metabolic disorders under this Plan. **Injury:** Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An Injury to the teeth caused by trauma from an external source. This **does not include** an Injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable under Oral services in the Schedule of Medical Benefits.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board. A stay in a Health Care Facility after outpatient surgery for more than 24 hours is considered to be an inpatient Hospital service.

Intensive Care Unit or Coronary Care Unit: means a section or wing within the Hospital which is operated for critically ill patients and provides special supplies, equipment and supervision and care by a Registered Nurse (R.N.) or other trained Hospital personnel.

Intensive Outpatient Program (IOP): means providing treatment in a structured therapeutic outpatient behavioral health environment with individual and/or group counseling treatment on a schedule that is typically no less than six hours per week. Certain Intensive Outpatient Programs can be structured to allow an individual to be able to participate in their daily affairs, such as work or school, and then participate in IOP treatment program in the morning or at the end of the day. The IOP is an outpatient program and does not include an overnight stay in a facility or an inpatient admission. An IOP may be appropriate for individuals who do not require medically-supervised inpatient treatment (including detoxification) and is an enhanced level of behavioral health support as compared to the standard outpatient visits that involve one 30/45/60-minute visit or two 30/45/60 minute visits per week to an outpatient behavioral health Provider for counseling and/or medication management. Through a "step down" process, an IOP progressively transitions individuals to require less therapeutic support, to help the individual become more independent.

Investigational: See the definition of Experimental and/or Investigational.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.

Maximum Plan Benefits: The maximum amount of Benefits payable by the Plan (and described more fully in the Medical Plan Article of this document) on account of medical expenses incurred by any covered Plan Participant. There are two general types of Plan maximums, described below:

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

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

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

Medically Necessary:

- A. A medical or dental service or supply will be determined to be **“Medically Necessary”** by the Plan Administrator or its designee if it:
 - 1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
 - 2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
 - 3. is determined by the Plan Administrator or its designee to meet all of the following requirements:
 - It is consistent with the symptoms or diagnosis and treatment of an Illness or Injury; and
 - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
 - It is an **“Appropriate”** service or supply given the patient’s circumstances and condition; and
 - It is a **“Cost-Efficient”** supply or level of service that can be safely provided to the patient.
- B. A medical or dental service or supply will be considered to be **“Appropriate”** if:
 - 1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the Illness or Injury involved and the patient’s overall health condition.
 - 2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient’s overall health condition.
- C. A medical or dental service or supply will be considered to be **“Cost-Efficient”** if it is no costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
- D. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.
- E. A Hospitalization or confinement to a Health Care Facility will not be considered to be Medically Necessary if the patient’s Illness or Injury could safely and appropriately be diagnosed or treated while not confined.
- F. A medical or dental service or supply that can safely and appropriately be furnished in a Physician’s or Dentist’s office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.
- G. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.
- H. A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient’s family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

Medical Review: A Managed Care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to Precertification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation. Medical Review is sometimes referred to as Utilization Management, UM services, Utilization Review services, or UR services. Medical Review is provided by professionals employed by the Medical Review firm operating under a contract with the Plan.

Medicare: means the benefits provided under Title XVIII of the U.S. Social Security Act of 1965 as it is amended from time to time.

Member Assistance Program (MAP): means the program approved by the Board of Trustees, as amended from time to time, whereby a Participant may obtain counseling for mental, nervous, and emotional disorders and/or substance abuse problems. MAP is also referred to as an Employee Assistance Program or EAP.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a Midwife or certified as a certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. A Midwife may **not** independently manage moderate or high-risk mothers, admit to a Hospital, or prescribe all types of medications. See also the definition of .

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

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage or herbal tea. **Naturopathy is not a covered Benefit under this Plan.**

No Surprises Act: means the No Surprises Act that was signed into law as part of the Consolidated Appropriations Act of 2021.

Non-bargaining: Employees not covered by a union's collective bargaining agreement. Non-bargaining employees are not eligible for coverage under the Basic Plan.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Device). Only those Nondurable Supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-Participating Provider (Non-Preferred Provider): A Health Care Provider who **does not participate** in the Plan's Preferred Provider Organization (PPO).

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer Anesthesia in collaboration with a Physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a Physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate Health Care Practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Occupational Therapist: A person legally licensed as a professional Occupational Therapist who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a Physician to assess the presence of defects in an individual's ability to perform self-care skills and Activities of Daily Living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence. Other occupational therapy services can include assessment of perceptual motor and sensory activity, the design, fabrication or application of selected support devices (Orthotics) such as a wrist brace or ankle support, training on how to utilize prosthetic devices to maximize independence, guidance in the selection and use of adaptive equipment, teaching exercises to enhance functional performance and adaptation of environments for people with mental and physical disabilities.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate Office Visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. The following are not considered an Office Visit: a telephone discussion with a Physician or other Health Care Practitioner, internet/virtual Office Visit, a visit to a Health Care Practitioner's office where no Office Visit code is billed or a visit to a Health Care Practitioner's office for blood drawing, leaving a specimen, or receiving a routine injection.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or TMJ syndrome/dysfunction. See the definitions of Prognathism, Retrognathism, and TMJ syndrome/dysfunction.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Out-of-Network Services (Non-Network): Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO) as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

Out-of-Pocket Maximum: The maximum amount of Coinsurance, Copayments, and Deductibles that are incurred at an In-Network Provider that each covered person is responsible for paying during a Calendar Year before the Coinsurance, Copayments, and Deductibles required by the Plan cease to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of any additional covered expenses for the remainder of the Calendar Year. See the section on Out-of-Pocket Maximum in the Medical Plan Article for details about what expenses **do not count** toward the Out-of-Pocket Maximum.

Outpatient Services: Services provided either outside of a Hospital or Health Care Facility setting or at a Hospital or Health Care Facility when room and board charges are **not** incurred. However, a stay in a Health Care Facility after outpatient surgery for more than 24 hours is considered to be an inpatient Hospital service.

Partial Hospitalization: means treatment of mental, nervous, or emotional disorders and substance abuse for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period.

Participant: "Participant" means:

- a. an Eligible Employee;
- b. an Eligible Employee's Eligible Dependents; and
- c. COBRA Qualified Beneficiaries.

Participating Provider: A Health Care Provider who participates in the Plan's Preferred Provider Organization (PPO).

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional Physical Therapist who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a Physician to perform Physical Therapy services including the evaluation and treatment of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical Therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

Physical Therapy: means rehabilitation directed at restoring function following disease, Injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain Activities of Daily Living such as walking and getting in and out of bed.

Physician: means a Physician or Surgeon (M.D. or D.O.) licensed to practice medicine in the state in which he/she practices and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. To the extent that benefits are provided and while practicing within the scope of his license the term Physician includes a Dentist or Podiatrist. In addition, the term Physician will include, to the extent that benefits are provided for herein and while practicing within the scope of his/her license, the following Providers of care:

- a. a licensed psychologist;
- b. a licensed clinical social worker or clinical specialist psychiatric registered nurse (CSPRN) to the extent that he/she shall render services which he/she is legally qualified and licensed to perform; and

- c. any licensed and/or certified practitioner rendering counseling and therapy services when regulated by the appropriate state agency.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the definition in the section on Adopted Dependent Children in the Eligibility Article.

Plan or Fund: means the Eighth District Electrical Benefit Fund Basic Plan (established by the Trust Agreement) which is described in this document.

Plan Administrator: The Board of Trustees of the Eighth District Electrical Benefit Fund who has the fiduciary responsibility for the overall administration of the Plan.

Plan Participant: See the definition of Participant.

Plan Year: means the fiscal year, which begins January 1 and ends December 31. Benefits of the Medical Plan are provided on a Calendar Year basis beginning January 1 and ending December 31 of each year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Post-service Claim: See the Claim Filing and Appeal Information Article for the definition.

Post-Stabilization Services: For the purposes of the No Surprises Act, Post-Stabilization Services are covered services provided by an Out-of-Network Provider or Emergency Facility after a Participant's Emergency Medical Condition is stabilized. These services must be provided as part of outpatient observation, an outpatient stay, or an inpatient stay. Post-Stabilization services are considered to be Emergency Services under the No Surprises Act unless certain conditions are met, in which case the provisions related to notice and consent to waive Balance Billing may apply.

Pre-Admission Testing: Laboratory tests and x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled Hospital admission or outpatient surgery.

Precertification: Precertification is a review procedure performed by a Medical Review firm under contract to the Plan **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service is appropriate and Medically Necessary. See the Precertification and Medical Review Article for more information.

Preferred Provider: "Preferred Provider" means any Plan recognized Provider, corporation, organization or entity which has contracted with the Plan to provide discounted fees for covered charges in accordance with this Plan. With respect to Continuing Care Patients, "Preferred Provider" also means a former Preferred Provider that was rendering items or services to a Continuing Care Patient on the date the provider ceased to be a Preferred Provider until the earlier of (1) 90 days after the date the Covered Person is notified the Provider is no longer a Preferred Provider; or (2) the date the Covered Person is no longer a Continuing Care Patient.

For purposes of this definition, a Covered Person is a "Continuing Care Patient" if, with respect to the Provider, the Covered Person is: (1) undergoing a course of treatment for a serious and complex condition from the Provider; (2) undergoing a course of institutional or inpatient care from the Provider; (3) scheduled to undergo nonelective surgery from the Provider, including the receipt of postoperative care from the Provider with respect to such surgery; (4) pregnant and undergoing a course of treatment for the pregnancy from the Provider; or (5) determined to be terminally ill and is receiving treatment for such Illness from the Provider.

Preferred Provider Organization (PPO): An independent group or network of Health Care Providers (e.g. Hospitals, Physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution - Federal Law prohibits dispensing without prescription."
2. **Compound Drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Pre-Service Claim: See the Claim Filing and Appeal Information Article for the definition.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face. See also Orthognathic.

Prophylactic Surgery: A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on Genetic Information or Genetic Testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of a Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Provider: See the definition of Health Care Provider.

Qualified Beneficiary: means an individual who, on the day before a COBRA Qualifying Event is an Eligible Employee or is the Dependent of an Eligible Employee.

- A newborn child, adopted child or child Placed for Adoption with a Qualified Beneficiary who was a covered Employee shall become a Qualified Beneficiary in his/her own right and shall be entitled to benefits as a Qualified Beneficiary.
- A Qualified Beneficiary must notify the Administrative Office within ninety (90) days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

Qualifying Event: A Qualifying Event triggers the opportunity to elect COBRA when the Covered Individual LOSES health care coverage under this Plan as a result of the of the event. If a Covered Individual has a Qualifying Event but does not lose their health care coverage under this Plan, 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 participation due to the death of an Active Employee;
- b. termination of coverage as a result of termination of the hour bank participation due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct), reduction in hours of an Active Employee, or retirement;
- c. the divorce or legal separation of an Eligible Employee from his/her Spouse; and
- d. a Dependent Child ceasing to be a Dependent Child as that term is defined in this Article.;

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also the Eligibility Article of this document.

Reconstructive Surgery: A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental Injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Facility: means a facility that is recognized by the Plan and licensed or certified to perform rehabilitative health care services by the state or jurisdiction where services are provided. Services of such a facility must also be among those covered by the Plan.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of Illness, Injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the Injury, Illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. See the Schedule of Medical Benefits and the Exclusions Article of this document to determine the extent to which Rehabilitation Therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy, Habilitation and Cardiac Rehabilitation.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**

3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**
4. **Sword Health - Virtual Physical Therapy Solution.** The Plan will provide virtual physical therapy for the majority of qualified musculoskeletal diagnoses to Covered Individuals who qualify through the Plan's preferred musculoskeletal virtual provider Sword Health at NO COST to the Covered Individual. A Covered Individual must be suffering from pain in his or her neck, lower back, shoulder, knee, hip, ankle, wrist, or elbow, or has undergone surgery in these areas; Workers' compensation injuries are not covered under this virtual physical therapy benefit. If qualified, the Covered Individual will receive the required monitoring equipment in the mail and will access their physical therapy sessions through a tablet. In order to be eligible to participate in this benefit, a Covered Individual must meet the following criteria:
 - i. is over 13 years of age;
 - ii. is able to perform 20 minutes of light to moderate physical activity;
 - iii. does not have recent onset fever, chills, or visible inflammation in the affected area;
 - iv. does not have signs of progressive neurological issues in the area of pain;
 - v. does not have an active cancer or is receiving treatment for cancer; and
 - vi. pain is not related to significant trauma to that area.

For more information, please contact Sword Health at the contact information listed in the Quick Reference Chart.

Residential Treatment Program/Facility/Care: is a non-acute Hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for people with Behavioral Health Disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a Residential Treatment Facility under contract as an In-Network Facility.

However, if you are being treated by an In-Network Residential Treatment Program/Facility/Care that leaves the PPO Network, the Plan will notify you when the facility becomes a Non-Network facility and allow you to choose to continue care with the same facility. The Plan will additionally apply the same cost sharing as it applies to In-Network Residential Treatment Program/Facility/Care for the earlier of: (1) 90 days after you are notified; or (2) the date you are no longer a Continuing Care Patient.

Additionally, if you contact the PPO Network to inquire about whether a Residential Treatment Program/Facility/Care is an In-Network facility, and the PPO Network incorrectly advises you that the facility is an In-Network facility or fails to respond to your inquiry within one business day of receipt, the Plan will apply the In-Network facility cost sharing rates for facility fees you incur at the Non-Network facility. The Plan will also apply the In-Network facility cost sharing rates if you review the PPO Network Provider directory to determine whether a Residential Treatment Program/Facility/Care is an In-Network facility, and the directory incorrectly indicates that the facility is In-Network.

Respite Care: means care that is furnished to a Terminally Ill Patient when confined as an inpatient so that the family unit may have relief from the stress of the care of the Participant.

Restatement Effective Date: means January 1, 2026. This Plan has been amended and restated to incorporate all amendments and to update the wording of this Plan Document. This Plan Document/Summary Plan Description replaces all previously issued Plan Document/Summary Plan Descriptions and amendments to those documents.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face. See also Orthognathic.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were Medically Necessary and/or if the charges for them are Allowed Charges.

Second Opinion: A consultation and/or examination, by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing surgery or receiving a medical service.

Self-Pay Employee: means an Active Employee who subsequently loses eligibility who elects to continue coverage under the Plan in accordance with the Self-Pay/COBRA provisions of this Plan as described in the Self-Payment Provisions for Continuation of Coverage Including COBRA Article.

Self-Pay Participant: means a Self-Pay Employee or Eligible Dependent of a deceased Active Employee who subsequently loses eligibility and elects to continue coverage under the Plan under the Self-Payment Provisions as described in the Self-Payment Provisions for Continuation Coverage Including COBRA Article.

Service Area: The geographic area serviced by the In-Network Health Care Providers who have agreements with the Plan's PPO Network. See the Medical Networks Article for additional information.

Skilled Nursing Care: Services performed by a licensed Nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a Nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a Nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:

1. It is accredited by The Joint Commission as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Special Education: means specially designed instruction to meet unique needs of an individual, including classroom instruction, instruction in physical education, home instruction, and instruction in Hospitals and institutions.

Specialty Care Unit: A section, ward, or wing within a Hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a Physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to Illness, Injury or surgical procedure.

Spouse: See the definition of Dependent.

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute Illness, Injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

1. It is accredited by The Joint Commission as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse.

Subacute care facility is sometimes referred to as a specialty Hospital or long term care acute facility.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability section in the Coordination of Benefits Article for an explanation of how the Plan may use the right of subrogation to be substituted in place of a Covered Individual in that person’s claim against a third party who wrongfully caused that person’s Injury or Illness, so that the Plan may recover medical benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit. See also the definition of Tortfeasor.

Substance Abuse/Substance Use Disorder: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan Benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowed Charge will be allowed as the Plan’s Benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of Allowed Charge
Secondary and additional procedures	50% of Allowed Charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of Allowed Charge
First site secondary and additional procedures	50% of Allowed Charge per procedure
Second site primary and additional procedures	50% of Allowed Charge per procedure

Surgical Assistant: See Certified Surgical Assistant.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofascial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Terminally Ill Patient: means a patient whose Physician certifies that such patient is terminally ill and who is expected to live six (6) months or less.

Therapist: A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. For further information, see the definition of Occupational, Physical and Speech Therapy.

Third Opinion: A consultation and/or examination, by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing Surgery or receiving a medical service, provided by the Plan when the Second Opinion indicates that the recommended Surgery or medical service is not Medically Necessary.

Tort, Tortfeasor: A civil wrong or Injury, typically arising negligent or intentional act of an individual, who is called a tortfeasor. See also the definition of Subrogation.

Total Disability, Totally Disabled: The inability of a covered Employee to perform all the duties of his or her occupation as a result of an Illness or Injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age and sex. See also the definition of Disabled.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

- **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
- **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.
- **Xenographic/xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan.

See the Schedule of Medical Benefits and the Medical Plan Exclusions Articles for additional information regarding Transplants. See also the Precertification and Medical Review Article of this document for information about Precertification requirements for Transplantation services.

Trust Agreement or Trust: means the Agreement and Declaration of Trust establishing the Eighth District Electrical Benefit Fund, as modified or amended.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent Care Claim: See the Claim Filing and Appeal Information Article for the definition.

Urgent Care Facility: A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Management/Utilization Review: see Medical Review.

Visit: See the definition of Office Visit.

Vocational Rehabilitation: means teaching and training which allows an individual to resume his/her previous job or to train for a new job.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be Medically Necessary even though they are not provided as a result of Illness, Injury or congenital defect. The Plan's coverage of Well Child Care is described under Wellness/Preventive Care in the Schedule of Medical Benefits.

You, Your: When used in this document, these words refer to the Employee who is covered by the Plan. They do **not** refer to any Dependent of the Employee unless the context otherwise requires.