Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan

Plan Document and Summary Plan Description

2021 Edition

Your Funds. Your Foundation. Your Future.

Introduction

Each of us, at some point in our life, will experience a life event that affects our health care coverage. This book explains the Health and Welfare Plan benefits available to Active Employees and their Spouses and Dependents who meet the eligibility requirements described beginning on page 1.

COMPREHENSIVE BENEFIT PROTECTION

The Plan offers comprehensive health care coverage to help you and your Spouse and Dependent children stay healthy. This coverage can help provide financial protection against catastrophic health care bills. The Plan provides the following benefits for all Participants, unless otherwise noted:

- Medical Benefits;
- Prescription Drug Benefits;
- Dental Benefits;
- Access to the Health Reimbursement Arrangement (HRA);
- Vision Care Benefits;
- Loss of Time Benefits (Employees only);
- Death Benefits (Employees only); and
- Accidental Death and Dismemberment Benefits (Employees only).

This Summary Plan Description/Plan Document ("SPD/PD") is intended to give you an understanding of Plan benefits as of June 1, 2021. This edition, which includes all Plan changes adopted since the previous edition, replaces and supersedes any previous SPD/PD.

About This Book

It is your responsibility to read and understand the SPD/PD. If you need clarification of any benefit provided, contact the Claims Office at 800-461-9025. If you have any questions regarding eligibility or adding a Spouse or Dependent, contact the Fund Office at 866-661-1021.

This book has been prepared for Active Employees and their Spouses and Dependent children who are Participants in the Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan. This book serves as the Plan's Summary Plan Description (SPD) book and legal Plan Document (PD), as provided in Section 102 of the Employee Retirement Income Security Act of 1974, as amended (ERISA). This SPD/PD and supplemental documents such as the Plan's HIPAA Privacy Policies and Procedures and COBRA notices serve as the Plan's controlling legal documents. These documents are used by the Trustees of the Plan to determine the eligibility of Active Employees and their Spouses and Dependents for benefits provided by the Plan.

Only the Board of Trustees is authorized to interpret the Plan described in this book. Employers, Unions, or representatives of any Employer or Union are not authorized to interpret the Plan and cannot act as agents of the Trustees. You may only rely on information regarding the Plan that is communicated to you in writing and is signed on behalf of the Board of Trustees, either by the Trustees, or, if authorized by the Trustees, by the Fund Administrator.

The Trustees reserve the right and have been given broad discretion to amend, modify, or discontinue all or part of the Plan whenever, in their sole judgment, conditions so warrant. You will be notified in writing of any changes made to the Plan.

Benefits under the Plan will be paid only if the Trustees decide, in their discretion, that the Participant is entitled to them.

Grandfathered Status

The Trustees believe that this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), which permits our Plan to preserve certain basic health coverage already in effect before the law was passed. However, as with all grandfathered health plans, our Plan:

- May not include certain consumer protections of the Affordable Care Act that apply to other plans; and
- Must comply with certain other consumer protections in the Affordable Care Act (for example, the elimination of lifetime limits on benefits).

Contact the Fund Office if you have questions about what it means for a health plan to have a grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

IMPORTANT: It is your responsibility to read and understand this SPD/PD.

Questions about covered benefits and claims
should be directed to the claims office at 708-449-9004, 800-461-9025, or email fundoffice@ibew9mseca.org.

Questions about eligibility
should be directed to the Fund Office at 708-449-9004, 866-661-1021, or email fundoffice@ibew9mseca.org.

Questions about adding your Spouse and Dependent Children
should be directed to the Fund Office at 708-449-9004, 866-661-1021, or email fundoffice@ibew9mseca.org.

Table of Contents

Eligibility Requirements for Active Employees

INITIAL ELIGIBILITY

You become eligible for benefits after working 360 hours or more for a Contributing Employer in a Working Quarter. Coverage begins on the first day of the second month following the Working Quarter during which you worked 360 hours, as shown here:

If you work 360 hours during this Working Quarter…	You become eligible for coverage on…	And coverage continues for this Coverage Quarter…
January 1 through March 31	May 1	May 1 through July 31
April 1 through June 30	August 1	August 1 through October 31
July 1 through September 30	November 1	November 1 through January 31
October 1 through December 31	February 1	February 1 through April 30

INITIAL ELIGIBILITY EXAMPLES

Tom begins working in Covered Employment on January 9 and works 380 hours by March 31. Tom is eligible for benefits as of the May 1 Coverage Quarter since he worked 360 or more hours in the prior Working Quarter.

Steve begins working in Covered Employment on February 15 and works 200 hours by March 31. Since he did not work 360 hours by March 31, Steve does not begin coverage on May 1. He does not become eligible for coverage unless he completes 360 or more hours during the next Working Quarter of April 1 through June 30. If he completes 360 hours during that Working Quarter, his Coverage Quarter begins August 1.

However, if you are short 40 hours or less in any initial Working Quarter (that is, you worked at least 320 hours in your first Working Quarter), then you may pay the shortage of hours at the rate per hour that is determined by the Trustees from time to time. The rate is referred to as the "Self-Payment Option Rate." The Trustees reserve the right to change the contribution rate or to abandon the formula reflected above if they determine, using their discretion, that it is in the best interest of the Plan.

Coverage for you and your Spouse and Dependent children begins once you meet the Plan's initial eligibility requirements, but you must provide the necessary documentation for adding your Spouse and Dependent children. See pages 12 and 13.

TRAVELING EMPLOYEES

The IBEW established the reciprocal program to allow traveling Employees the opportunity to have benefits earned while working outside of their home local returned ("reciprocated") to their home funds. The IBEW has an Electronic Reciprocal Transfer System (ERTS), which streamlines the reciprocal process.

Here's how the IBEW ERTS program works:

- When you travel to another local to work, the contractor you are working for is required (by that local's collective bargaining agreement) to pay your benefits not to the Local No. 9 Plan, but to the health and welfare plan that is in effect for the jurisdiction in which you worked.
- You should register with ERTS either before you leave Local 9's jurisdiction or upon "clearing out" at the jurisdiction ("local") to which you have traveled. When you clear out, you should:
  - Advise the local that you are registered with ERTS; or
  - Ask to register in ERTS while you are there if you are not already registered.
- Registration is a simple five-minute process during which you provide your personal and home fund information to be entered into the secure ERTS system. You need to perform the registration process only once.

- After you register, your designated home fund—and for purposes of this explanation we will assume you have designated this Plan as your home fund—receives electronic notification that you have registered. This Plan then sets up in ERTS an approval for reciprocity. (You are eligible to reciprocate to any plan/fund under which you have been eligible at any point during the past six years.)
- When you are registered in ERTS and the local to which you have traveled is made aware of it, they will simply access your reciprocity information from the ERTS system and set you up in their system so that your funds are returned to this Plan.
- You must always remember to advise the local that you are registered in the ERTS system so that they know to look up your home fund information.
- This Plan will provide reciprocity on an hour-for-hour basis for hours worked in the local to which you traveled, except as noted below.
- After eight continuous Working Quarters during which there have been no contributions made on your behalf by Contributing Employers for hours worked in IBEW Local 9's jurisdiction and during which contributions made on your behalf have been made only from reciprocal funds (without regard to Self-Payments and Hour Bank usage), if the local fund to which you have traveled has an hourly contribution rate that is less than the current hourly contribution rate then in effect for this Plan, this Plan will provide reciprocity of hours on a pro rata basis, so that you will only be credited with the number of hours that is the quotient of the benefit contributions actually received by this Plan divided by the current hourly contribution rate then in effect for this Plan.
- After prorating begins, this Plan will provide reciprocity on an hour-for-hour basis only after you return to work exclusively in Local 9's jurisdiction and become eligible for a Coverage Quarter by having contributions made for hours worked in Local 9's jurisdiction (and not by means of reciprocal contributions) for a full Working Quarter.
- This Plan will provide reciprocity based only on contributions actually received. Under no circumstances will you receive duplicate credit or coverage for the same contributions or hours worked.

SPOUSE AND DEPENDENT CHILDREN

Generally, your Spouse and Dependent children become eligible for coverage on the date you become eligible, or, if later, on the date you acquire a Spouse or Dependent. If you acquire a Spouse or Dependent while eligible for coverage, you should notify the Plan within the required time limit, or as soon as possible, to add your Spouse or Dependent to your coverage. See ***Family Status Changes*** on page 12 for more information. Eligible Spouses and Dependents are defined in the ***Glossary of Terms*** beginning on page 77.

SPECIAL ENROLLMENT

If you decline enrollment for yourself, your Spouse, or your Dependents because of other health insurance or group health plan coverage, you may be able to enroll them in the Plan if you or they later lose eligibility for that other coverage (or if the employer stops contributing towards your or your Spouse or Dependents' other coverage). However, you must submit enrollment documentation to the Fund Office within 90 days after the other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new Spouse as a result of marriage, or a new Dependent child as a result of birth, adoption, or placement for adoption, you may be able to enroll yourself and your Spouse and Dependent children. However, you must submit enrollment documentation to the Fund Office within 90 days after the marriage, birth, adoption, or placement for adoption.

You and your Spouse and Dependent children may also enroll in the Plan if you (or they) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and you (or they) lose eligibility for that coverage. However, you must submit enrollment documentation to the Fund Office within 90 days after the Medicaid or SCHIP coverage ends.

You, your Spouse, and your Dependent children may also enroll in the Plan if you (or they) become eligible for a premium assistance program through Medicaid or SCHIP. However, you must submit enrollment documentation to the Fund Office within 90 days after you (or they) are determined to be eligible for such assistance.

If you miss the prescribed 90-day window explained above, you may still be able to enroll your Spouse or Dependents, but their coverage will be effective on the date that the enrollment request plus any additional documentation required (such as birth or marriage certificates) are received at the Fund Office.

To request special enrollment or obtain more information, contact the Fund Office.

CONTINUING ELIGIBILITY

Once you become eligible for coverage, your coverage continues for the appropriate Coverage Quarter provided you worked 360 or more hours in the corresponding Working Quarter. Refer to the table on page 1 under **Initial Eligibility**.

If your coverage ends because you enter active military service, your coverage will be reinstated if you apply for reemployment with a Contributing Employer within the time required by federal law. Coverage for you and your Spouse and Dependent children will be reinstated in accordance with federal law. See the **Military Service** Section on page 7.

CONTINUED ELIGIBILITY EXAMPLE

Jack became initially eligible for coverage on May 1 based on the hours he worked in the previous Working Quarter (January – March). His coverage automatically continues during the corresponding Coverage Quarter, May 1 – July 31. His coverage will continue automatically for the next Coverage Quarter (August 1 – October 31) provided he works 360 or more hours during the April – June Working Quarter.

CONTINUING COVERAGE

If you are unable to work due to a total disability and are eligible for Loss of Time Benefits, your benefit coverage under the Plan may continue for up to six months under the Loss of Time Benefit (see page 33). The Trustees may change, modify, or discontinue all or part of the benefits available to you at any time.

SUSPENSIONS

If your Employer fails to make timely Contributions on your behalf, you will receive a written notice (no later than the last business day of the month that the Contributions are due) informing you of your Employer's delinquency in making the required Contributions. If your Employer does not pay the amounts due, the Plan will suspend your benefits on the 15th day of the month after the date the contributions were due, unless you stop employment with the delinquent Employer before that date.

The suspension will continue until the earlier of the date your Employer pays all contributions and other amounts due to the Plan or until you stop employment with the delinquent Employer.

Changes to Eligibility Rules

The Trustees reserve the right, at their discretion, to change, modify, or discontinue all or part of the eligibility rules or the benefits provided under the Plan, at any time.

WHEN COVERAGE ENDS

Your eligibility for Plan benefits will end on the earliest of the:

- Last day of the Coverage Quarter in which you did not work at least 360 hours or more in the preceding Working Quarter for one or more Contributing Employers;
- First day of the month in which you qualify for Medicare;
- Last day of the Coverage Quarter following the Working Quarter in which employment by a Contributing Employer(s) ends;
- First day of the Calendar Year in which you have not completed a Family Survey;
- Failure to make self-payments
- Last day of the month in which you enter the armed forces of any country (subject to the conditions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA));
- Date the Trustees discontinue the Plan; or
- Date you die.

When coverage under the Plan ends, no conversion to individual coverage is available. When your coverage ends, you may be able to continue coverage by making Self-Payments or by electing COBRA Continuation Coverage. Any claims incurred before coverage ends will be paid according to the Plan's provisions.

For Your Spouse and Dependent Children

Your Spouse and Dependent children's coverage will end on the earliest of the:

- Date you are no longer eligible for Plan benefits for any reason other than death;
- Date your Spouse no longer meets the Plan's definition of a Spouse;
- Date your Dependent no longer meets the Plan's definition of a Dependent;
- Date the Trustees discontinue benefits for Spouses and Dependent children under the Plan;
- Date the Trustees discontinue the Plan;
- Date your Spouse or Dependent child enters the military;
- End of the month in which your Dependent children reach age 26; or
- Last day of the Coverage Quarter when your Hour Bank is depleted and the Self-Payment option has been exhausted, in the event of your death.

RESCISSION OF COVERAGE

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- When the Plan terminates your coverage retroactive to the date you lose eligibility for coverage, if there is a delay in administrative recordkeeping between the date you lose eligibility and the date the Plan is notified of your loss of eligibility; or
- When the Plan retroactively terminates your coverage because you fail to make timely self-payments for your coverage.
- When the Plan terminates your former spouse's coverage back to the date of divorce.
- When any other unintentional mistakes or errors result in you or your Spouse or Dependents being covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – for the future – once the mistake is identified.

REESTABLISHING ELIGIBILITY

If you do not meet the continuing eligibility requirements, you are required to meet the Plan's initial eligibility requirements before you will once again be covered under the Plan.

Continuation Coverage

Once you meet the Plan's initial eligibility requirements (see page 1), you will continue to remain eligible for subsequent Coverage Quarters by working 360 hours or more for a Contributing Employer in the corresponding Working Quarters.

HOUR BANK

When you work and your employer makes contributions to the Fund on your behalf, any hours you work during a Working Quarter that are in excess of 360 will be reserved in your Hour Bank for future use toward continuing eligibility. Your Hour Bank total may not exceed 2,880 hours if you have not reached age 55.

If you are age 55 or older, you are allowed to accumulate an additional year's worth of hours (an additional 1,440 hours) for future use toward continuing eligibility. However, these additional hours that you accumulate must be based only on hours you work after the first of the month in which you reach age 55, and your Hour Bank total may not exceed 4,320 hours. If you have not yet reached age 55, your Hour Bank total will still not be allowed to exceed 2,880 hours.

If you do not work the 360 hours required to be eligible during the corresponding Working Quarter, any hours that you are short will be automatically applied from your Hour Bank and your Hour Bank will be reduced by those hours.

If you die and you still have hours remaining in your Hour Bank, your surviving Spouse and Dependent children may elect to continue coverage under this Plan until your Hour Bank has been exhausted. Your surviving Spouse's and Dependent children's election for continuation coverage by using your remaining Hour Bank runs concurrently with their right to COBRA Continuation coverage due to your death.

Your surviving Spouse and Dependent children will not be eligible for COBRA Continuation Coverage if they elect to continue coverage by using your remaining Hour Bank if your remaining Hour Bank is sufficient to continue coverage for the number of months that would have been available under COBRA Continuation Coverage due to your death. If your remaining Hour Bank is sufficient for less than the number of months of continuation coverage provided under COBRA due to your death, your surviving Spouse and Dependent children will only be eligible for COBRA Continuation Coverage for the remainder of the months (after Hour Bank months have been exhausted) that would have been available under COBRA due to your death.

SELF-PAYMENT OPTION

General Self-Payment Option—If your Hour Bank balance does not have enough hours to fulfill a shortage as described above, you will be given the opportunity to pay the difference between the hours you have accumulated and the required 360 hours; this is called the Self-Payment Option. In order to qualify for the Self-Payment Option, you must be registered on the Out-of-Work Book at the Local Union No. 9, IBEW union office. Once you begin the Self-Payment Option, you will be allowed to continue it for a total of 18 months. You may not skip paying for certain months and then resume payment for any subsequent months; your 18 months using the Self-Payment Option must be consecutive and without breaks.

Of course, at any point that you resume working in covered employment so that your eligibility reinstates because you worked 360 hours in a Working Quarter, the 18 months under the Self-Payment Option will stop and any future shortages will begin new 18-month counts.

When you receive notice that the Self-Payment Option is required to continue your coverage, you will have until the 30th day of each month for which payment is required to deliver your Self-Payment to the Fund Office. For example, the Self-Payment for June 2021 coverage is due by June 30, 2021. No exceptions will be made to this due date, except that when the 30th day falls on a Saturday, a Sunday, or banking holiday, the Self-Payment must be delivered no later than the next business day.

Keep in mind that even though you have until the 30th day of the month to deliver your payment, any claims incurred during that month will not be paid until your Self-Payment for that month is received at the Fund Office.

You may make monthly Self-Payments in advance.

The Self-Payment Option rate is subject to change annually and usually goes into effect in November each year.

If the Fund Office has not received your Self-Payment by the 30th day of the same month in which the payment is due, you will be sent an offer of COBRA Continuation Coverage. Because the Board of Trustees has determined, in accordance with federal regulations, that the Self-Payment Option is more advantageous to you than COBRA Continuation Coverage, the length of time you may continue your coverage via COBRA will be shortened by any months that you made Self-Payments following your most recent occurrence of Hour Bank depletion. Refer to page 8 for additional information about COBRA Continuation Coverage. If your Self-Payment subsequently arrives at the Fund Office and it was delivered, as defined in this Plan, the COBRA offer will be voided by the Fund Office.

Extension Option Self-Payment—Employees whose Hour Bank balance is greater than zero (0) when their employment ends are eligible to continue their coverage under the Plan up to 60 consecutive months (immediately following the last Coverage Quarter for which they worked 360 hours or continued coverage using the Self-Payment Option) or up to age 65, whichever comes first. This is called the "Extension Option," and you have the option of determining how long your Extension Option will run within those parameters.

When you choose an Extension Option to continue your coverage under this Plan upon your retirement, your classification as a "Retired Employee" will not be changed. Your participation in the Retired Employees Plan will continue during your Extension Option period. Although you will be a participant in this Plan and the Retired Employees Plan at the same time and both plans provide a Death Benefit, you will only be eligible for the Death Benefit under the Retired Employees Plan, even if you die during your coverage Extension Option period.

Once you determine your Extension Option (which you cannot change later), the Fund Office will calculate any monthly payment you may be required to make based upon the balance in your Hour Bank divided by the number of months you decide to continue coverage; this payment is your Extension Option Self-Payment, or EOSP. If the total number of hours in your Hour Bank divided by the number of months you wish to continue coverage does not equal 120, you will be required to pay the difference between the number of hours available and the 120 hours, at the then-current Self-Payment Option rate. The Self-Payment Option rate is subject to change annually and the change usually goes into effect in November each year. You will be notified of any rate changes.

You may not skip paying for certain months and then resume payment for any subsequent months; your maximum of 60 months for using the Extension Option must be consecutive and without breaks.

You will have until the 30th day of each month for which payment is required for coverage to continue to deliver your EOSP to the Fund Office. For example, the EOSP for June 2021 coverage is due by June 30, 2021. No exceptions will be made to this due date, except that when the 30th day falls on a Saturday, a Sunday, or banking holiday, the EOSP must be delivered no later than the next business day.

You may make monthly EOSP's in advance.

Keep in mind that even though you have until the 30th day of the month to deliver your payment, any claims incurred during that month will not be paid until your EOSP for that month is received.

If the Fund Office has not received your EOSP by the 30th day of the same month in which the payment is due, your Extension Option will be terminated and your remaining balance in your Hour Bank balance will be automatically reduced each month by 120 hours to continue your coverage until your Hour Bank is exhausted. If your final month of Hour Bank usage is less than 120 hours, you will be given the opportunity to pay the difference between the Hour Bank balance and 120 hours at the then-current Self-Payment Option rate. If your EOSP subsequently arrives at the Fund Office and it was delivered, as defined in this Plan, the Extension Option termination and Hour Bank reduction will be reversed.

Lastly, if 1) your Extension Option was terminated due to non-payment of your EOSP, and 2) your time of coverage under the Extension Option and the subsequent Hour Bank usage was less than 18 months, and 3) you are under age 65, you will be sent an offer of COBRA continuation coverage to complete the 18 months of coverage or to extend your coverage to age 65, whichever time period is less. You should refer to page 8 for additional information about COBRA Continuation Coverage.

MILITARY SERVICE

If you enter military service (active duty or inactive duty training) for up to 31 days, your health care coverage will continue if you make any necessary Self-Payments. If you enter military service for more than 31 days, you may continue your coverage by making Self-Payments under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Your Plan coverage will continue until the earliest of the:

- Date you or your eligible Spouse or Dependents do not make the required Self-Payments;
- Date the Plan no longer provides any group health benefits;
- Date you reinstate your eligibility for coverage under the Plan;
- End of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- Last day of the month after 24-consecutive months.

Continuation coverage under USERRA will be administered in the same manner and at the same cost as continuation of coverage under COBRA, including the election period for USERRA continuation coverage, except that only the Employee may elect continuation coverage under USERRA for the Employee and Spouses and Dependents, and coverage may continue for up to 24 months under USERRA. For more information about continuing coverage under USERRA, refer to the COBRA Continuation Coverage section on page 8, or contact the Fund Office.

Coverage will not be offered for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected disabilities.

Reemployment

Following your honorable discharge from service, you may be eligible to apply for reemployment with your former Employer in accordance with USERRA. Such reemployment may include your right to elect reinstatement in any existing health care coverage provided by your Employer. Contact the Fund Office for more information.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- Birth, adoption, or Placement for Adoption of a child with you for foster care or adoption;
- Care of a seriously ill spouse, parent, or child;
- Your serious Illness; or
- Your urgent need ("qualifying exigency") for leave because your spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member in the U.S. armed services. The service member must be:

- Your spouse, son, daughter, parent or next of kin;
- Undergoing medical treatment, recuperation, or therapy for a serious Illness or Injury incurred in the line of Duty while in military service; and
- An outpatient or on the temporary disability retired list of the armed forces.

You are eligible for a leave under FMLA if you:

- Have worked for a covered Employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and

- Work at a location where at least 50 Employees are employed by the Employer within a 75-mile radius.

The Plan will maintain your prior eligibility status until the end of the leave, provided your Employer properly grants the leave under the federal law and your Employer makes the required notification and payment to the Plan.

If you return to work within 12 weeks (or 26 weeks, if applicable), you will not lose health care coverage. If you do not return to work within that time, you will then qualify to continue your coverage under COBRA Continuation Coverage for up to 18 months.

Your eligibility for leave under the FMLA is determined by your Employer. If you and your employer disagree over your eligibility for coverage under the FMLA, your benefits will be suspended until the disagreement is resolved. The Plan will not intervene in any Employer-Employee disputes.

COBRA CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your Spouse or Dependents may continue health care coverage past the date coverage would normally end if you and/or your Spouse or Dependents lose Plan medical, prescription drug, dental, or vision coverage due to a qualifying event described below. Under certain circumstances, by making Self-Payments, you or your Spouse or Dependents may continue:

- Medical and prescription drug benefits; or
- Medical, prescription drug, dental, and vision benefits.

Please note that you will not receive HRA contributions while you are on COBRA Continuation Coverage.

The COBRA Continuation Coverage will be identical to the coverage you had under the Plan, except that you will not be eligible for Loss of Time Benefits or Death Benefits.

If you have a newborn child, adopt a child, or have a child Placed for Adoption with you (for whom you have financial responsibility) while your COBRA Continuation Coverage is in effect, you may add the child to your coverage.

To have this child added to your coverage, you must provide written notification to the Fund Office within 30 days of the birth, adoption, or Placement for Adoption of the child.

Children born, adopted, or Placed for Adoption as described above, have the same COBRA Continuation Coverage rights as a Dependent who was covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, these children's continued coverage depends on timely and uninterrupted Self-Payments on their behalf.

It is important to notify the Fund Office of a qualifying event to maintain your COBRA Continuation Coverage rights. Failure to do so may disqualify you for COBRA Continuation Coverage.

There may be other coverage options for you and your family. Under key parts of the Affordable Care Act, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Keep in mind that as long as you are covered under this Plan, you are not eligible to buy coverage through the Health Insurance Marketplace.

Qualifying Events

You do not have to show that you are insurable for COBRA Continuation Coverage. It is offered if you or your Spouse or Dependents lose coverage because of a qualifying event.

If you are an Employee, you will be entitled to elect COBRA Continuation Coverage if one of the following qualifying events results in a loss of Plan coverage for you:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are a covered Spouse, you will be entitled to elect COBRA Continuation Coverage if one of the following qualifying events results in a loss of Plan coverage for you:

- Your spouse-Employee dies and you do not elect to continue coverage by using your spouse-Employee's remaining Hour Bank;
- Your spouse-Employee's hours of employment are reduced;
- The Employee stops making self-payments;
- Your spouse-Employee's employment ends for any reason other than his or her gross misconduct;
- Your spouse-Employee becomes entitled to Medicare; or
- You divorce or become legally separated from your spouse-Employee.

For a covered Dependent child, the Dependent child will be entitled to elect COBRA Continuation Coverage if one of the following qualifying events results in a loss of Plan coverage for the child:

- The parent-Employee dies and the Dependent child does not elect to continue coverage by using his or her parent-Employee's remaining Hour Bank;
- The parent-Employee's hours of employment are reduced;
- The Employee stops making self-payments;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare;
- The parents' divorce or become legally separated; or
- The child no longer meets the Plan's definition of a Dependent.

When a Qualifying Event occurs, your coverage will continue under the Plan through the end of the month in which the Qualifying Event takes place. The COBRA benefits for which you qualify and which you may elect will begin the first day of the month following the month in which the Qualifying Event occurred.

Notifying the Fund Office

You or your Spouse or Dependent must inform the Fund Office, in writing, of a legal separation, divorce, or a child losing Dependent status under the Plan within 60 days of the later of the qualifying event or the date your Spouse or Dependent would otherwise lose Plan coverage. If you or they do not notify the Fund Office within 60 days, you (or they) will lose the right to elect COBRA Continuation Coverage.

Your Employer should notify the Fund Office of your termination of employment, reduction in hours, death, or entitlement to Medicare. However, because Employers contributing to multi-employer funds may not be aware of all qualifying events, the Fund Office will rely on its records for determining when eligibility is lost under certain circumstances. To help ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Fund Office, in writing, of any qualifying events as soon as they occur.

When the Fund Office is notified that one of these events has occurred, you and your Spouse and Dependents will be notified as to whether or not you have a right to elect COBRA Continuation Coverage. If you are not eligible for COBRA Continuation Coverage, you will be notified, including information relating to why you (or your Spouse or Dependents) are not eligible.

Once you receive a COBRA Continuation Coverage notice, you have to respond within 60 days of the later of the qualifying event or the date you receive the COBRA Continuation Coverage notice if you wish to elect COBRA Continuation Coverage. Your Spouse and Dependent children will be given the opportunity to elect coverage independently from you. If you and/or your Spouse and Dependents do not respond by the deadline, you and they will not be able to elect COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage

The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage will be determined by the Trustees on an annual basis, and will not exceed 102% of the cost to provide this coverage. The cost for extended disability COBRA Continuation Coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your and/or your Spouse or Dependents' coverage under the Plan ended. Your first payment must be delivered no later than 45 days after the date you or your Spouse or Dependents returned the signed COBRA Continuation Coverage election form to the Fund Office.

Subsequent payments must be delivered by the first business day of each month for which coverage is provided with a 30-day grace period. If your COBRA premium is not received at the Fund Office by the first business day of the month, the Plan will suspend your coverage during the grace period and then will reinstate your coverage if your payment is delivered to the Fund Office within the grace period. If payment is not delivered to the Fund Office by the end of the grace period, all benefits will end immediately. Once your COBRA Continuation Coverage ends, it cannot be reinstated.

The Plan does not pro-rate COBRA payments. Because your coverage under the Plan ends on the date in which the COBRA Qualifying Event occurs, a monthly COBRA payment may be due for the month that the Qualifying Event occurred. Your monthly payments for COBRA Continuation Coverage will cover full months of coverage. If you obtain new health plan coverage and are terminating COBRA coverage under this Plan, the Plan will not pro-rate your payment for your final month of coverage, even if your COBRA coverage overlaps with your new coverage.

Periods of Coverage

Coverage Continues for 18 Months. You may elect to purchase continued coverage for yourself and your Spouse and Dependent children for up to 18 months if coverage ends due to your termination of employment or your reduction in hours.

Coverage Continues for 18 Months for Second Qualifying Event. If a second qualifying event occurs within the initial 18-month COBRA continuation period, the maximum period of coverage for your Spouse and Dependent children is 36 months. A second qualifying event may include your death, divorce, or legal separation, or a Dependent child no longer meeting the Plan's definition of a Dependent. These events are a second qualifying event only if they would have caused your Spouse or Dependent to lose Plan coverage if the first qualifying event had not occurred. You must notify the Fund Office, in writing, of any second qualifying event within 60 days after the second qualifying event.

Coverage Continues for 24 Months for Military Service. You may elect to purchase continued coverage for yourself and your Spouse and Dependent children for up to 24 months if coverage ends due to your termination of employment to enter military service. If a second qualifying event occurs within the 24-month period, the maximum period of coverage for your Spouse and Dependent children is extended up to 36 months. A second qualifying event may include your death, divorce, or legal separation or a Dependent child no longer meeting the Plan's definition of a Dependent. These events are a second qualifying event only if they would have caused your Spouse or Dependent to lose Plan coverage if the first qualifying event had not occurred. You must notify the Fund Office, in writing, of any second qualifying event within 60 days after the second qualifying event.

Continued coverage for military service will run concurrently with COBRA Continuation Coverage, if applicable. If both COBRA and military service apply, an election for continuation coverage will be an election to take concurrent COBRA/military service coverage. Continued coverage for military service may end sooner if:

- You or your Spouse or Dependents do not make the required payments by the due date;
- The Plan stops providing any group health benefits;

- You again become covered under the Plan; or
- You lose rights under USERRA because you are dishonorably discharged, fail to return to work within the time required under USERRA, or because of other conduct specified in USERRA.

All of the rules and procedures regarding COBRA Continuation Coverage apply to military leave coverage, except that the deadline for electing continuation coverage will not apply to military service coverage if under the circumstances it was unreasonable or impossible for you to make timely election of coverage (for example, emergency military deployment). In addition, if your military leave is for less than 31 days, the Plan will require you to pay only the normal employee contribution for the level of coverage you continue.

Update your information on file with the Fund Office. To protect your and your Spouse and Dependent's rights, you should notify the Fund Office, in writing, of any address change for you or your Spouse or Dependents. You should also keep a copy, for your records, of any notice you send to the Fund Office.

Coverage Continues for 29 Months with a Social Security Disability Benefit. If your employment ends due to your termination of employment or reduction in hours and, at that time or within 60 days of the event, you or your Spouse or one of your Dependents is totally disabled (as determined by the Social Security Administration), coverage may continue for you and your Spouse and Dependent children for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify the Fund Office, in writing, of the determination of disability by the Social Security Administration. Written notice must be provided by the latest of the date of the disability determination, the date your employment ended or your hours were reduced, or the date you would lose Plan coverage as a result of your employment ending or your hours being reduced. In addition, if you (or your Spouse or Dependents) later learn that you are no longer considered totally disabled by the Social Security Administration, you must notify the Fund Office, in writing, within 30 days of the determination.

Coverage Continues for 36 Months. Your Spouse and/or Dependent children may elect COBRA Continuation Coverage for up to 36 months if coverage ends because of:

- Your death;
- Your Spouse's entitlement to health care coverage under Medicare;
- Your legal separation or divorce from your Spouse; or
- Your Dependent child no longer qualifying for Dependent coverage under the Plan.

Following your death, your surviving Spouse and Dependent children may elect to continue coverage by using your remaining Hour Bank. The continuation coverage will run concurrently with the COBRA Continuation Coverage under this section. If the continuation coverage from your remaining Hour Bank is less than the number of months of continuation coverage available under this section, your surviving Spouse and Dependent children will only be eligible for the COBRA Continuation Coverage that would have been available under this section due to your death.

Loss of Continued Coverage

The period of COBRA Continuation Coverage for you or your Spouse or Dependents may end sooner if:

- You or your Spouse or Dependents do not make the required COBRA Self-Payments by the due date;
- The Plan stops providing any group health benefits;
- You or your Spouse or Dependents become covered under any other group health care plan after the date on which COBRA Continuation Coverage is elected; or
- You or your eligible Spouse first becomes entitled to Medicare after the date on which COBRA Continuation Coverage is elected. However, your Spouse and/or Dependents who are not entitled to Medicare and who are receiving COBRA Continuation Coverage will be eligible to continue COBRA Continuation Coverage until the end of the 18-month period immediately following the expiration of the initial 18-month period during which you would have been eligible to make Self-Payments if you had not become entitled to Medicare.

Family Status Changes

At some point in your life, you may experience a change in family status that affects your benefits. It is important that you understand what you or your Spouse or Dependents need to do when you experience a change in family status.

NOTIFY THE FUND OFFICE

You can help avoid delays in payment of benefits by notifying the Fund Office of:

- A new Spouse or Dependents;
- A legal separation or divorce;
- When a Spouse or Dependent is no longer eligible for coverage (you or they may want to continue their coverage through COBRA); or
- A change of address, email, or phone number.

When you experience a change in family status, you should contact the Fund Office within 90 days of such change, or as soon as possible following the status change event for any necessary forms or required paperwork. You are responsible for confirming that the Fund Office received any paperwork, documentation or payments that you send to the Fund Office. See **Adding a Spouse or Dependent** on this page. It is important that you return all requested information to the Fund Office so that the Fund Office has your correct address and family information on file. It also enables the Fund Office to keep updated marital status, Spouse and Dependent information, and information about whether you or your Spouse or Dependents have other benefits coverage. This information helps in processing your claims quickly and accurately.

FAMILY SURVEY

The Fund Office periodically distribute a Family Survey that you must complete and return to the Fund Office in order for your claims to be considered. All claims will be denied and you and your Spouse and Dependent children will be considered ineligible for coverage until the Family Survey is properly completed and delivered to the Fund Office. Failure to complete and return the Family Survey by the stated deadline will result in suspension of benefits under this Plan; your benefits will not be reinstated until the Fund Office has received your Family Survey.

ADDING A SPOUSE OR DEPENDENT

If you are eligible for benefits and you acquire a Spouse through marriage or a Dependent child through birth, adoption, or Placement for Adoption, coverage for that Spouse or Dependent begins immediately at the effective date of the event, as long as you deliver the required documentation within the appropriate timeframe. You should notify the Fund Office within 90 days of the date that one of these events occurs for coverage to be effective as of that date. You may add a Spouse or a Dependent child after 90 days of the birth or adoption (or Placement for Adoption) of a child; however, coverage will only be available for future claims as of the date notification is received by the Fund Office. You should contact the Fund Office as far in advance of the event (marriage, birth, adoption, or Placement for Adoption) as possible to learn what documents you are required to deliver to the Fund Office.

In all cases, you should contact the Fund Office to confirm that your submitted documentation has been received; it is not the Fund Office's responsibility to contact you.

To add a Spouse, the Fund Office will examine the original or state- or county-certified copy of the returned marriage license. If the document is delivered to the Fund Office within 90 days of the marriage, the Spouse's coverage will be effective on the date of the marriage. If the document is delivered to the Fund Office after the first 90 days, the Spouse's coverage will be effective on the date the document was delivered to the Fund Office. Delivery of these documents by scans, copies, emails, and fax transmissions will not be accepted; the Fund Office must examine the county, state, or court seal. Your originals will be returned to you. In addition, Social Security Numbers or Tax Identification Numbers must be submitted.

To add a Dependent child:

- By birth of your natural-born child, the county- or state-certified copy of the birth certificate must be delivered to the Fund Office within 90 days of the date of birth of the child you wish to add as a Dependent. However, the Fund Office will accept, for temporary 90-day coverage, effective with the child's date of birth, a fax, scan (emailed), copy or original of a hospital-issued certificate of birth or hospital-issued memento-type certificate of birth, in which the Employee is named as a parent; this document must be Delivered within 90 days of birth in order to provide ongoing coverage for the child. In addition, Social Security Numbers or Tax Identification Numbers must be submitted as soon as they are available.
- By adoption or Placement for Adoption, the court-certified adoption or Placement for Adoption papers must be Delivered to the Fund Office within 90 days of the date of adoption or Placement for Adoption of the child you wish to add as a Dependent.
- By marriage (i.e., a stepchild), the Fund Office will examine the state- or county-certified original birth certificate that shows your Spouse as the parent. If your Spouse's name on the birth certificate differs from that on the marriage license for you and your Spouse, then additional original, official documentation proving the succession of name changes will be required by the Fund Office as well. If the document is Delivered to the Fund Office within 90 days of the marriage, the stepchild's coverage will be effective on the date of the marriage. If the document is Delivered to the Fund Office after the first 90 days, the stepchild's coverage will be effective on the date the document was delivered to the Fund Office. Delivery of these documents by scans, copies, emails, and fax transmissions will not be accepted; the Fund Office must examine the county, state, or court seal. Your originals will be returned to you. In addition, Social Security Numbers or Tax Identification Numbers must be submitted.

REMINDER: Delivery of these documents by scans, copies, emails, and fax transmissions will not be accepted; the Fund Office must examine the county, state, or court seal. Your originals will be returned to you.

SOCIAL SECURITY NUMBERS

Under Federal law, the Plan is obligated to report Social Security Numbers or Tax Identification Numbers of persons covered under the Plan, to the Center for Medicare Services, who uses this reporting to prevent fraud and duplication of payments under Medicare. Therefore, every covered person must provide their Social Security Number or Tax Identification Number to the Fund Office. Those individuals who do not provide Social Security Numbers or Tax Identification Numbers will have their coverage under the Plan suspended until they do so.

DEPENDENT REACHES AGE 26

When your Dependent child reaches age 26, his or her eligibility for coverage will normally end at the end of the month.

Notify the Fund Office of any change in your family status.

You must also contact the Fund Office to update your address, if you move. If the Fund Office receives returned mail that was addressed to you, your coverage under the Plan will be suspended until you contact us with your new address.

DEPENDENT LOSES ELIGIBILITY FOR COVERAGE

If your Dependent loses eligibility for coverage and wants to continue coverage under COBRA, contact the Fund Office within 60 days from the date your Dependent loses eligibility. See page 8 for more information about COBRA Continuation Coverage.

IN THE EVENT OF LEGAL SEPARATION OR DIVORCE

In the event of a legal separation or divorce, if your ex-spouse was covered under the Plan and wants to continue coverage under COBRA, you or your ex-spouse have 60 days from the date of the legal separation or divorce to request COBRA Continuation Coverage information from the Fund Office. See page 8 for more information about COBRA Continuation Coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan recognizes Qualified Medical Child Support Orders (QMCSOs), including a National Medical Support Notice, and provides benefits for a Dependent child(ren) as required by a court order in the event of a divorce or other family law action. Orders must be submitted to the Fund Administrator who will determine whether the order is a QMCSO, as required under federal law. Contact the Fund Office for more information.

IN THE EVENT OF YOUR DEATH

In the event of your death, your surviving Spouse or Dependents should contact the Fund Office. Your surviving Spouse or Dependent children may be eligible to continue coverage under the Plan (see page 9). In addition, your beneficiary(ies) may be eligible for a Death Benefit.

WHEN YOU RETIRE

At retirement, you may qualify to continue coverage under the Local No. 9, IBEW and Outside Contractors Retired Employees Health and Welfare Plan. It is a good idea to contact the Fund Office well in advance of your retirement. The Fund Office will guide you through the retirement process and answer any questions you may have about your benefits and the self-payment process.

DISENROLLING A SPOUSE OR DEPENDENT

Because enrolling a Spouse or Dependent is voluntary and not required by the Plan, you may disenroll a Spouse or Dependent at any time by completing and submitting the Spouse or Dependent Disenrollment Form.

Once a Dependent child under age 18 is enrolled in the Plan, he or she may not be disenrolled by a Participant without the written consent of all of the Dependent's parents or guardians, provided that the Dependent otherwise remains eligible for coverage. Once a Dependent child age 18 or older is enrolled in the Plan, he or she may not be disenrolled by a Participant without the Dependent's written consent, provided that the Dependent otherwise remains eligible for coverage.

You may not backdate a disenrollment, except in the case of divorce or legal separation of a Spouse. Otherwise, the coverage end date for the disenrolled person will be the date the Fund Office receives the properly completed disenrollment form; in cases of disenrollment, the delivery date does not apply.

The Fund Office will send an offer of COBRA Continuation Coverage to the disenrolled Spouse or Dependent child if the disenrollment constitutes a qualifying event as described on page 8.

Medical Benefits

The benefits described in this section apply to you and your Spouse and Dependent children, unless noted otherwise.

HOW THE PLAN WORKS

Medical Benefits pay for a wide range of services and supplies. The way the Plan works is simple. In general, this is how the Plan pays Medical Benefits each Calendar Year (January 1 – December 31):

- **Deductible:** You are responsible for meeting your Calendar Year Deductible before the Plan begins to pay for most covered medical expenses.
- **Emergency Room Copayment:** If you or your Spouse or Dependents visit a Hospital Emergency room, you are required to pay a Copayment for each visit, which is waived if you are admitted.
- **Coinsurance:** Once you or your Spouse or Dependents meet the Deductible (where applicable), the Plan pays a percentage of covered medical expenses, and you pay the rest.
- **Calendar Year Out-of-Pocket Maximum:** Once you or your Spouse or Dependents' covered medical expenses reach the Out-of-Pocket Maximum in a Calendar Year, the Plan pays 100% of most covered medical expenses incurred for the remainder of that Calendar Year, up to any specific benefit Calendar Year Maximums.

Calendar Year Maximum: There is no Calendar Year Maximum. Note that some benefits and expenses may be covered differently or may be subject to benefit maximums. See the ***Schedule of Benefits*** and specific benefit descriptions for more information.

Preferred Provider Organization (PPO)

The Plan offers a Preferred Provider Organization (PPO) through BlueCross BlueShield of Illinois (BCBSIL). When you use a BCBSIL PPO provider, you save money for yourself and the Plan because BCBSIL has an agreement with providers that participate in their network to charge negotiated rates. For information about participating providers, contact BCBSIL:

- By calling 800-810-2583; or
- Visiting www.bcbsil.com (click on "Provider Finder" then click on "Labor Accounts").

Generally, treatment and services received at a PPO provider are reimbursed at a higher percentage compared to care received from a non-PPO provider (as specified on the ***Schedule of Benefits***). In addition, the Deductible and Out-of-Pocket Maximums vary depending on whether you use PPO or non-PPO providers.

BlueCard Program

The BlueCard Preferred Provider Organization (PPO) gives you access to BlueCross BlueShield network providers throughout the country. This means that if you travel or reside outside the Illinois area and visit a participating BlueCard Physician or Hospital, the Plan pays most covered expenses at the PPO provider rate (after you meet your Calendar Year Deductible). In addition, when you use BlueCard PPO providers, you generally do not have to file claim forms. To locate a participating provider, call BlueCard Access at 800-810-2583 or visit www.bcbs.com.

Use of PPO Providers

Deductible amounts, Coinsurance percentages, and Out-of-Pocket Maximums vary depending on whether you use PPO or non-PPO providers.

PPO

A PPO is a network of providers that have agreed to charge negotiated rates. Since PPO providers have agreed to these negotiated rates, you help control health care costs for yourself and the Plan when you use PPO providers.

It is your decision whether or not to use a PPO provider. You always have the final say about the Physicians and Hospitals you and your family use.

PPO SAVINGS EXAMPLE

To give you an idea of how much you could save by using PPO providers, let's compare what Diana pays when using a PPO Hospital versus a non-PPO Hospital. This example assumes that Diana has already met her Deductible.

	PPO Hospital*	Non-PPO Hospital
Hospital Stay Charges	$5,000	$8,400
Plan Pays	$4,500 (90%)	$6,300 (75%)
Diana Pays	$500 (10%)	$2,100 (25%)

Diana saves $1,600 by using a PPO Hospital.

** This example assumes a PPO savings rate of approximately 40%. The actual savings may vary depending on the actual Hospital confinement.*

Calendar Year Deductible

Each year, the Plan begins to pay benefits after you satisfy the Calendar Year Deductible (January 1 through December 31).

There are separate Deductible amounts for PPO and non-PPO provider expenses. The PPO Deductible must be met before the Plan begins to pay PPO provider expenses, except as discussed below in **Benefits Not Subject to the Calendar Year Deductible**. The non-PPO Deductible must be met before the Plan begins to pay non-PPO provider expenses. The Calendar Year Deductible amounts are listed on the ***Schedule of Benefits***.

The individual Deductible applies to each Participant. For a family, once the family has combined Deductibles for covered expenses equal to the family maximum, no further individual Deductibles are required. Amounts paid toward meeting the Deductible apply toward meeting your Out-of-Pocket Maximum.

Benefits Not Subject to the Calendar Year Deductible

The following benefits are not subject to the Calendar Year Deductible:

- In-Network mental health and substance abuse treatment benefits;
- Wellness benefits;
- Prescription drug benefits;
- Hearing benefits;
- Smoking cessation benefits;
- Dental benefits;
- COVID-19 vaccines as a Qualifying Coronavirus Preventive Service;
- Vision benefits; and
- Breast Pump benefits.

Emergency Room Copayment

In the event of an Emergency, there are several treatment alternatives including going to a Physician's office, visiting an urgent care facility, or going to a Hospital Emergency Room. In many instances when you need immediate attention, you may receive the same level of care at a Physician's office or urgent care facility as in a Hospital Emergency Room—and generally that care will cost substantially less.

When it's not possible to seek treatment at your Physician's office or an urgent care facility, or in a life-threatening situation, you should go to the Emergency Room for treatment. When you go to the Emergency Room, you pay the Copayment amount (a flat dollar amount) specified in the ***Schedule of Benefits***, and then the Plan pays a percentage of the remaining covered charges, once you meet your Deductible. If you are admitted to the Hospital, the Plan will waive the Emergency Room Copayment.

The Plan pays emergency room providers as well as lab tests and x-rays conducted during an emergency room visit at the network rate when performed at a network facility, regardless of whether or not the provider is a network provider.

The most important consideration in the event of an Emergency is to get medical care, especially in a life-threatening situation. However, to be prepared in an Emergency, you should find out in advance what your Physician's hours and Emergency procedures are, and you should locate the urgent care facility nearest you.

Coinsurance

Coinsurance, expressed as a percentage, is your share of the cost of covered services or supplies. Each Calendar Year, after you or your family meet the Calendar Year Deductible, the Plan pays a percentage of covered charges and you pay the rest (up to the Out-of-Pocket Maximum). The percentage the Plan pays is listed in the ***Schedule of Benefits***.

Keep in mind that the percentage the Plan pays varies, depending on whether you use a PPO or non-PPO provider. The Plan pays a higher percentage of covered charges when you use a PPO provider. That is, you pay more when you use a non-PPO provider.

Out-of-Pocket Maximum

To help manage your Out-of-Pocket expenses, the Plan limits what you pay for covered medical expenses each Calendar Year. Once you reach the Out-of-Pocket Maximum, which includes amounts you pay toward meeting your Deductible, the Plan pays 100% of most covered medical expenses for the remainder of the Calendar Year, up to any applicable Calendar Year maximums on specific benefits. There are separate PPO and non-PPO Out-of-Pocket Maximums. The PPO Out-of-Pocket Maximum must be met before the Plan begins to pay 100% of most PPO provider expenses. The non-PPO Out-of-Pocket Maximum must be met before the Plan begins to pay 100% of most non-PPO provider expenses.

The individual Out-of-Pocket Maximum applies to each Participant. For a family, once the family has combined Out-of-Pocket medical expenses equal to the family maximum, the Out-of-Pocket Maximum will be met for all family members.

Expenses Not Subject to the Out-of-Pocket Maximum

Certain expenses do not apply toward meeting the Out-of-Pocket Maximums, including:

- Copayments;
- Prescription medications;
- Amounts for services or supplies not covered under the Plan; and
- Amounts in excess of Allowable Charges or any Plan maximums.

Calendar Year Maximum

There is no Calendar Year Maximum. Specific benefit maximums are listed in the ***Schedule of Benefits***.

Managing Your Care – Utilization Management (UM)

The Plan offers a pre-authorization program and a case management medical review program designed to help you receive quality treatment and maximize your Plan benefits. This program helps ensure that you get the right care at the right time because the program evaluates the necessity, appropriateness, and efficiency of medical services, procedures, and facilities.

Generally, services and supplies will be pre-authorized if they are Medically Necessary, efficiently provided in the most appropriate setting, and consistent with the way other providers would treat the same condition.

The Claims Office or pharmacy benefit manager may refer certain procedures, diagnoses or medications to case management. See the Prescription Drug Benefits section for information about medications that are subject to pre-authorization.

Your Physician or Hospital must call Case Management Specialists at 800-861-8744 for pre-authorization before receiving benefits that require pre-authorization. If you do not obtain pre-authorization, your charges will not be covered.

Required Pre-Authorization

In order for you to receive Plan coverage for the following services and/or supplies, you, your doctor or hospital will have to contact Case Management Specialists and have the following services and/or supplies pre-authorized. Some of the following services and/or supplies will also be subject to ongoing case management over the period of time you are receiving them:

- Inpatient hospitalizations, excluding routine deliveries;
- C-sections;
- Discograms;
- Durable Medical Equipment, for a rental that exceeds three months or at a cost that exceeds $500;

- Ear/Nose/Throat surgeries;
- Genetic Testing;
- Hand/Wrist surgery;
- Home Health Care;
- Hospice care;
- Hysterectomies;
- Mental Health or Substance Abuse Treatment in Residential, Partial Hospitalization, or Intensive Out-Patient levels of care;
- Neuropsychological Testing;
- Organ transplants;
- Psychological Testing;
- Radiofrequency Ablation;
- Sleep disorder diagnostics and treatments;
- Speech therapy;
- Spinal surgery and treatment, except for chiropractic;
- Surgery/treatment/care that could be considered Cosmetic, such as Abdominoplasty, Breast Augmentation/reduction (other than reconstruction following a mastectomy), birthmarks, Blepharoplasty (eyelid surgery), Botox injections, Panniculectomy, and scar removal/revision; and
- Varicose Vein procedures;

If necessary, preauthorization can be conducted retroactively and without penalty for procedures covered under the Plan. However, if it is determined that the procedure or service is not Medically Necessary, it will not be covered under the Plan.

COVERED MEDICAL BENEFIT EXPENSES

Covered medical expenses include the Allowable Charges for the following Medically Necessary services and supplies to treat a non-occupational bodily Illness or Injury.

- **Allergy services**, including:
  - Allergy sensitivity testing, including skin patch or blood test such as Rast or Mast.
  - Desensitization and hyposensitization (allergy shots given at periodic intervals).
  - Allergy antigen solution.
- **Ambulance services**, including:
  - Ground vehicle transportation to the nearest appropriate facility as Medically Necessary for treatment of a Medical Emergency, acute Illness, or inter-health care facility transfer.
  - Air/sea transportation only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.
  - Ambulance services are covered at the PPO rate.
- **Birth control provided or prescribed by a Physician**, including surgical procedures, implants, appliances, and devices for all covered individuals. (Prescription drugs are covered under the Plan's *Prescription Drug Benefits*, as described on page 24.) **Over-the-counter items are not covered.**
- **Blood transfusions and blood products** and equipment for its administration.

If you have questions about expenses covered under the Plan's Medical Benefits, contact the Claims Administrator at 800-461-9025.

- **Casts, splints**, trusses, crutches (not returnable to the provider), and braces.
- **Chemotherapy** and chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, health care facility, Physician's office, or at home.
- **Chiropractic services** (Spinal Manipulation), which includes spinal manipulation services from a Physician or chiropractor and related ancillary services (for example, Office Visits and X-rays) performed along with spinal manipulation, up to the Calendar Year maximum listed on the ***Schedule of Benefits***.

- **Charges for routine colonoscopies and sigmoidoscopies for Participants age 50 and over,** subject to the following limitations:
  - One routine colonoscopy every five years following the 50th birthday; or
  - One routine sigmoidoscopy every five years following the 50th birthday.
- **Charges for routine colonoscopies for Participants under age 50** are allowed when there is family history or a related diagnosis that makes testing Medically Necessary.
- **COVID-19 Tests and Test-Related Services:** Effective on February 11, 2020 through the end of the COVID-19 Emergency Period, the Plan will cover a COVID-19 Test and COVID-19 Test-Related Services through the BCBS network and Out-of-Network providers at no cost and without deductible. Out-of-Network providers will be reimbursed according to the cash price for such service that is listed by the provider on a public website.
- **Corrective appliances**, including:
  - Artificial limbs, eyes, and larynx.
  - Purchasing of prosthetic appliances used to aid in the function of or to replace a limb, limited to a Lifetime maximum of one artificial limb or organ if the appliance is the original appliance, or a replacement is required by pathological change or normal growth. This includes electronic heart pacemakers.
  - Purchasing of orthopedic appliances used to correct the shape or function of the body, to provide easier movement capability, or reduce pain.
- **Coverage of preventive services and vaccines for COVID-19**
  - Effective January 1, 2021, the Plan will cover a preventive service on an in-network basis, without participant cost-sharing (such as a copayment, coinsurance, or a deductible), prior authorization, or other medical management requirements.
  - Effective January 1, 2021 through the end of the COVID-19 Emergency Period, the Plan will cover a preventive service on an out-of-network basis, without participant cost-sharing (such as a copayment, coinsurance, or a deductible), prior authorization, or other medical management requirements. The plan will reimburse an out-of-network provider for the item or service in an amount that the Plan determines is reasonable, as determined in comparison to prevailing market rates for such services. A reasonable amount shall include the amount that the provider would be paid under Medicare for the item or service.
- **Dental treatment** covered under the Plan's Medical Benefits include:
  - Treatment for Injuries to natural teeth within 12 months after the incident (replacement or repair of a denture are not covered under this benefit).
  - Treatment or removal of a tumor.
  - Medical care, services, supplies provided by a Hospital during Medically Necessary confinement in connection with dental treatment.
  - Extraction of wisdom teeth and impacted teeth. To be covered under the Plan's Medical Benefits, dental treatment must be provided by a Physician, dentist, or oral surgeon.
- **Diagnostic X-rays** and laboratory examinations. Any x-ray or lab charge will be covered at a network rate when performed at an in-network facility.
- **Dialysis, hemodialysis, or peritoneal dialysis** and supplies administered under the direction of a Physician in a Hospital, health care facility, Physician's office, or at home.
- **Dressings**.
- **Durable Medical Equipment** when ordered by a Physician or health care practitioner, including:
  - Rental of Durable Medical Equipment, but only up to the allowed purchase price.

- Purchase of standard models of Durable Medical Equipment when approved by the Plan.
- Repair, adjustment, servicing, or Medically Necessary replacement of Durable Medical Equipment due to a change in the Participant's physical condition or if the equipment cannot be satisfactorily repaired.
- Medically Necessary oxygen and equipment and supplies required for its administration.
- Breast pump purchase up to the limits shown in the ***Schedule of Benefits***.

- **Emergency room and urgent care facility services** for a Medical Emergency, including ancillary charges (such as lab or X-ray; any x-ray or lab charge will be covered at a network rate when performed at an in-network facility) performed during the Emergency Room or urgent care visit.

  The Plan pays emergency room providers as well as lab tests and x-rays conducted during an emergency room visit, at the network rate when performed at a network facility, regardless of whether or not the provider is a network provider.
- **Extended Care Facility** services.
- **Fertility and reproductive services**, including:
  - Diagnosis and treatment of medical problems that contribute to infertility and charges in connection with the promotion of conception, subject to the limitation shown in the ***Schedule of Benefits***.
  - Voluntary sterilization.
- **Hearing benefits**, which include a hearing exam, aids, and related expenses, as specified and up to the hearing benefit limits listed in the ***Schedule of Benefits***. The Deductible does not apply to hearing benefits.
- **Home health care services** when ordered by a Physician or health care practitioner and provided by a licensed Home Health Care Agency, including:
  - Part-time, intermittent skilled nursing care services; and
  - Medically Necessary supplies to provide home health care services.
- **Hospice inpatient and home** care.
- **Hospital room and board** charges in a semiprivate room or private room with general nursing services, including:
  - Specialty care units (for example, Intensive Care Unit or Cardiac Care Unit).
  - Lab, X-ray, and diagnostic services.
  - Related Medically Necessary ancillary services.
  - Newborn care while the mother is Hospital confined (including Inpatient charges, circumcision, and Physicians' visits).

  "Semiprivate" means the charge by the Hospital for semi-private room and board accommodations or the average semi-private room rate of other Hospitals in the same geographical area if the Hospital does not provide semi-private accommodations.
- **Maternity services and supplies** for your or your covered Spouse's pregnancy and pregnancy-related conditions. Covered items include (but are not limited to):
  - Inpatient Hospital charges.
  - Physicians' or a midwife's delivery fees.
  - Prenatal laboratory and X-ray examinations.
  - Sonograms and ultrasound testing.
  - Prenatal and Postnatal Office Visits (coverage for your pregnant dependent child, up to age 26, is provided only for prenatal and postnatal office visits. The costs related to the delivery of the baby are not covered).
  - Anesthesia and its administration.
  - Tubal ligation.

  In addition to the above, the Plan provides an $800 **weekly maternity benefit** in connection with a birth for active eligible female Participants. The benefit is payable for six (6) weeks for a traditional delivery and eight (8) weeks for a cesarean section delivery. This benefit takes effect immediately upon the child's birth.

- **Mental health and substance abuse treatment facility** charges and psychiatric service charges of a Physician for mental or nervous disorder or substance abuse treatment subject to the applicable provisions described below. All services below, except for outpatient treatment, require pre-certification.
    - Psychiatric (mental/nervous treatment) benefits are available for Inpatient facility care, Inpatient practitioner care, treatment in residential treatment center, and day/evening treatment programs.
    - Outpatient treatment including individual or group sessions with a licensed, qualified professional.
    - Intensive Outpatient Programs (IOP).
    - Partial Hospitalization Program (PHP).
    - Residential level of care.

Refer to page 16 for more information about Emergency Room benefits including information about the Emergency Room Copayment.

The Newborns' and Mothers' Health Protection Act of 1996

Federal law requires that benefits be provided to the mother and/or newborn child for Hospital confinement of at least 48 hours following a vaginal delivery or 96 hours following a cesarean section, unless the mother's or newborn's provider, after consulting with the mother, chooses to discharge the mother or newborn from the Hospital sooner. In addition, the law provides that the Plan may not require the provider to obtain authorization for prescribing a length of stay that does not exceed 48 hours (or 96 hours following cesarean section).

LASIK surgery is covered under the Plan's medical benefits, subject to the Plan's Deductible and Coinsurance provisions for Employees only.

- **Foot Orthotics (orthopedic or corrective shoes), other supportive appliances for the feet and orthotic devices** when prescribed by a Physician or health care practitioner, as Medically Necessary. Over-the-counter orthotics are not covered.
- **Physician and other health care practitioner services** in an office, Hospital, Emergency Room, or other covered health care facility location. Covered Physician's and health care practitioner's fees include:
    - Surgeon.
    - Assistant Surgeon if Medically Necessary, but limited to the amount shown in the ***Schedule of Benefits***.
    - Anesthesia.
    - Pathologist.
    - Radiologist.
    - Emergency room Physician.

  The Plan pays anesthesiologist, pathologist, radiologist, laboratory, ambulance, and emergency room physician covered expenses at the network rate, of the Allowable Charge, when performed at a network facility, regardless of whether or not the provider is a network provider.
- **Preadmission testing** such as X-ray examinations and/or laboratory tests made before a Hospital admission. Payment is made if the:
    - Tests are ordered by the attending Physician or surgeon;
    - Tests are performed in the Outpatient department of the Hospital to which you are being admitted;
    - Hospital confinement is scheduled to begin within 48 hours after the tests are performed; and
    - Tests are medically valid at the time of the Hospital admission.
- **Private duty nursing care** and services of a professional registered nurse or licensed practical nurse other than one who ordinarily resides in your home or who is a member of your immediate family.
- **Radium and radioisotope treatment.**
- **Skilled Nursing Facility** care.
- **Smoking Cessation** expenses, including prescription or over-the-counter medications and/or program charges for smoking cessation programs, as noted in the ***Schedule of Benefits***.

- **Speech therapy** provided for developmental delay on an outpatient basis by an American Speech-Language-Hearing Association (ASHA) certified and, where applicable, state licensed speech-language pathologist.

When you need to see a Physician…

- Call BlueCross BlueShield of Illinois at 800-810-2583 to see if your Physician is a participating provider.
- Call your Physician's office to make an appointment.
- Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you are taking. Be sure to note how often you take the medications.
- When you go to your appointment, make sure to show your BlueCross BlueShield of Illinois medical ID card. If you go to a PPO provider, your provider will file claims for you. If you go to a non-PPO provider, you may need to file your claim with the Claims Administrator.

The Plan pays radiologist, anesthesiologist, pathologist, emergency room physician, laboratory and ambulance covered expenses at the network rate, of the Allowable Charge, when performed at a network facility, regardless of whether or not the provider is a network provider.

Please refer to the ***Schedule of Benefits*** for information about specific limitations that apply to some benefits.

- **Surgical benefits**, including:
  - Second Surgical Opinions.
  - Services and supplies provided in an in-network Outpatient surgical facility, Hospital Outpatient department, Physician's office, clinic, or elsewhere because of a surgical procedure performed other than in a Hospital.
  - Benefits for reconstructive breast surgery following a mastectomy are provided on the same basis as other surgical procedures covered by the Plan, including:
    - Reconstruction of the breast on which a mastectomy is performed.
    - Reconstructive surgery on the other breast to produce a symmetrical appearance.
    - Prostheses.
    - Physical complications of any stage of mastectomy, including lymphedemas.

Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, as described above.

- **Telehealth Services:** From March 1, 2020 through the end of the COVID-19 Emergency Period, the Plan will provide medically necessary Telehealth Services through the BCBS network at no cost-sharing and without deductible. Telehealth services received through an Out-of-Network provider will be reimbursed according to the cash price for such service.
- **Transplant benefits** when received from BlueCross BlueShield of Illinois PPO providers, including the following transplants:
  - Cornea;
  - Kidney;
  - Heart;
  - Liver;
  - Lung;
  - Heart/lung;
  - Bone marrow; and
  - Small bowel/liver or small bowel multi visceral.

  Note: Donor out-of-pocket expenses (i.e. lodging and meals) are covered up to the limit shown in the ***Schedule of Benefits***.
- **Immunosuppressive medications** required after a transplant will also be covered under the Plan through the Plan's *Prescription Drug Benefits* (see page 24).

Wellness Benefits

Wellness Benefits include charges for routine physical examinations and tests for you, your Spouse, and your Dependent children. Covered Wellness Benefits expenses include:

- Routine physical examinations and tests.
- Immunizations for Dependent children including COVID-19 vaccines as a Qualifying Coronavirus Preventive Service.

- One gynecology exam and one Pap smear lab test per Calendar Year.
- One screening mammogram (for women age 35 and older) and interpretation of it.
- Adult immunizations, as follows:
    - Tetanus, diphtheria, pertussis (Td/Tdap) vaccine, limited to once every 10 years.
    - Human Papillomavirus (HPV) vaccine up to age 26 (administered in three doses).
    - Measles-Mumps-Rubella (MMR) vaccine.
    - Varicella vaccine (administered in two doses at an interval of 4-8 weeks).
    - Influenza vaccine for all Participants annually.
    - Pneumococcal vaccine Participants age 65 and older.
    - Hepatitis A and B vaccines.
    - Zoster vaccine (for prevention of herpes zoster and post-herpetic neuralgia) for Participants age 60 and older
    - Travel vaccines, as necessary, for cholera, typhoid, malaria, rabies, polio, meningitis, encephalitis, and Lyme disease
    - COVID-19 vaccines for all Participants as a Qualifying Coronavirus Preventive Service.

  Please note that some adult immunizations may require certain risk factors to be present in order for them to be considered Medically Necessary and to be covered.

DOT/Physical Exam Benefits

The Plan covers Department of Transportation (DOT) certifying physical exams/drug tests for Employees only. Under this separate, additional benefit, the Plan pays 100%, no deductible, up to $125 per test if the exam/test is performed through Concentra, the Plan's preferred provider for this benefit. If a Concentra provider is not used, the Plan pays 100%, no deductible, up to $125 per test. Any covered expenses that exceed the DOT Exams maximum may be covered under the Plan's medical benefits and will be subject to the Plan's Calendar Year Deductible and Coinsurance provisions.

Member Assistance Program

You may call Employee Resource Systems (the Plan's Member Assistance Program) at 800-292-2780 for telephone counseling for minor problems, or for assessment and referral assistance for mental health and substance abuse problems. If further treatment is recommended, the MAP counselor can assist you in arranging for additional services to be provided under the Plan's Medical Benefits.

The MAP case manager may also monitor your treatment programs as treatment progresses (called concurrent review) to assist you in determining the necessity of continued stay and appropriateness of the level of care, as well as any ancillary services.

EXPENSES NOT COVERED UNDER MEDICAL BENEFITS

For information about expenses not covered under the Plan's Medical Benefits, see ***General Plan Limitations and Exclusions*** on page 36.

Prescription Drug Benefits

Prescription drug expenses are one of the fastest increasing health care expenses. Recognizing the importance of this coverage, the Plan offers prescription drug benefits to you and your Spouse and Dependent children.

You do not need to satisfy the annual Deductible before prescription drug benefits are paid under the Plan. Prescription drug benefits are not considered when calculating your annual Out-of-Pocket Maximum.

HOW THE PRESCRIPTION DRUG PROGRAM WORKS

The Plan provides prescription drug benefits through a pharmacy benefits manager ("PBM"), which includes a:

- Retail pharmacy program for your short-term prescriptions (up to a 90-day supply);
- Mail order program for your long-term prescriptions (up to a 90-day supply); and
- Therapeutic Quantity Limits (QL) Program, which will impose quantity limits on certain categories of medications.

RETAIL PHARMACY PROGRAM

The Plan has contracted with the PBM network of pharmacies (called participating pharmacies) to provide prescription drugs at discounted prices. You can go to any retail pharmacy that participates in the PBM network to have your short-term prescription filled for up to a 90-day supply. Prescriptions obtained from Wal-Mart or Sam's Club are not covered by the Plan. You should refer to the Important Contact Information in your ***Schedule of Benefits*** for the name of the PBM and contact information you will need to determine which pharmacies participate in the network.

When you have your prescription filled at a participating pharmacy and present your PBM information (contained on the lower right corner of your BCBSIL ID card), there are no claim forms to file. Generally, when you pick up your prescription, you pay your Coinsurance for up to a 30-day supply of your prescription at the time it is filled and the Plan pays the rest. The amount of Coinsurance is listed in the ***Schedule of Benefits***.

For benefits to be paid under the prescription drug program, you need to have your prescriptions filled at participating pharmacy and present your BCBSIL ID card. Prescriptions filled at a non-participating pharmacy are also covered under the Plan; however, you must pay the full cost of the prescription and then submit a claim for reimbursement to the PBM (refer to the ***Schedule of Benefits*** insert for information on reimbursement).

Coverage of prescriptions obtained from a non-participating pharmacy: When you fill your prescription at a non-participating retail pharmacy, your prescription will be covered by the Plan. However, you must pay the full cost of the prescription and then submit a claim for reimbursement to the PBM.

To obtain prescriptions through mail order you must use the Plan's mail order drug provider.

Participating Pharmacies

The PBM pharmacy network available to you includes most major national chain stores, including Dominick's, Walgreens, and CVS. **Certain pharmacies are excluded from your network, such as Walmart and Sam's Club Pharmacies.**

To find out if a particular pharmacy participates in the PBM pharmacy network:

- Ask the pharmacy;
- Visit the PBM's website listed in the *Important Contact Information* in your ***Schedule of Benefits***;
- Call the PBM at the number listed in the *Important Contact Information* in your ***Schedule of Benefits***.

MAIL ORDER PROGRAM

A mail order program that is affiliated with the PBM provides you and your Spouse and Dependent children with coverage for your long-term prescription needs. Long-term medications are those that you take on an ongoing basis, such as for high blood pressure, arthritis, heart conditions, and diabetes. If you take a medication on an ongoing basis, you should fill your prescription through the mail order program.

Generic Medications Save You Money

Generally, generic medications cost less than brand-name medications, so your share of the cost (the coinsurance that you pay) is a percentage of a lower amount.

If you have any questions regarding your prescription drug benefits or need to locate a participating pharmacy near you, contact the PBM as indicated on the *Important Contact Information* section in your ***Schedule of Benefits***.

Through the mail order program, you can receive up to a 90-day supply (plus refills when appropriate) of your long-term medications delivered right to your home. Generally, when you have a prescription filled through the mail order program you pay the Coinsurance amount for each prescription. The Coinsurance amount, which is listed in the ***Schedule of Benefits***, depends on whether the prescription is filled with a generic or brand-name medication.

Filling Prescriptions

When you have a prescription you want to fill through the mail order program, follow these steps:

- Ask your Physician for a written prescription for up to a 90-day supply, plus refills if appropriate.
- Register with the mail order program in one of the following ways:
  - Visit the website listed in *the Important Contact Information* in your ***Schedule of Benefits*** and follow the prompts. Your account will activate within 24 hours. By registering online, you may track the progress of your orders.
  - Call the number listed in the *Important Contact Information* in your ***Schedule of Benefits*** to speak with a representative.
  - Mail your completed Registration and Prescription Order Form that is available from the Fund Office, or download the form from the Fund Office website at www.myfundoffice.com.
- Once you have registered, your Physician can fax your prescriptions to the mail order program using the fax number listed in the *Important Contact Information* in your ***Schedule of Benefits***. Your Physician must include your date of birth and contact information on the fax. Only faxes that are sent from a Physician's office will be valid.

Refilling Prescriptions

If your written prescription indicates that refills are available, you can refill your prescription through the mail order program. You may order a refill of your prescription by phone, online, or through the mail.

THERAPEUTIC INTERCHANGE AND "TRY ONE ON US" PROGRAMS

These programs promote the use of generic medications instead of their more costly, but no more effective, brand-name alternative medications. If you are taking a high cost brand-name medication, you will receive a letter from the Plan's Pharmacy Benefit Manager that lets you know about lower cost alternatives that you can take to treat your condition. You should share this information with your doctor and/or your pharmacist to see if the alternative makes sense for you.

The following therapeutic drug categories are covered by this program:

- ARB's for Hypertension
- Antihypertensive Combinations
- Triptans for Migraine
- Statins for Cholesterol
- Proton Pump lnhibitors
- SSRI and SNRI Antidepressants
- Sleep Aids
- Nasal Sprays
- Osteoporosis Medications
- Cox 2 Anti-lnflammatory (Celebrex)
- Prostaglandin Eye Drops for Glaucoma

If you decide to try the lower cost generic option, the Plan will provide your first prescription fill for free through the "Try One on Us" program.

SPECIALTY PHARMACY

Specialty medications are usually high-cost, complex pharmaceuticals that have unique clinical, administration, distribution, or handling requirements. They require close supervision and monitoring. They are often given by injection or infusion to treat complex, chronic conditions such as Cancer, Rheumatoid Arthritis, Hepatitis, Multiple Sclerosis and Psoriasis.

Specialty medication services are provided through the PBM's Specialty Pharmacy. If you have any questions about specialty medications, call number listed in the Important Contact Information in your ***Schedule of Benefits***.

COVERED PRESCRIPTION DRUG EXPENSES

Covered expenses include Federal Legend drugs that require a written prescription from a Physician or dentist. A licensed pharmacist must dispense these prescriptions. In addition, the following is a list of medications covered under the Plan:

- Insulin and insulin syringes;
- Other syringes;
- Diabetic supplies;
- Mental health medications;
- Injectable drugs, subject to pre-authorization, except that the following self-injectables are not subject to pre-authorization: bee sting kit, glucose injection, Imitrex, and insulin; if pre-authorization is required and you do not obtain pre-authorization, then the Plan will not cover the charges for the drugs;
- HIV/AIDs-related medications;
- Prescription vitamins, including pre-natal vitamins;
- Smoking cessation medications, including prescription and over-the-counter medications; prescription and over-the-counter smoking cessation medications have a lifetime limit per person, as noted in the ***Schedule of Benefits***;

If you need your prescription medication immediately, have your Physician write two prescriptions—one for up to a 30-day supply to be filled at a participating pharmacy and the second for up to a 90-day supply (plus refills if appropriate) to send to the mail order program. That way, when your retail prescription is about to run out, you will have the mail order prescription available to meet your continuing needs.

For medication where authorization is required, authorization is good for only one year, or less, depending upon the prescription's filling limits, after which time a new authorization is required. If pre-authorization is required and you do not obtain pre-authorization, then the Plan will not cover the charges for the drugs.

- Contraceptives, including Ortho Evra, NuvaRing, implants, topical, and oral, for the Employee, Spouse, and Dependents. Injectable contraceptives are subject to pre-authorization.
- Retin-A for non-cosmetic purposes; however, Physician authorization is required;
- Viagra/impotency/erectile dysfunction (ED) medications; oral medications are limited to a maximum of four doses every 30 days; ED medications that are injectable drugs are subject to pre-authorization;
- Growth hormones, subject to pre-authorization;
- Acne medications that are not for cosmetic purposes, subject to pre-authorization;
- Testosterone; injectable testosterone is subject to pre-authorization;
- Specialty medications; injectable specialty medications are subject to pre-authorization
- Vaccinations and immunizations including COVID-19 vaccines as a Qualifying Coronavirus Preventive Service; and
- Prescription vitamins are covered; injectable vitamins are subject to pre-authorization.

GENERIC VERSUS BRAND NAME MEDICATIONS

By law, both generic and brand-name medications must meet the same standards for safety, purity, and effectiveness. A generic drug is a copy of a brand-name drug that is no longer protected by a patent. A generic drug usually serves the same purpose as the original brand drug, but the generic's purchase price is generally less than the brand name. Whenever available, the generic equivalent will be substituted, subject to state law.

If you request a brand-name medication when a generic equivalent is available and your prescription does not specify "dispense as written" (DAW) by the prescriber, you pay your Coinsurance percentage plus the difference in cost between the brand-name and generic medication.

FORMULARY MEDICATIONS

The Plan's PBM has a list of preferred medications known as a formulary. When you use medications listed on the formulary, both you and the Plan take advantage of the discounted prices negotiated by the PBM.

You can see the formulary by going to the PBM website listed in the Important Contact Information section in your ***Schedule of Benefits***. You may also call the PBM's number listed on the back of your BCBS ID card for information if you don't see your medications on the list. The PBM regularly reviews its Preferred Drug List and makes changes from time to time.

PRE-AUTHORIZATION OF PRESCRIPTION DRUGS – UTILIZATION MANAGEMENT (UM)

The Plan offers a pre-authorization program that specializes in helping you receive quality prescription medications, and at the same time, helping you maximize your Plan benefits. This program helps ensure that you get the right prescription medications at the right time because the program evaluates the necessity, appropriateness, and efficiency of the use of certain prescription medications.

Generally, prescription medications will be pre-authorized if they are Medically Necessary and used in a manner consistent with the treatment of the condition for which they are prescribed.

Your Physician or your pharmacy must call the Pharmacy Benefit Manager (PBM) for pre-authorization. If you do not obtain pre-authorization, your prescription medications will not be covered. As provided in the *Covered Prescription Drug Expenses* section, the following prescription medications must be pre-authorized before you receive them:

- Injectable drugs, including injectable contraceptives, injectable ED medications, injectable testosterone and injectable prescription vitamins; self-injectable bee sting kits, glucose injection, Imitrex and insulin need not be pre-authorized;
- Retin-A for non-cosmetic purposes;
- Acne medications; and
- Specialty medications.

EXPENSES NOT COVERED UNDER PRESCRIPTION DRUG BENEFITS

Prescription drug benefits do not provide coverage for most over-the-counter drugs or medications, which include any drugs or medications that do not require a written prescription by a Physician and do not have to be dispensed by a licensed pharmacist. In addition, some prescription drugs are not covered under the Plan. These prescription drugs include, but are not limited to:

- Weight loss medications.
- Cosmetic drugs.
- Devices/appliances.
- Experimental medications.
- Dietary supplements, except as specifically listed as covered (such as pre-natal vitamins).
- Blood and blood plasma.
- Allegra, Zyrtec and similar non-sedating antihistamine medications (NSAs).
- Over-the-counter (OTC) vitamins.
- Drugs for which pre-authorization is required if you do not obtain pre-authorization for the drugs.

Dental Benefits

Dental Benefits help you manage the amount you pay for dental treatment.

The Plan provides you and your Spouse and Dependent children with Dental Benefits up to the Calendar Year maximum amount shown in the ***Schedule of Benefits***. Dependent children under the age of 19 are not subject to the Calendar Year maximum. The Plan also provides coverage for orthodontic benefits up to the individual maximum amount shown in the ***Schedule of Benefits***. The Plan's dental benefits are considered "excepted" from the group health plan requirements of the Affordable Care Act (ACA).

You may go to any dentist (Doctor of Dental Surgery or Doctor of Medical Dentistry) to receive treatment. You do not need to meet a Deductible before the Plan begins to pay benefits. Sometimes it can happen that Dental Benefits are not exhausted in one Calendar Year. If you incur covered charges during the first 90 days of a new Calendar Year for treatment that began before the first of that year, charges will be applied toward any remaining benefits balance from the previous year.

EXAMPLE

Jake is single and receives treatment for covered dental services in October. As of December 31, the Plan paid $1,100 on Jake's behalf for covered dental services. In the following January, he undergoes follow-up dental treatment for the same condition he was treated for in October. Before applying covered services to his new Dental Benefit maximum for the year beginning in January, the Plan will exhaust Jake's $900 balance from the previous year ($2,000 maximum—$1,100 paid out in the previous Calendar Year for covered dental services).

If you anticipate receiving extensive dental work (which usually involves covered dental charges of $500 or more), you can have your dentist submit a treatment plan to the Claims Administrator to receive an estimate of how much of your anticipated expenses the Plan will cover. A treatment plan is a written report made by your dentist or Physician describing their findings of your condition and their recommended dental treatment to correct your condition.

When you need dental care…

- Contact DNOA to find a dentist that is in-network, or to find out if your current dentist is in the DNOA network. You can go online to www.dnoa.com, or call 866-522-6758 for this information.
- Keep in mind that your costs will generally be lower if you use a provider in the DNOA network.
- Schedule your dental appointment.
- Pay your provider for the services and/or supplies received.

If your provider is in the DNOA network, they will submit your claim for you. If your provider is not in the network, you should submit an itemized bill, including the Employee's full name and BCBSIL ID number as well as the patient's full name to the Claims Administrator for reimbursement.

COVERED DENTAL BENEFIT EXPENSES

An expense is incurred when the service is performed or completed.

Expenses must be dentally necessary and rendered and billed for by a dentist, Physician, or dental hygienist under the supervision of a dentist. The Plan will reimburse only after receipt of the dentist's or Physician's report for services is received.

Covered expenses for Preventive, Restorative and Major Dental Services include:

- Apicoectomy
- Biopsies of oral tissue
- Cast post and core is covered only for teeth that have had root canal therapy
- Crowns (not partial or bridge) provided the tooth cannot be restored by a filling and (for replacements) at least five years have elapsed since the last placement; Crowns for the primary purpose of periodontal splinting, altering vertical dimension, or restoring occlusion are not covered
- Dental implants
- Dental X-rays, including full mouth and bitewings

- Dentures, full or partial, and bridges, fixed and removable, subject to the following:
  - Replacement or alteration of full or partial dentures or fixed bridgework is covered only if the original full or partial dentures or fixed bridgework cannot be made serviceable
  - Three years have elapsed since the last placement (this limitation is not applicable if the replacement is made necessary by the initial placement of an opposing full denture)
- Endodontics (root canal therapy)
- Fillings
- General anesthesia administered in connection with a covered dental service
- Gold or silver inlays and onlays (for replacements, at least five years must have elapsed since the last placement)
- Initial oral examination
- Night guards for prevention of teeth grinding
- Oral surgery
- Palliative Emergency treatment and Emergency oral examinations
- Periodic oral examinations
- Periodontics, including, but not limited to:
  - Gingival curettage
  - Gingivectomy and gingivoplasty
  - Osseous surgery, including flap entry and closure
  - Scaling and root planing (full mouth), limited to once each quadrant each six-month period
- Prophylaxis (routine)
- Pulp vitality tests, not more than once during any 12-consecutive months:
- Recementing of crowns, inlays, and/or bridges
- Repair of removable dentures or bridgework
- Space maintainers for Dependent children
- Simple extractions not requiring flap or bone removal
- Topical application of sealants for Dependent children
- Topical fluoride application for Dependent children

Orthodontic Dental Services

Installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth.

Diagnostic benefits, including examination, study models radiographs, and all other diagnostic aids used to determine orthodontic needs will be provided only once in any five-year period, beginning on the date of your initial visit to the dentist, orthodontist, or Physician.

Orthodontic treatment is limited to the lifetime dollar maximum shown in the ***Schedule of Benefits***. It is paid monthly but only if the person undergoing treatment is eligible under the Plan during that billing period.

No benefits will be provided for the replacement and/or repair of any appliance used during the course of orthodontic treatment. Course of orthodontic treatment means the period that begins when the first orthodontic appliance is installed and ends when the last orthodontic appliance is removed.

EXPENSES NOT COVERED UNDER DENTAL BENEFITS

In addition to the ***General Plan Limitations and Exclusions*** (see page 36), covered dental charges do *not* include charges for services, supplies, and treatment:

1. Unless they were prescribed by a dentist or Physician.
2. Incurred on account of:
   - War, declared or undeclared, including armed aggression.
   - Services received from a dental or medical department maintained by an employer, mutual benefit association, labor union, trustee, or similar type of group.
   - Illness or Injury connected with employment with any employer, including self-employment.
   - Loss or theft of dentures or bridgework.

3. For installation, replacement or alteration of, or additions to dentures or fixed bridgework, except as provided above under ***Covered Dental Benefit Expenses***.
4. For cosmetic dentistry purposes, including the alteration or extraction and replacement of sound teeth to change appearance.
5. That does not meet the standard of dental practice accepted by the American Dental Association.
6. That are in excess of Allowable Charges.
7. For non-occupational Injury to natural teeth (benefits for such charges may be payable under the Plan's Medical Benefits).

Vision Benefits

Eye care is an important part of your overall health. The Trustees recognize this and, as a result, provide vision care benefits for you and your Spouse and Dependent children. The Plan's vision care benefits are provided via the Vision Service Plan (VSP) network and are considered to be "excepted" from the group health plan requirements of the Affordable Care Act (ACA). If you do not wish to receive vision benefits, you will be given the opportunity to complete an opt-out form each fall in order to decline vision benefits or to opt back in for the following year.

COVERED VISION EXPENSES

For the most comprehensive vision benefit coverage, you should see a licensed optometrist that participates in the VSP network. You may also go to any licensed Out-of-Network Physician or optometrist for vision benefit services, but you will have to pay for those services in full and then request a reimbursement from VSP. The Plan pays for covered services up to the amounts shown in the ***Schedule of Benefits***. No annual deductible applies to Vision Benefits. Eye exams are limited to one exam per Calendar Year. Examples of covered expenses include:

- Eye exam;
- Frames;
- Lenses, including single vision, lined bi-focal, lined tri-focal, and polycarbonate lenses for Dependent children;
- In-Network lens options, including standard, premium, and custom progressive lenses; and
- Contact lenses, including standard lenses in lieu of eyeglasses, Medically Necessary lenses, and In-Network lens exam (fitting and evaluation).

VSP also offers access to their Diabetic Eyecare Plus Program, and they offer other discounts on lens enhancements and laser vision correction.

When you receive care from a VSP provider, the provider will submit your claim for you. When you receive care from an Out-of-Network provider, you should submit an itemized bill, including the Employee's full name and ID number as well as the patient's name to VSP. To be covered by the Plan, Out-of-Network services must be provided by, and supplies received from, a Physician or an optometrist acting within the usual scope of his or her practice.

VISION BENEFIT LIMITATIONS

Vision Benefits are limited as follows:

- Eye exams are limited to one per person per Calendar Year.
- Lenses are limited to two lenses per person per Calendar Year.
- Frames are limited to one set per person per Calendar Year.
- Contact lenses are subject to the limits provided in the ***Schedule of Benefits*** and are covered when Medically Necessary.
- The Plan will not cover both frames/lenses and contact lenses for a covered person in the same Calendar Year.

EXPENSES NOT COVERED UNDER VISION BENEFITS

In addition to the ***General Plan Limitations and Exclusions*** (see page 36), Vision Benefits will not provide coverage for the following:

- Services and materials in connection with special procedures such as orthoptics, visual training, supplemental testing, or in connection with medical or surgical treatment.
- Eye examinations required by an employer as a condition of employment that the employer is required to provide under a labor agreement.
- Replacement of lenses or frames for which a benefit was provided by the Plan and that have been lost, stolen, or broken.
- Two pairs of glasses instead of bifocals;
- Replacement of lenses, frames, or contacts;
- Nonprescription lenses;

- Additional office visits for contact lens pathology;
- Contact lens modification; or
- Polishing or cleaning.

When you need vision care…

- Schedule an appointment with a VSP provider or the Out-of-Network licensed Physician or optometrist of your choice.
- Pay your VSP provider for the services and/or supplies received.
- For Out-of-Network providers, submit an itemized bill, including the Employee's full name and ID number as well as the patient's full name to VSP for reimbursement.

LASIK surgery is covered under the Plan's medical benefits for the Employee only (no Spouses or Dependents) and is subject to the Plan's Deductible and Coinsurance provisions. The VSP program offers discounts on LASIK surgery.

If you have questions about your VSP benefits, you should visit vsp.com or call 800-877-7195.

In the Event of Your Disability or Death

The Plan provides disability and death benefits. Loss of Time Benefits, Death Benefits, and Accidental Death and Dismemberment Benefits may help provide financial protection to you and/or your family upon your disability or death. These benefits are not available to Spouses and Dependent children, nor to any Participant who is covered via COBRA Continuation Coverage.

LOSS OF TIME BENEFITS FOR EMPLOYEES ONLY

Loss of Time Benefits are designed to help you pay for daily living expenses until you are able to return to work. If you are totally disabled, you may be eligible to receive Loss of Time Benefits. You are considered totally disabled if you are physically unable to perform the regular duties of your occupation or employment because of a non-occupational or occupational Illness, Injury, pregnancy, or childbirth. This determination is at the discretion of the Trustees. To be eligible for benefits, you must be under the direct and continuing care of a Physician.

Limited benefits are payable for an accidental Illness, Injury, or Disease for which you are eligible for benefits under any workers' compensation, employer liability, occupational disease, or similar law. In addition, if you become disabled as the result of an Illness or Injury that is not covered under the Plan or is specifically listed as a general exclusion or limitation under the Plan (see page 36), you may not be eligible for Loss of Time Benefits under the Plan. Contact the Fund Office for more information.

If you think you might be eligible for Loss of Time Benefits, you should call the Fund Office as soon as possible. You may download an application for benefits from www.myfundoffice.com, or the Fund Office will mail you one. You are responsible not only for completing your portion of the application, but also for having your employer and attending Physician complete their portions of the application. Once the application is submitted for consideration, the Claims Administrator will contact your attending Physician for information, including the estimated duration of your disability.

Benefits

The amount of the benefit is:

- $400 per week (Monday through Friday) for up to 26 weeks for a total disability caused by a non-occupational accidental Illness or Injury whether or not actively employed by a Contributing Employer at the time that the disability occurred; or
- $800 per week (Monday through Friday) for up to six weeks from the date of delivery for a traditional birth or up to eight weeks from the date of delivery for a cesarean birth; or
- $100 per week (Monday through Friday) for up to 26 weeks for a total disability caused, or contributed to, by an accidental Illness or Injury arising out of or in the course of employment for wage or profit.

Benefits are paid from the:

- First work day of a disability caused by accidental Injury;
- Date of delivery, in the case of childbirth;
- Sixth work day of a disability caused by Illness; or if later,
- Date on which you came under the regular care of a Physician.

Successive periods of disability due to the same or related causes that are not separated by a return to work for at least a two-consecutive-week period will be considered one period of disability.

While you are eligible to receive Loss of Time benefits from the Plan, the Plan will credit your Welfare Plan Hour Bank with eight (8) hours per weekday for the period of your disability, up to a maximum of six (6) months. This allows you to continue coverage under the Plan during your disability through the use of your Welfare Plan Hour Bank.

Concurrent Claims for Loss of Time Benefits

Receiving benefits for more than one claim for Loss of Time Benefits is not allowed under the Plan. If you experience a second occurrence for which a Loss of Time Benefit would otherwise be payable, you may submit the claim but you will not receive weekly benefits until your first Loss of Time Benefit payment has ceased, and then only for the duration of the second Loss of Time occurrence. For example, if your second Loss of Time occurrence started while you were still receiving 5 weeks of benefits from the first occurrence, and the second occurrence lasted 12 weeks in duration, you will receive only the final 7 weeks of benefit payments for the second occurrence.

Expenses Not Covered under Loss of Time Benefits

Loss of Time Benefits will not be paid for any period:

- For which Disability Pension benefits are paid.
- After which a Retirement Pension Benefit begins.
- For illnesses or injuries that would not be covered by the Plan, except in the case of work-related injuries.
- After the date you become eligible for coverage under the Local Union No. 9, IBEW and Outside Contractors Retired Employees Health and Welfare Plan.

DEATH BENEFIT (ONLY APPLICABLE TO EMPLOYEES)

In the event of your death, the Plan pays a Death Benefit to your beneficiary, as listed on the ***Schedule of Benefits***. Death benefits are generally subject to taxation. Please consult with your personal tax advisor as to the taxability of these benefits.

This section will not apply to a retired Employee who has elected an Extension Option to continue coverage under this Plan in accordance with the "Pensioner" subsection of the "Hour Bank" section under the "Continuation Coverage" heading.

Another provision of the Death Benefit is that when your coverage under this Plan terminates, you may convert your coverage to an individual policy if you apply to do so within 31 days. You should contact the insurance company listed in the *Important Contact Information* in the ***Schedule of Benefits*** for information on conversion after your coverage ends so that you can meet this deadline.

The Death Benefit also provides that in the event you are diagnosed with a terminal illness, you may apply to receive an accelerated death benefit. You should contact the insurance company listed in the *Important Contact Information* in the ***Schedule of Benefits*** for information about this benefit. Certain requirements and exclusions apply.

To designate or update your beneficiary(ies) for Death Benefits, you need to complete a beneficiary designation form. This form is available for download at www.myfundoffice.com or from the Fund Office.

Your designation is effective as of the date the Fund Office receives your properly completed beneficiary designation form. If you do not designate a beneficiary, your benefits will be paid to your:

- Spouse; or if none,
- Children; or if none,
- Parents; or if none,
- Siblings; or if none,
- Estate.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (ONLY APPLICABLE TO EMPLOYEES)

Accidental Death and Dismemberment Benefits provide a benefit in the event of your loss of life or if you experience an accidental bodily Injury that results in loss of any of the following (within one year after the Injury):

- Both hands;
- Both feet;
- Sight of both eyes;
- One hand and one foot;
- One hand and sight of one eye;
- One foot and sight of one eye;

- Loss of speech and hearing;
- Quadriplegia;
- One hand;
- One foot;
- Sight of one eye;
- Paraplegia;
- Hemiplegia;
- Loss of speech;
- Loss of hearing in both ears; or
- Thumb and index finger of the same hand.

This benefit is paid to your beneficiary in the event of your death or to you in the event of your disability. Accidental Death Benefits are in addition to any Death Benefit that may be paid. The amount of the Accidental Dismemberment Benefit is based on your Injury as shown in the ***Schedule of Benefits***.

After your death, your Spouse and Dependents may be able to continue certain coverage under the Plan through COBRA Continuation Coverage (see page 8).

When Accidental Death and Dismemberment Benefits are Not Paid

Accidental Death and Dismemberment Benefits are not paid for losses that in any way result from or are caused by:

- Any disease or infirmity of mind or body, and any medical or surgical treatment thereof.
- An infection, except an infection of an accidental injury.
- Suicide or attempted suicide, while sane or insane.
- Any intentionally self-inflicted injury.
- Travel or flight in a non-commercial aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft.
- While under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence.
- Death benefits for war or act of war if the cause of death occurs while the insured is serving in the military, naval or air forces of any country, combination of countries or international organization, provided such death occurs while in the such forces or within 6 months after termination of services in such forces.
- Direct result of the insured's intoxication as defined by the laws of the jurisdiction in which the accident occurred or 0.08% blood alcohol content if the jurisdiction in which the accident occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated.
- Active participation in a riot. Riot means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, with a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.
- Death benefits will not be paid for loss of life resulting from or caused by war or act of war if the cause of death occurs while the insured is serving in the military, naval or air forces of any country, combination of countries or international organization, provided such death occurs while in the such forces or within 6 months after termination of services in such forces

General Plan Limitations and Exclusions

The following general Plan limitations and exclusions apply to all Medical, Dental, Vision, Death, Accidental Death and Dismemberment, and Loss of Time Benefits. These limitations and exclusions are in addition to any exclusion listed elsewhere throughout this book.

Generally, benefits are payable only for care and treatment provided to a Participant as the result of a non-occupational bodily Injury or Illness, unless an expense is specifically listed as a covered expense under this Plan. These exclusions and limitations also apply to Loss of Time Benefits. For example, if you incur medical expenses for an Injury or Illness that is not covered under the Plan's medical benefits, and you are disabled as a result of this Injury or Illness, Loss of Time Benefits will not be paid.

This listing is not all-inclusive, and is only representative of the type of charges for which benefits are limited or not payable under the Plan. Just because a service or supply is not listed as an exclusion does not mean it is a covered expense. Only benefits listed as covered are considered covered expenses under the Plan. In addition, benefits are not payable for amounts in excess of allowable expenses as defined by the Plan.

No payment will be made for the following under the Plan.

1. For or in connection with an Injury arising out of, or in the course of, any employment for wage or profit, except relating to Loss of Time Benefits for Employees.
2. For or in connection with an Illness or Injury for which the Employee or Spouse or Dependent is entitled to benefits under any workers' compensation, occupational disease, or similar law, except relating to Loss of Time Benefits for Employees.
3. In a Hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required.
4. For charges that the Participant is not legally required to pay or for charges that would not have been made if no coverage had existed.
5. Expenses in excess of Allowable Charges (depending on contract provisions, this limitation may not apply to charges from network providers or non-network providers who are utilized as a result of requests or requirements of network providers). The determination made by the Fund Administrator of the general level of charges made by others within the area will be presumed to be correct, and any person claiming that such determination is erroneous will have the burden of proving the general level of charges made by others in the area.
6. For care or treatment that is not Medically Necessary.
7. For services and supplies that do not meet accepted standards of medical or dental practice including, but not limited to, Investigative or Experimental services and supplies and related services and supplies.
8. For charges incurred related to suicide, attempted suicide, or intentionally self-inflicted Injury; charges for medical expenses incurred for Illness or Injury related to suicide, attempted suicide or intentionally self-inflicted Injury will not be excluded if such actions are a result of an underlying mental or physical health condition that can be documented by a physician's records and patient history as being instrumental in causing such action.
9. For corrective eye surgery, except that LASIK surgery is covered under the Plan's medical benefits for Employees only.
10. For routine vision care or routine hearing care except as specifically stated otherwise in this document.
11. For Custodial Care (long-term care). Expenses incurred to assist a person in daily living activities are considered costs for Custodial Care. Costs for medical maintenance services and supplies in connection with Custodial Care due to age or mental or physical conditions are not covered if such care cannot reasonably be expected to improve a medical condition.

12. For charges in connection with Cosmetic Surgery and/or Treatment, except to correct:
    a. Deformities resulting from Injuries sustained in an accident or due to an Illness such as breast cancer, including all services mandated by federal provisions related to mastectomy treatment (see page 22).
    b. A functional disorder (functional disorders do not include mental or emotional distress related to a physical condition).
    c. Treatment to correct a functional abnormal congenital condition.
13. Due to bodily Illness or Injury resulting from participation in an insurrection or riot or on account of war.
14. For Injury to any Participant sustained in the course of any criminal act or acts initiated or committed by that Participant (criminal acts will include but not be limited to acts defined as criminal under any federal or state law, penal code, or motor vehicle code), except that Injuries or Illness sustained as the result of domestic violence will be covered by the Plan, and will not be excluded. Determination of coverage will not be dependent upon a conviction by the governmental authority, and may be made on the basis of citations being issued by the governmental authority. For instance, if you receive a citation for speeding, running a light, etc., you are not covered if you get hurt or injured in an incident where you received a citation for your actions.
15. For coverage under the Medical Benefits for treatment of or to the teeth, the nerves or roots of the teeth (except as stated on page 19), or the repair or replacement of a denture.
16. For charges in connection with the treatment of TMJ Dysfunction or Syndrome, unless such condition is supported by evidence of documented organic joint disease or physical trauma.
17. For services and supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, trustee, or similar person or group when no charge would normally be made for such services or supplies.
18. For maintenance therapy, including but not limited to maintenance physical therapy and maintenance occupational therapy.
19. For occupational therapy when it is not a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.
20. For speech and vision therapy when it is rendered for other than the correction of a physical impairment caused by Illness, Injury, congenital deformity, or developmental delay.
21. Personal comfort items or supplies of common use including blood pressure kits, exercise equipment, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, saunas, steam rooms, and swimming pools.
22. For instruction or activities for weight reduction or weight control, including charges for vitamins, diet supplements, or physical fitness programs even if the services are performed or prescribed by a Physician.
23. For surgery or treatment for obesity under any circumstance.
24. For the following types of counseling:
    a. Pastoral, or spiritual counseling.
    b. Sex counseling or therapy-counseling in preparation for or associated with a gender reassignment operation.
    c. Special education, counseling, or other services for developmental delay, learning deficiencies, or behavioral problems, unless the condition meets the definition of mental or nervous disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, which is current as of the date services are rendered) in which case, psychiatric treatment will be covered as shown in the ***Schedule of Benefits***.
25. For court ordered confinement or treatment, except if such treatment is found to be Medically Necessary through the application of the Plan's own internal procedures for assessing the appropriateness of the proposed treatment in relation to the condition being treated.
26. For non-medical expenses such as preparing medical reports, itemized bills, or charges for mailing.

27. For training, educational instructions, or materials, even if they are performed or prescribed by a Physician, except that the Plan covers diabetic training.
28. For legal fees and expenses incurred in obtaining medical treatment.
29. For Friday, Saturday, or Sunday admissions unless due to a Medical Emergency or if surgery is scheduled within the 24-hour period immediately following admission.
30. For charges for services and supplies incurred because of pregnancy, pregnancy-related medical conditions, miscarriage, or childbirth, except when such charges are incurred by a covered female Employee or a Spouse of an Employee.
31. For expenses in connection with voluntary abortions (not performed for medical reasons), except that the Plan will cover complications due to an abortion.
32. For surgical reversal of elective sterilizations.
33. For sex/gender reassignment and treatment for sexual dysfunction or inadequacy (except as may be covered under the Plan's prescription drug benefits), including implants and related hormone treatment.
34. For charges resulting from participation in a Hazardous Pursuit, Hobby or Activity.
35. For charges resulting from participation in professional or semi-professional athletics.
36. For routine foot care such as removal of corns, calluses, or toenails, except in the treatment of a peripheral-vascular disease when recommended by a Doctor of Medicine or Doctor of Osteopathy.
37. For splints or braces for non-medical purposes (i.e., supports worn primarily during participation in sports or similar physical activities).
38. For treatment by a Physician, registered nurse, licensed practical nurse, or other Non-Physician Medical Professional if such person is related by blood, marriage, or by legal adoption to the Participant.
39. For treatment provided by any person who ordinarily resides with the Participant.
40. For Investigative or Experimental services or for treatment not generally recognized or deemed clinically acceptable by professional medical peer groups, such as the:
    a. American Medical Association (AMA); and
    b. Similar national medical organizations in the United States.
41. For over-the-counter drugs even if prescribed by a Physician.
42. For any form of medication or treatment not prescribed in relation to an Injury, Illness, or pregnancy, unless specifically provided otherwise.
43. For any expense in excess of any maximum or limit as stated elsewhere in this document.
44. For charges incurred for services and supplies to the extent that the benefits provided by this Plan are duplicated because the spouse, parent, and/or child are full-time active Employees of one or more Contributing Employers, and each is eligible separately for the benefits of this Plan.
45. For charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services (otherwise, Medically Necessary services incurred outside the United States will be covered, to the extent that they are not covered under the national health programs of the country in which services are incurred, but only on a member reimbursement basis).
46. For the services of a massage therapist, regardless of whether licensed as a health care provider.
47. For the services of a naprapath, regardless of whether licensed as a health care provider.
48. For surgical implantation of an artificial or mechanical organ, except for an artificial larynx or eye.
49. For acupuncture, except as a treatment modality under chiropractic coverage.
50. For facility charges or fees from either a licensed or unlicensed non-PPO Ambulatory Surgical Facility or Ambulatory Surgical Treatment Center.
51. For charges or fees related to surgery performed at the offices of any non-PPO Physician.
52. For facility charges or fees from either a licensed or unlicensed non-PPO Extended Care Facility.
53. For facility charges or fees from either a licensed or unlicensed non-PPO birthing center.
54. For failure to provide any additional documentation or information as explained in the ***Claims and Appeals*** section on page 47.

55. For charges or fees related to surgery in an out-of-network outpatient surgicenter.
56. For any expenses relating to gene therapy, which typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. Some examples of gene therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well as other therapies, such as Luxturna and Zolgensma. Expenses relating to the gene therapy are excluded regardless of whether the gene therapy has received approval from the U.S. Food and Drug Administration (FDA) or is considered experimental or investigational.

Marriage and family counseling may be covered under the MAP.

Health Reimbursement Arrangement

The Health Reimbursement Arrangement (HRA) (also called the HRA Account) permits you to obtain reimbursement of certain Qualified Medical Care Expenses (defined below) on a non-taxable basis from your HRA Account.

Most of the rules regarding the HRA are dictated by the Internal Revenue Code and cannot be adjusted, changed, or eliminated.

HRA Account Definitions

- **Dependent** means any individual who is considered a Dependent or Spouse of the Employee as defined in the Plan Document.
- **Eligible Employee** means an Employee eligible to participate in this HRA Account.
- **HRA Account** means an unfunded recordkeeping entry of contributions received and claims paid on behalf of an Eligible Employee and his/her Dependents that is maintained by the HRA Account.
- **Qualified Medical Care Expenses** generally means medical care expenses incurred by an Employee or his or her eligible Spouse or Dependents for medical care, as defined in Internal Revenue Code Sections 105 and 213(d) (including, for example, amounts for certain hospital bills, doctor and dental bills), but does not include expenses that are described in the exclusions subsection. Reimbursements due for medical care expenses incurred by the Employee or the Employee's eligible Spouse or Dependents will be charged against the Employee's HRA Account.
- **Benefit Plan Year** means the Calendar Year for the HRA Account, the period of time from January 1 to December 31 of each year; the Plan Year or Fiscal Year for the HRA is the period of time from November 1 to October 31.

Any unused HRA Account balance remaining at the time you, while covered by the HRA, retire from active employment or otherwise retire after age 65 but are ineligible for a pension, may be used for reimbursement of Qualified Medical Care Expenses incurred during retirement. However, no additional credits may accumulate in your HRA Account after your active participation in the HRA terminates.

REIMBURSEMENT OF QUALIFIED MEDICAL CARE EXPENSES INCURRED BY RETIREES

The Health Reimbursement Arrangement (HRA) Account permits you to be reimbursed for certain Qualified Medical Care Expenses (defined below) on a nontaxable basis.

The primary objective of the HRA Account is to provide reimbursement of Qualified Medical Care Expenses after you retire. However, under very limited circumstances, as described below, the HRA Account may reimburse you for Qualified Medical Care Expenses incurred before you retire.

OVERVIEW OF HOW THE HRA ACCOUNT WORKS

The Plan will maintain an HRA Account in your name to keep a record of the balances available for reimbursement of eligible Qualified Medical Care Expenses. In no event will the HRA Account provide benefits in the form of cash or any other taxable or nontaxable benefit other than reimbursement for eligible Qualified Medical Care Expenses. HRA Accounts are funded solely by employer contributions made on behalf of Eligible Employees of employers who are required to contribute to the HRA under a collective bargaining agreement.

The Plan will maintain an HRA Account in your name to keep a record of the balances available for reimbursement of eligible Qualified Medical Care Expenses. In no event will the HRA Account provide benefits in the form of cash or any other taxable or nontaxable benefit other than reimbursement for eligible Qualified Medical Care Expenses. HRA Accounts are funded solely by employer contributions made on behalf of Eligible Employees of employers who are required to contribute to the HRA under a collective bargaining agreement or participation agreement.

While an Active Employee (not retired), once your HRA Account balance exceeds $10,000, you may use the amount over $10,000 to pay deductibles, copayments, coinsurance, and other Qualified Medical Care Expenses (as defined below). The entire HRA Account balance will be available for reimbursement of Qualified Medical Care Expenses to you or your Eligible Spouse and Dependents after you retire or die.

For reimbursement of Qualified Medical Care Expenses, you must submit a claim using a designated HRA claim form and provide a receipt showing that you or your eligible Spouse and Dependent incurred a Qualified Medical Care Expense. Claims should be submitted no later than 12 months after the expense is incurred. After the end of the Calendar Year, any unused amounts will remain available in the HRA Account (to roll over into) the next Calendar Year.

ELIGIBILITY FOR HRA ACCOUNT BENEFITS

You are **eligible to participate** in the HRA Account if you work for an employer required to make HRA contributions to this Plan under a collective bargaining agreement or participation agreement on your behalf.

In addition, in order to comply with the Affordable Care Act and IRS Notice 2013-54, if you are eligible to participate in the HRA, you are also subject to the following rules:

1. If you are not actually enrolled in this Plan or the Retired Employees Plan, you must be actually enrolled in another group health plan that provides minimum value pursuant to Internal Revenue Code Section 36B(c)(2)(C)(ii) in order to use the HRA Account for reimbursements, regardless of whether the other group health plan is sponsored by this Plan. A group health plan provides minimum value if the coverage has an actuarial value of at least 60 percent under standards determined by the Internal Revenue Service.
2. Proof of other group health plan coverage will be required in a manner to be determined by the Trustees. If proof is not provided, HRA benefits will be restricted, as defined in section (3) below.
3. If you do not provide proof of enrollment in other group health plan coverage that provides minimum value, in a manner determined by the Trustees, benefits from the HRA Account will be reduced as required by IRS Notice 2013-54. Specifically, if you are enrolled in other group health plan coverage, but the coverage does not provide minimum value, then the HRA Account benefit is limited to reimbursement of copayments, coinsurance, deductibles, and premiums for the other group health plan coverage to the extent such premiums are paid on an after-tax basis, as well as medical care as defined under Internal Revenue Code Section 213(d) that does not constitute essential health benefits.
4. Amounts credited to your HRA Account cannot be used to reimburse premiums for individual market coverage or insurance plans purchased from a state or federal Health Insurance Marketplace. Individual Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies are also not reimbursable.
5. When you have an HRA Account balance, you will be allowed, at least annually, to permanently opt out of HRA coverage and waive future reimbursements from your HRA Account.
6. If you terminate employment, you may elect, effective on the date of employment termination or later, to forfeit your HRA Account balance.

TERMINATION OF HRA ACCOUNT BENEFITS

You will cease to participate in the HRA Account when you have a zero balance in your HRA Account, when you waive or forfeit the balance in your HRA Account pursuant to item 5 or 6 above, or the HRA benefit is terminated.

Any HRA benefit payments (e.g., uncashed reimbursement checks) that are unclaimed 12 months after the Calendar Year in which the Qualified Medical Care Expense was incurred will be forfeited.

IN THE EVENT OF YOUR DEATH

If you die, your surviving Spouse will continue to be entitled to reimbursements for Qualified Medical Care Expenses until your HRA Account reaches a zero balance or the HRA benefit is terminated. Your Dependent children may continue participating in the HRA Account until they no longer meet the definition of "Dependent," have exhausted their COBRA period, until your HRA Account reaches a zero balance, or the HRA benefit terminates. If there is no eligible Spouse or there are no eligible Dependents, amounts left in your HRA Account will not be paid to any other individual. In these cases, any remaining amount will revert to the HRA benefit and will be used for administrative expenses. In no event will the HRA Account pay the remaining assets in cash.

REIMBURSEMENT OF QUALIFIED MEDICAL CARE EXPENSES INCURRED BY RETIREES

Any unused HRA Account balance remaining at the time you, while covered by the HRA benefit, retire from active employment or otherwise retire after age 65 but are ineligible for a pension, may be used for reimbursement of Qualified Medical Care Expenses incurred during retirement. However, no additional credits may accumulate in your HRA Account after active participation in the HRA benefit terminates.

FUNDING THE HRA ACCOUNT

Employer Contributions

Each month employer contributions will be credited to your HRA Account in an amount determined by the Trustees and according to the work you have performed for the Employer.

Employee Contributions

You may not personally contribute to the HRA Account according to current tax regulations.

No Funding Under Cafeteria Plan

Under no circumstances will the HRA Account fund benefits with salary reduction contributions.

QUALIFIED MEDICAL CARE EXPENSES ELIGIBLE FOR REIMBURSEMENT FROM THE HRA ACCOUNT

Under the HRA benefit, you may receive reimbursement for Qualified Medical Care Expenses (as defined below) incurred during a calendar year according to the rules and procedures previously described. Expenses payable from the HRA Account must be substantiated.

A Qualified Medical Care Expense is incurred at the time the medical care or service is received, and not when the expense is formally billed, charged, or paid. Qualified Medical Care Expenses incurred before you first become covered by the HRA benefit are not eligible.

Qualified Medical Care Expenses

Generally, "Qualified Medical Care Expenses" means expenses you, your Spouse, or Dependents incur for medical care, as defined in IRC Sections 105 and 213(d) (including, for example, amounts for certain hospital bills, doctor and dental bills). It will not include expenses that are described in Subsection 105(c) of the Code or that are described here as exclusions. Medical Care Expenses shall include premiums for Part B of Title XVIII of the Social Security Act (Medicare Part B premiums), premiums for group health insurance covering medical care (including premiums for group Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies), COBRA premiums, or premiums for any qualified long-term care insurance contract as defined in Code Section 7702B(B) provided, however, that any such premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan. Reimbursements due for Qualified Medical Care Expenses you, your Spouse, or eligible Dependents incur will be charged against your HRA Account.

Qualified Medical Care Expenses can only be reimbursed to the extent that the expense incurred by you or your Spouse or Dependent is not otherwise reimbursable through this Plan, nor any other insurance, accident or health plan. Special circumstances apply to reimbursements through Health FSAs; see the subsection entitled *Coordination of Benefits; Health FSA to Reimburse First* on page 46 if the other health plan is a Health FSA. If only a portion of a Qualified Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes copayment or deductible limitations), the HRA Account can reimburse the remaining portion of such expense (e.g., the deductible or copayment) if it otherwise meets the requirements of a Qualified Medical Care Expense.

Allowable Qualified Medical Care Expenses

Allowable Qualified Medical Care Expenses means expenses incurred by you, your Spouse or Dependent children for medical care. Eligible medical expenses include amounts paid by you or your covered Dependents for deductibles, copayments, and coinsurance under this Plan or under another qualified group health plan that you are enrolled in. Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and for the purpose of affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

Medical care expenses must be primarily to alleviate or prevent a physical or mental disability or illness. They don't include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Medical expenses include the premiums you pay for insurance that covers the expenses of medical care, and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

Medical care is defined in Internal Revenue Code Section 105 and Section 213(d), and includes, for example:

- Amounts for certain hospital bills, doctor and dental bills, prescription drugs certain over-the-counter drugs, and menstrual products.
- Premiums for group health insurance covering medical care,
- Amounts paid as premiums under Part B, C or D of Title XVIII of the Social Security Act,
- COBRA premiums, or
- Premiums paid for a qualified long term care insurance contract.

Expenses listed above are not allowable qualified medical care expenses if they are paid through salary reduction contributions under the terms of an Internal Revenue Code Section 125 plan. Also, see additional exclusions listed in the next section.

What are Qualified Medical Expenses?

The following list is based on Internal Revenue Service Publication 502, which explains eligible medical and dental expenses. The items below are examples of qualified medical expenses and are listed in alphabetical order. Please note that this is not an exhaustive list.

- Abortion
- Acupuncture
- Alcoholism
- Ambulance
- Annual Physical Examination
- Artificial Limb
- Artificial Teeth
- Bandages
- Birth Control Pills
- Body Scan
- Braille Books and Magazines
- Breast Pumps and Supplies
- Breast Reconstruction Surgery
- Capital Expenses
- Car
- Chiropractor
- Christian Science Practitioner
- Contact Lenses
- Crutches
- Dental Treatment
- Diagnostic Devices
- Disabled Dependent Care Expenses

- Drug Addiction
- Drugs
- Eye Exam
- Eyeglasses
- Eye Surgery
- Fertility Enhancement
- Founder's Fee
- Guide Dog or Other Service Animal
- Health Institute
- Health Maintenance Organization (HMO)
- Hearing Aids
- Home Care
- Home Improvements
- Hospital Services
- Insurance Premiums
- Intellectually and Developmentally Disabled, Special Home for
- Laboratory Fees
- Lactation Expenses
- Lead-Based Paint Removal
- Learning Disability
- Legal Fees
- Lifetime Care—Advance Payments
- Lodging
- Long-Term Care
- Meals
- Medical Conferences
- Medical Information Plan
- Medicines
- Nursing Home
- Nursing Services
- Operations
- Optometrist
- Organ Donors
- Osteopath
- Oxygen
- Physical Examination
- Pregnancy Test Kit
- Premium Tax Credit
- Prosthesis
- Psychiatric Care
- Psychoanalysis
- Psychologist
- Special Education
- Sterilization
- Stop-Smoking Programs
- Surgery
- Telephone
- Television
- Therapy
- Transplants
- Transportation
- Trips
- Tuition
- Vasectomy
- Vision Correction Surgery
- Weight-Loss Program
- Wheelchair
- Wig
- X-ray

EXCLUSIONS

"Qualified Medical Care Expenses" **do not include** the following expenses. The expenses listed here are not reimbursable under this HRA benefit (even if they meet the definition of "medical care" under IRC Section 213 or are reimbursable under IRS guidance pertaining to HRAs):

- Advance payment for services.
- Athletic, fitness, or health club membership.
- Automobile insurance premium allocable to medical coverage.
- Boarding school fees.
- Bottled water.
- Commuting expenses of a disabled person.
- Controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Cosmetic surgery and procedures.

- Cosmetics, hygiene products, and similar items.
- Diaper service.
- Domestic help.
- Funeral, cremation, or burial expenses.
- Health programs offered by resort hotels, health clubs, and gyms.
- Illegal operations and treatments.
- Illegally procured drugs.
- Long-term care and custodial care services.
- Massage therapy (unless prescribed).
- Maternity clothes, other special clothing or uniforms.
- Nurse's salary to care for a healthy newborn at home.
- Premiums for individual market coverage or insurance plans purchased from a state or federal Health Insurance Marketplace. Individual Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies are also not reimbursable.
- Premiums for life insurance, income protection, disability, loss of limbs, sight, or similar benefits, or any premiums paid through salary reduction contributions under the terms of an Internal Revenue Code Section 125 Plan.
- Scientology counseling.
- Social activities.
- Special foods or beverages.
- Specially designed car for the handicapped other than an autoette or special equipment.
- Swimming pool.
- Travel for general health improvement or other transportation expenses.
- Tuition and travel expenses for a problem child to a particular school.
- Vitamins and food supplements.
- Voluntary abortion expenses.
- Weight loss programs for general health.
- Any item not considered "medical care" under IRC Section 213.

In addition, the HRA will not cover any medical expenses that are excluded from HRA coverage under the Affordable Care Act (ACA) or the ACA Regulations.

The HRA will not cover any medical expenses that are excluded from HRA coverage under the Affordable Care Act (ACA), the ACA Regulations, or IRS Notice 2013-54.

ADMINISTRATION OF THE HRA ACCOUNT

An HRA Account will be established and maintained with respect to each Eligible Employee.

Crediting of Accounts

Your HRA Account will be credited each month as funds are received from Contributing Employers. The balance of any unused HRA Account funds remaining from a prior Calendar Year will remain in the HRA Account.

Debiting of Accounts

Your HRA Account will be reduced by the amount of any reimbursement of Qualified Medical Care Expenses paid to you.

Available Amount

The amount available for reimbursement of Qualified Medical Care Expenses prior to retirement is the amount credited to your HRA Account reduced by (and debited for) prior reimbursements. However, as previously noted, before retirement, your HRA Account balance must exceed $10,000 before you can apply for reimbursement and only the excess over $10,000 will be available for reimbursement. After you retire, the full HRA Account balance will be available for reimbursement.

Unused Amounts in the HRA Account

Any unused amounts in the HRA Account will be carried over from one Calendar Year to the next Calendar Year.

Upon loss of eligibility under the Plan, your HRA Account balance remains yours. This means that you will be eligible to receive reimbursements for Qualifying Medical Care Expenses incurred after your participation in the Plan terminates. In no event will you receive a cash-out of, or be permitted to assign, transfer or pledge any remaining balance in your HRA Account.

REIMBURSEMENT PROCEDURE

Timing of Reimbursements from HRA Account

Except for the final claim for a 12-month period, any claim you submit must total at least $50. You must submit a claim within 12 months after the date of occurrence; thereafter, it will not be eligible for reimbursement. Within 30 days after the Fund Office receives a request for HRA Account reimbursement (for the $50 minimum), the HRA will reimburse you for the Qualified Medical Care Expenses or you will receive written notification that the claim has been denied (see the Appeal procedure below regarding the procedure for claim denials and appeals). This time period may be extended for an additional 15 days for matters beyond the control of the Plan or its designee, including cases where a reimbursement claim is incomplete. You will receive written notice of any extension, including the reasons for the extension, and you will have 45 days to complete an incomplete reimbursement claim request.

CLAIMS SUBSTANTIATION

You may apply for reimbursement by submitting a claim form, which is available from the Fund Office and on the Plan's website, www.myfundoffice.com. Through the Fund's debit card vendor, you will receive a VISA debit card that you can use for certain Qualified Medical Care Expenses. After using the debit card you must submit a receipt for all charges except for prescription medications. You can provide the receipt on the debit card provider's website, mobile app, or in writing to the Fund Office. It is important that you provide the receipts as soon as possible, but no later than December 31st of the year that you used the debit card for a Qualified Medical Care Expense.

All expenses must be substantiated prior to the end of the calendar year. The amounts for any unsubstantiated claims will be reported to the IRS and you will receive a 1099-Miscellaneous form in January following the calendar year end. You will be responsible for the appropriate income taxes on those amounts used on the debit card that are unsubstantiated with the Fund Office.

In addition to using the HRA debit card, you can submit a written request for HRA reimbursement. The request must include the following:

- The person or persons on whose behalf Qualified Medical Care Expenses have been incurred;
- The date the expense was incurred;
- A description of the expense incurred;
- The amount of the requested reimbursement;
- A receipt for payment from the provider; and
- A statement that the expenses submitted for reimbursement have not been nor will be otherwise reimbursed.

In addition to the claim form, please include an Explanation of Benefits (EOB) from your health plan or insurance carrier. Or, if the medical expense is not covered by insurance, an invoice from the provider which gives the provider's name, address, telephone number, the amount of the expense, a description of the expense, the date the expense occurred and the name of the patient, and a statement that the expenses submitted for reimbursement have not been nor will be otherwise reimbursed.

COORDINATION OF BENEFITS; HEALTH FSA TO REIMBURSE FIRST

Benefits under this HRA Account are intended to pay benefits solely for Qualified Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Qualified Medical Care Expense is covered or reimbursable from another source, that other source must pay or reimburse prior to payment or reimbursement from this HRA Account. Without limiting the foregoing, if your Medical Care Expenses are covered by both the HRA and by a Health FSA, then the HRA is not available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

APPEAL PROCEDURE IF BENEFITS ARE DENIED UNDER THIS HRA ACCOUNT

If a claim for reimbursement under this HRA Account is denied in part or completely, you will receive written notice of the denial that will include the reason(s) why the claim was denied. You may file a written appeal to the Trustees according to the procedures detailed on page 53 of this SPD.

COBRA AND THE HRA ACCOUNT

If coverage terminates under the HRA Account because of a COBRA qualifying event, you, your Spouse, and/or Dependents (Qualified Beneficiaries) may use the balance in your HRA Account until there is a zero balance in your HRA Account.

Claims and Appeals

FILING CLAIMS

There are three basic types of claims under the Plan:

- Health care claims,
- Disability claims, which are claims for Loss of Time Benefits for Employees only, and
- Claims for Accidental Death and Dismemberment Benefits and Death Benefits for Employees only.

Once you are eligible for coverage, you must ensure that you receive all the benefits to which you are entitled by filing a claim for those benefits. You may contact the Claims Administrator or visit www.myfundoffice.com to obtain the proper claim form.

You should file your claim for benefits within 90 days, or as soon as possible. In no event, will the Plan pay claims submitted later than one year after the date the loss or expense was incurred.

HEALTHCARE CLAIMS

Most health care providers will submit claims for you. Be sure to show your ID card so your provider knows where to submit the claim. If your provider does not submit a claim for you, it is your responsibility to do so.

The following describes the procedures for you to follow in filing a claim for healthcare benefits under the Plan and to appeal the decision if your claim has been denied in whole or in part.

If your provider does not submit an electronic claim form on your behalf for health care services, you or your Spouse or Dependent may submit a written claim for benefits. To assist the Claims Administrator in processing written claims as quickly as possible, please follow the steps listed below.

- Obtain the proper claim form from the Claims Administrator or by visiting www.myfundoffice.com.
  - If possible, obtain the claim form before your Hospitalization or before you begin treatment; or
  - In the case of an Emergency, have the Hospital or a family member obtain a claim form as soon as possible. The person who calls should be able to provide the Employee's name and BCBSIL ID number.
- Complete your portion of the form by filling in all information requested. Be sure to sign your form and include:
  - Employee's name;
  - Patient's name, date of birth, address, and identification number;
  - Date the service was performed or treatment received;
  - Physician's service or procedure code (CPT-4);
  - Diagnosis code (ICD-9);
  - Billed charge for the service performed or treatment received;
  - Number of units (for anesthesia and certain other claims);
  - Service provider's name, address, phone number, professional degree or license, and federal tax identification number; and
  - Accident details if treatment was due to an accident. Refer to ***Subrogation, Reimbursement, and Third Party Liability*** on page 59 for more information relating to expenses incurred due to an accident.
  - Have your provider complete the appropriate portion of the form, if applicable.
  - Attach all bills or receipts relating to the service provided.
  - Make sure each bill clearly identifies the service or supply, fee, patient's name, and date of service.
  - If you are also covered by Medicare or another plan, attach a copy of the itemized bill relating to the health service provided and a copy of Medicare's or the other plan's Explanation of Benefits (EOB). Both the bill and EOB must be submitted.

- Forward the completed form and all related bills as follows (contact details are listed on the ***Important Contact Information*** insert to this book):

Most medical providers will file claims for you.

A claim for benefits is a request for benefits made in accordance with the Plan's claims procedures. Simple inquiries or phone calls about the Plan's provisions that are unrelated to a specific claim are not claims for benefits.

You should review any bills you receive for services performed or treatment obtained for accuracy. You should report any discrepancies to the Plan. A separate claim is required for each person for whom services were performed or treatment obtained. If another plan or fund is the primary payer, you should include the Explanation of Benefits (EOB) from the other plan or fund when you file your claim for benefits.

  - Medical post-service claims for you and your Spouse and Dependent children to the PPO provider.
  - Transplant benefit claims to the Fund Office.
  - All other healthcare claims, including prescription drug claims (for prescriptions not filled at a participating pharmacy) to the Claims Administrator.

Receipt of completed claim forms, invoices from providers, and receipts for payment of covered services or supplies are considered as notice of claim and must be given to the Plan within 90 days of the occurrence of such an Illness or Injury, or as soon thereafter as is reasonably possible. In no case will the Plan pay claims submitted later than one year of the date the loss or expense was incurred.

Reimbursement for covered expenses will be made to you unless benefits have been assigned, in which case payment will be made to the provider of the service.

All claims should be submitted within 90 days after you receive a bill for services or supplies. In the case of extenuating circumstances, you must file your claim within one year after the date the loss or expense was incurred. If you do not meet this deadline, your claim will be invalidated.

TYPES OF HEALTHCARE CLAIMS

Under the Plan, there are four types of healthcare claims (including medical, dental, vision, and prescription drug claims):

- **Urgent Care:** A claim for care or treatment that would:
  - Seriously jeopardize your life or health if normal pre-service standards were applied; or
  - Subject you to severe pain that cannot be adequately managed without the care or treatment for which pre-authorization is sought, in the opinion of a Physician with knowledge of your condition.
- **Pre-Service:** A claim for care or treatment where pre-authorization is required. You are required to get pre-authorization for organ transplant benefits.
- **Concurrent:** A claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits or termination of the benefits.
- **Post-Service:** A claim for health care benefits for which you have already received the service.

The claims procedures for benefits are different for each type of claim, as described in the following sections.

TIMING OF HEALTHCARE CLAIM DECISIONS

When a claim is submitted, the responsible Plan provider/representative will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims will be processed promptly after complete claim information is received. The Plan will make an initial determination on your healthcare claim within certain timeframes, as follows:

Benefits will not be denied for pre-service claims if:

- It is not possible for you to obtain pre-authorization; or
- The pre-authorization process would jeopardize your life or health.

- Health Care Claims:
  - *Urgent Care Claims:* An initial determination will be made as soon as possible and no later than 72 hours from receipt of the claim. Notice of a decision on an urgent care claim may be provided orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process the claim, notification will be provided within 24 hours of receipt of the claim. You then have up to 48 hours to respond. The Plan will notify you of its determination within 48 hours of the later of receipt of the additional information or the end of the 48-hour period for you to provide the additional information.
  - *Pre-Service Claims:* An initial determination will be made within 15 days from receipt of the claim. If additional time is needed to make a determination, due to matters beyond the control of the Plan, written notification will be provided within the initial 15-day deadline that up to 15 additional days may be needed. If additional information is needed to process the claim, the initial period will be suspended and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made before the end of the initial period, which begins to run again.
  - *Concurrent Claims:* In general, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If an extension of approved urgent care treatment is requested (i.e., longer than the prescribed period or number of treatments), the Plan will act on the request within 24 hours after receiving it, as long as the claim is received at least 24 hours before the expiration of the approved treatment. If a concurrent care claim does not involve urgent care treatment or is filed less than 24 hours before the expiration of the previously approved period or number of treatments, the Plan will respond according to the type of claim involved.
  - *Post-Service Claims:* An initial determination will be made within 30 days from receipt of the claim. If additional time is needed to make a determination due to matters beyond the control of the Plan, written notification will be provided within the initial 30-day deadline that up to 15 additional days may be needed. If additional information is needed to process the claim, the initial period will be suspended and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made before the end of the initial period, which begins to run again. Post-service claims include claims involving a rescission of coverage.

Once the Plan makes payment on a claim, no further payment will be made.

You will be notified of an initial determination within certain timeframes. If a concurrent or post-service claim is approved, payment will be made, you will receive an Explanation of Benefits (EOB), and the payment and EOB will be considered your notice that the claim was approved. However, for urgent care, pre-service, and disability claims, you will be given written notice of a determination on your claim.

If circumstances require an extension of time for making a determination on a claim, written notification will be provided stating the special circumstances for the extension and the date a determination is expected.

If a concurrent claim is not an urgent care claim, it will be processed in the same manner as a pre-service or post-service claim, whichever is applicable.

LOSS OF TIME (DISABILITY) BENEFIT CLAIMS

When you have a disability that qualifies you for Loss of Time Benefits, as explained on page 33, you must file a claim for benefits. You may contact the Claims Administrator or visit www.myfundoffice.com to obtain the proper claim form. You and your Physician must complete the claim form and submit it to the Fund Office within 90 days of the date your disability begins. In no event, will the Plan pay claims submitted later than one year after the first date of your disability. The Plan will make an initial determination on your Loss of Time claim within certain timeframes, as follows:

- **Disability Claims** (Loss of Time Benefits): An initial determination will be made within 45 days from receipt of the claim. If additional time is needed to make a determination, due to matters beyond the control of the Plan, written notification will be provided within the initial 45-day deadline. The initial deadline may be extended up to an additional 60 days maximum. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary. If additional information is needed to process the claim, the initial period will be suspended and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made before the end of the initial period, which begins to run again.

Once you have recovered from your disability, or once the Plan has paid the maximum Loss of Time Benefit, no further payments will be made.

DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT CLAIMS

When you have a disability that qualifies you for an Accidental Dismemberment Benefit, or upon your Death or Accidental Death, as explained on page 34, you or your survivors must file a claim for benefits. You may contact the Claims Administrator or visit www.myfundoffice.com to obtain the proper claim form. You or your survivors must complete the claim form and submit it to the Fund Office within 90 days of the date of loss. In no event, will the Plan pay claims submitted later than one year after the date of loss. The Plan will make an initial determination on your Death or Accidental Death and Dismemberment claim within certain timeframes, as follows:

- **Death and Accidental Death and Dismemberment Benefit Claims.** An initial determination will be made within 90 days from receipt of the claim. If additional time or information is needed to make a determination, due to matters beyond the control of the Plan, written notification will be provided within the initial 90-day deadline that up to 90 additional days may be needed. If additional information is needed to process the claim, the initial period will be suspended and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made within 90 days.

Once the Plan makes payment on a claim, no further payment will be made.

IF A CLAIM IS DENIED

If your claim for benefits is denied, in whole or in part, you will be provided with oral and/or written (or electronic, if possible) notice in the form of an EOB not later than the period permitted to make the determination (as previously described).

When the Plan notifies you of its initial denial on a claim, the written notice will include:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of why it is needed;
- A copy of the Plan's review procedures and periods to appeal your claim, including:
    - A description of the expedited review process for urgent healthcare claims, if applicable; and
    - A statement that you may bring a lawsuit under ERISA following the appeal and review of your claim; and
- If your healthcare claim is denied based on:
    - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
    - Medical Necessity, Investigative or Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.
- The written statement shall also include:
    - An explanation for disagreeing with or not following:
    - The views you presented to the Plan of the health care professionals treating you and vocational professionals who evaluated you;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in conjunction with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A determination regarding your disability that you presented to the Plan made by the Social Security Administration.
    - If the adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
    - Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
    - A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- In the case of an adverse benefit determination with respect to a claim for a disability benefit, the notification shall be provided in a culturally appropriate manner pursuant to Department of Labor Regulation Section 2560.503-1(o);
- For disability benefit claims , the following shall also apply:
    - If the Plan fails to establish or follow claims procedures consistent with the requirements of the Plan, you will be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under ERISA §502(a);

- If the Plan fails to strictly adhere to all the requirements of the Plan's claims and appeal procedures with respect to disability benefit claims, you are deemed to have exhausted the administrative remedies available under the Plan (unless the violations are "de minimis" in accordance with DOL Reg. §2560.503-1(l)(2)(ii)). Accordingly, you are entitled to pursue any available remedies under ERISA §502(a). If you choose to pursue remedies under ERISA §502, in these circumstances the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary;
- To ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

When filing or appealing a claim, you may authorize a representative to act on your behalf (see page 56).

Information Requirements

If your appeal is denied, in whole or in part, you will be provided with oral and/or written notice no later than the period permitted to make the determination (as previously described).

When the Plan notifies you of a denial on appeal, the written notice will include:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A statement that you may bring a lawsuit under ERISA following the appeal and review of your claim;
- A statement of any voluntary Plan appeal procedures; and

Allowable Expenses

Any necessary, Reasonable, and Customary Charge, at least part of which is covered under one of the plans covering you or your Spouse or Dependents for which benefit payment is made. If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid.

Allowable expenses under medical benefits are not considered allowable expenses under dental benefits and vice versa.

- If your appeal is denied based on:
  - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
  - Medical Necessity, Investigative or Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.
- Effective for claims for a disability benefit or for retroactive terminations of disability benefits , the following will also apply:
  - Prior to the date that the Plan issues an adverse benefit determination on an appeal of a disability benefit claim, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination (or at the direction of the Plan insurer or such other person) in connection with your claim; such evidence must 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 in order to give you a reasonable opportunity to respond prior to that date; and

- Prior to the date the Plan can issue an adverse benefit determination on an appeal of a disability benefit claim based on a new additional rationale, the Plan will provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on a review is required to be provided in order to give you a reasonable opportunity to respond prior to that date.

- In the case of an adverse benefit determination on an appeal with respect to a claim for a disability benefit, the determination will include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views you presented to the Plan of the health care professionals treating you and vocational professionals who evaluated you;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in conjunction with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A determination regarding your disability that you presented to the Plan made by the Social Security Administration;
  - If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- In the case of an adverse benefit determination on an appeal with respect to a claim for a disability benefit, the notification will be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor Regulation Section 2560.503-1 (o).

You must follow the Plan's claims and appeals procedures completely before you bring an action in court under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) to obtain benefits.

APPEALING A DENIED CLAIM

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Fund Administrator at the Fund Office as soon as possible. For urgent healthcare claims, your appeal may be made orally.

If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within 60 days from the date of the initial determination of a Death Benefit or Accidental Death and Dismemberment Benefit, or within 180 days from the date of the initial determination of adverse healthcare and Loss of Time (disability) benefit determinations.

Your written appeal must explain the reasons you disagree with the decision on your claim. When filing an appeal you may:

- Submit additional materials, including comments, statements, or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial of a healthcare claim was based if the denial was based on Medical Necessity, Investigative or Experimental treatment, or similar exclusion or limit.

BENEFIT APPEALS COMMITTEE

The Board of Trustees has established a Benefit Appeals Committee that has the authority and power to review and hear the appeals of all adverse benefit determinations. The Trustees will appoint up to two Union Trustees and up to two Employer Trustees to the Benefit Appeals Committee, each of whom will serve until the Trustees appoint replacements.

The Benefit Appeals Committee (and the Board of Trustees) has discretionary authority to determine all benefit claim appeals and to interpret the Plan. The determination of the Benefit Appeals Committee (or the Board of Trustees) will be given judicial deference in any later court action to the extent it is not arbitrary and capricious.

When you appeal a denied claim, the Benefit Appeals Committee and Fund Counsel will be provided the following information:

- Your claim for benefits with any forms, invoices, and other materials you have submitted.
- A copy of the Fund Administrator's denial, which should be dated and contain:
  - The specific reason(s) for the denial;
  - The specific reference to applicable Plan provisions on which the denial is based;
  - A description of any additional information or information necessary for you to complete the claim and an explanation of why the material or information is necessary; and
  - An explanation of the claim appeal procedures and the right to bring a civil action under ERISA following an adverse benefit determination.
- Any additional relevant information.

If the Benefit Appeals Committee agrees to approve, reverse, or remand the appeal, then the decision is final and binding. If they tie on a decision, the appeal will be referred with recommendations to the full Board of Trustees for consideration within the required appeal time limits. For appeals referred from the Benefit Appeals Committee and heard by the full Board of Trustees, the Benefit Appeals Committee will not vote when the full Board considers the matter.

If the decision on a claim or the decision on review is not furnished within the time limits established in this section, the claim or the review will be deemed to have been denied. No claim will be deemed to have been denied until you have exhausted all of the Plan's claim and appeal procedures.

Every final decision of the Benefit Appeals Committee will be distributed to the full Board of Trustees at the next regular Board meeting following the decision.

APPEAL DECISIONS

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be made and the decision-maker will not defer to the initial decision. You will be notified, in writing, of the decision on any appeal within the timeframes noted in the *Appeal Timeframes* subsection below. However, oral notice of a determination on an urgent care claim may be provided sooner.

The Board of Trustees' Appeals Committee or the Board will perform the appeal review and make a decision on your claim. The appropriate fiduciary of the Plan that conducts the review will not be:

- The individual who made the initial decision to deny the claim; or

- An individual who reports to or works for the individual who made the initial decision to deny the claim.

Neither you nor your authorized representative has a right to appear before the Board of Trustees' Appeals Committee or the Board to present your case. However, as part of your request for review, you or your authorized representative may inspect all documents relating to your claim.

Appeal Timeframes

The Plan's determination will be made within certain timeframes. The deadlines differ for the different types of claims as follows:

- **Health Care Appeals**
  - Urgent Care Appeals—A determination will be made as soon as possible and no later than 72 hours from receipt of the appeal by the Board of Trustees' Appeals Committee.
  - Pre-Service Appeals—A determination will be made within 30 days from receipt of the appeal by the Board of Trustees' Appeals Committee.
  - Concurrent Appeals—A determination will be made before reduction or termination of the benefit, if possible.
  - Post-Service Appeals—A determination will be made within 60 days from receipt of the appeal by the Board of Trustees' Appeals Committee.
- **Disability Appeals**—A determination will be made within 45 days from receipt of the appeal by the Board of Trustees' Appeals Committee.
- **Death Benefit Appeals**—A determination will be made within 60 days from receipt of the appeal by the Board of Trustees' Appeals Committee. If special circumstances exist that require an extension of time to make a determination on the appeal, notification will be provided before the end of the 60-day appeal determination period. A determination will be made no later than 60 days from the initial 60-day appeal determination period.
- **Accidental Death and Dismemberment Appeals**—A determination will be made within 60 days from receipt of the appeal by the Board of Trustees' Appeals Committee. If special circumstances exist that require an extension of time to make a determination on the appeal, the Fund Office will send you written notification before the end of the 60-day appeal determination period. A determination will be made no later than 60 days from the initial 60-day appeal determination period.
- **Other Appeal**—A determination will be made within 60 days from receipt of the appeal by the Board of Trustees' Appeals Committee. If special circumstances exist that require an extension of time to make a determination on the appeal, notification will be provided before the end of the 60-day appeal determination period. A determination will be made no later than 60 days from the initial 60-day appeal determination period.

Information Requirements

If your appeal is denied, in whole or in part, you will be provided with oral and/or written notice no later than the period permitted to make the determination (as previously described).

When the Plan notifies you of a denial on an appeal, the written notice will include:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A statement that you may bring a lawsuit under ERISA following the appeal and review of your claim;
- A statement of any voluntary Plan appeal procedures; and
- If your appeal is denied based on:
  - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or

- Medical Necessity, Investigative or Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.

You must follow the Plan's claims and appeals procedures completely before you bring an action in court under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) to obtain benefits.

Allowable Expenses

Any necessary, Reasonable, and Customary Charge, at least part of which is covered under one of the plans covering you or your Spouse or Dependents for which benefit payment is made. If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid.

Allowable expenses under medical benefits are not considered allowable expenses under dental benefits and vice versa.

MEDICAL JUDGMENT

A medical judgment includes a review of a claim or appeal on the basis that it is:

- Investigative;
- Experimental;
- Not Medically Necessary; or
- Appropriately excluded from medical coverage.

The Plan's appeal procedures require independent medical review if a denial is based on medical judgment. If a claim is denied based on a medical judgment, the decision-maker on appeal will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

The review will identify the medical or vocational experts whose advice was obtained on behalf of the Plan, whether or not the decision-maker relied on the advice.

AUTHORIZED REPRESENTATIVE

For benefit claims and appeals, you may authorize certain individuals to act on your behalf. You will need to submit a HIPAA-compliant written statement (available from the Fund Office) authorizing this individual. Your authorized representative will be responsible for, and will receive all information related to, your benefit claim or appeal.

Only the following will be recognized as your authorized representative upon receipt of a written statement from you:

- Health care provider;
- Spouse;
- Dependent child age 18 or older;
- Parent or adult sibling;
- Grandparent;
- Court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator; or
- Other adult.

For an urgent care claim, a health care professional with knowledge of your condition will be recognized as your authorized representative without a written statement from you.

COORDINATION OF BENEFITS

The Plan is designed to help you meet the cost of health care expenses. It is not intended, however, to give you greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will take into account any coverage you or a Spouse or Dependent has under other plans. Benefits under this Plan will be coordinated with the benefits payable to you or your Spouse or Dependents under other plans. Specifically, in a Benefit Plan Year or Calendar Year, this Plan will always pay to you either its regular benefits in full or a reduced amount that, when added to the benefits payable to you by the other plan(s), will equal the total allowable expenses. However, no more than the maximum benefits payable under this Plan will be paid.

If you and your Dependent child are both members of IBEW Local 9 and eligible for coverage through the Plan, your Dependent child can have their own coverage and be covered as your Dependent (as long as he or she meets the eligibility criteria for a Dependent child).

If you and your Spouse are both members of IBEW Local 9 and eligible for coverage through the Plan, you and your Spouse can each have your own coverage and be covered as Dependents of each other.

If you or your Spouse or Dependents are covered under another plan, you must report such duplicate group coverage to the Claims Administrator to secure reimbursement of allowable expenses incurred. If you gain coverage under another plan as an active employee, then that coverage is primary and coverage under this Plan is secondary.

This Plan's secondary benefits will be limited if, under this Plan's coordination of benefits rules:

- This Plan's coverage is secondary; and
- The primary plan includes a provision that results in the primary plan paying a lesser benefit when there is secondary coverage. In this situation, as the secondary payer, this Plan may limit benefits to no more than the lesser of the:
    - Difference between the amount that the Participant's primary plan would have paid if the primary plan had been the only plan providing coverage and the total amount of covered charges; or
    - Amount that this Plan would have paid had this Plan's coverage been primary.

This rule takes precedence over any contrary provision in the primary plan and applies whether the coverage under the primary plan is provided through a sub-plan, wrap-around plan, or any other designation.

"Other plan" means any plan providing benefits or services for health care that are provided by:

- Group insurance coverage or group-type insurance (for example, individually underwritten group insurance), whether insured or uninsured (self-funded), blanket, franchise, general liability, or common carrier insurance;
- Service plan contracts, group practice, individual practice, and other prepayment coverage;
- Coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, employee benefit organization plan, or any other group arrangement or employer provided individual coverage;
- Any homeowner's policy or other policy providing liability coverage;
- Any coverage for students sponsored by or provided through a school or other educational institution;
- Any mandatory no-fault automobile insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of accidental bodily Injuries arising out of a motor vehicle accident and any other payment received under any automobile policy; or

If you and your spouse are both eligible for coverage as Employees:

- You will each be covered by this Plan primarily as an Employee and secondarily as the Spouse of an Employee; and
- Your Dependent children will be considered Dependents of you or your spouseSince your Dependent children will only be covered under you or your spouse, this Plan will not coordinate benefits with itself.

Government programs or any coverage required or provided by any law, including Medicare. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301 et seq.), as amended from time to time).

Qualified Medical Child Support Orders

In the event of a divorce and/or remarriage, the financial responsibility for Dependent child medical coverage may be addressed by a court order. However, the court order is only enforceable if it is a Qualified Medical Child Support Order, which means it has been "qualified" by the Fund Administrator. For the Fund Office to determine the qualified status of the order, you must submit any legal documents requested by the Fund Office. Contact the Fund Office for more information.

Order of Payment

If you or your Spouse or Dependents are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits payable do not exceed 100% of total charges incurred, but no more than the plan's actual benefit.

The following rules determine which plan is the primary plan:

- A plan that does not have a coordination of benefits rule is always primary.
- A plan—including Medicare—that covers a person other than as a dependent (for example, a retired employee) is primary.
- A plan that covers an individual as an employee is primary. For example, if a plan covers an individual as an active employee, who is neither laid off nor retired (or as the dependent of that individual), that plan is primary and will pay benefits first before the plan that covers the individual as a laid off or retired employee (or as the dependent of that individual). This is known as the "active employee rule." 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.
- If a Dependent child is covered under two separate plans for which the child's parents are eligible, the benefits are paid first under the parent's plan whose birthday (month and day) falls earliest in the year. If both parents have the same birthday, the benefits of a plan that has covered the parent for the longer period will be paid before those of the other parent. However if the dependent child's parents are separated or divorced, the following order applies:
  - The plan of the parent with custody is primary.
  - The plan of the step-parent with custody (if any) is secondary.
  - The plan of the parent without custody is third.
- If a plan covers an individual who is also covered under COBRA Continuation Coverage (or other federal or state law continuation coverage), the following order applies:
  - The plan covering the individual as an employee, member, or subscriber (or the dependent of that individual) is primary; and
  - The continuation coverage plan is secondary.
- This is known as the "continuation coverage rule." 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.
- If a Dependent child is married and is covered under either or both parents' plans and is also covered as a dependent under the child's spouse's plan, the benefits are paid first under the plan that covered the Dependent child for the longer period of time and the Plan that covered the Dependent child for the shorter period of time shall be secondary. In the event that the Dependent child's coverage under the child's spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule outlined in the fourth bullet in this list of rules.
- If none of the above apply, the benefits of a plan that has covered the person for whom the claim has been incurred for the longest period will be paid before those of the other plan.

If you or your Spouse or Dependent are eligible for Medicare and elect not to be covered under this Plan, no benefits will be paid under this Plan.

If you or your Spouse or Dependents receive benefits from the Plan while not eligible to receive such benefits, the Plan may recover and collect those payments from you, your Spouse or Dependents, or such other organization(s) that may be liable to the Plan for such repayments. The Plan may also release or obtain data needed to determine the benefits payable under this Plan and repay any party for a payment made by the party when this Plan should have made the payment. See page 59 for more information.

Coordination of Benefits with Medicare

Medicare is a multi-part program:

- Medicare Part A: Officially called *Hospital Insurance Benefits for the Aged and Disabled*, Part A primarily covers Hospital benefits, although it also provides other benefits.
- Medicare Part B: *Officially called Supplementary Medical Insurance Benefits for the Aged and Disabled*, Part B primarily covers Physician's services, although it, too, covers a number of other items and services.
- Medicare Part C: Also called *Medicare Advantage*, Part C is the managed care portion of Medicare and allows more choices in selecting medical coverage by making it possible for people who are eligible for Medicare to select the managed care health plan that they would like to join. Your specific choices under Part C will depend on where you live. Some plans charge an additional monthly premium, but many do not. You may also pay the plan a Copayment per visit or service.
- Medicare Part D: Officially called *Medicare Prescription Drug Coverage*, Part D is Medicare's prescription drug benefits.

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, dependent widow, or have End-Stage Renal Disease (ERD or ESRD). You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for Medicare. Since Part A is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Part B and possibly for Parts C and/or D.

For all purposes of this provision, if you or your Spouse or Dependents are entitled to benefits or other compensation under Medicare and Medicare is your primary plan, the Plan will reduce your benefits by the amount Medicare would have paid, even if you are not enrolled or participating in Medicare. Provided Medicare has not been elected as the primary health care coverage, this Plan is primary and will pay first if you or your Spouse or Dependent are eligible for Medicare:

- Because of age or disability and have Plan coverage due to your current employment status (i.e., you are an active employee or the dependent of an active employee); or
- Based on ESRD and are within the first 30 months of the ESRD coordination period.

Otherwise, any benefits payable to you or your Spouse or Dependents under any portion of this Plan will be reduced by the amount of any benefits or other compensation to which you are entitled under any federal law, rules, or regulations constituting a governmental health plan, such as Medicare. Benefits will similarly be reduced if you or your Spouse or Dependents are above age 65 and Medicare is the primary plan over this Plan for the same Illness or Injury, regardless of whether or not you have received or made application for such benefits or compensation.

Accidental Injury Liability

In certain instances, benefits under this Plan are considered secondary and excess coverage to certain other types of insurance, known as "other insurance." Other insurance includes, but is not limited to:

- Automobile, motorcycle, or other motor vehicle insurance;
- Common carrier's liability insurance (such as bus or commercial airline); or
- Insurance coverage authorized by law to provide benefits to or for a Participant for bodily and/or psychological Injury.

This provision applies to, but is not limited to, related Hospital, surgical, dental, and other medical expenses that are covered by this Plan if the other insurance was issued in conformity with "no-fault" or "personal injury protection" type laws or other similar state or local laws or regulations.

No payment will be made until proof is submitted to and judged acceptable by the Trustees that a proper claim has been made for the other insurance. Plan benefits will be:

- Paid if the other insurance has been denied; or
- Coordinated with the other insurance, if any.

The above designation of other insurance as primary will prevail over any state or local law, regulation, or provision if the other insurance is contrary to or inconsistent with this designation.

Information Gathering

To implement the Plan's coordination of benefits provisions, the Trustees, Claims Administrator, or Fund Administrator may, without the consent of, or notice to, any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person that the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan must provide to the Trustees, Claims Administrator, or Fund Administrator such information as may be necessary to implement the provisions of this section or to determine their applicability. These information gathering provisions are subject to the Plan's Privacy Policy, as summarized on page 63.

If a third party is liable for any benefits provided by the Plan, you should make a claim or take any legal action necessary against the third party.

SUBROGATION, REIMBURSEMENT, AND THIRD PARTY LIABILITY

This provision applies when you and/or your Spouse or Dependent(s) are Ill or Injured due to the act or omission of another person or party (referred to throughout this section as Third Party). In these instances, if you and/or your Spouse or Dependent(s) receives benefits under the Plan for such Illness or Injury, you and/or your Spouse or Dependent(s) will be required to reimburse the Plan for those benefits from all recoveries from a Third Party whether by lawsuit, settlement, or otherwise. This provision also applies in the event that an Illness or Injury arises in the course of your or your Spouse or Dependent(s) work or while engaged in some activity for wage or profit that may lead to liability under a workers compensation claim. The employer or workers compensation insurance carrier may deny the claim. In such a case, the Trustees may agree to pay the claim subject to the reimbursement and other terms of this provision.

Advance on Plan Benefits

The Plan does not cover expenses for services or supplies for which there is any recovery from, or potential legal liability of, any Third Party; this includes expenses arising from a work-related Illness or Injury. The recovery may be acquired by settlement, judgment, or otherwise. However, the Board of Trustees, in its sole discretion, may advance payment on account of Plan benefits (referred to throughout this section as an Advance), subject to its right to be reimbursed to the full extent of any Advance payment from you and/or your Spouse or Dependent(s) if and when there is any recovery from any Third Party.

The Plan's right to reimbursement applies even if the recovery is not:

- Characterized in a settlement or judgment as being paid on account of the medical, dental, or other expenses for which the Advance was made; or
- Sufficient to make the Ill or Injured covered individual whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule).

If the Plan makes an Advance, the Plan is subrogated to all rights of recovery, which means the Plan has a right to first reimbursement out of any recovery obtained.

The Plan is entitled to first-dollar reimbursement from your and/or your Spouse or Dependent's claim against the Third Party. Under the Plan's right to reimbursement, the amount of the Plan's reimbursement is not affected or reduced:

- If the recovery is reduced due to your or your Spouse or Dependent's negligence (sometimes referred to as contributory negligence) or any other common law defense; or
- By any legal fees or other expenses you and/or your Spouse or Dependent(s) incur in connection with the recovery from the Third Party or the Third Party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule).

The Plan's right to reimbursement applies regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the Illness or Injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule).

Reimbursement and/or Subrogation Agreement

You and any Spouse or Dependent on whose behalf an Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (referred to throughout this section as Agreement) in a form provided by or on behalf of the Plan. If one or more of the Ill or Injured covered individuals is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child), spouse, or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed by the covered individual(s), at the Plan Administrator's request, or if the Agreement is modified in any way without the consent of the Plan Administrator, the Plan may refuse to make any Advance. However, in its sole discretion, if the Plan Administrator makes an Advance in the absence of an Agreement, or if the Plan makes an Advance in error, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to reimbursement or subrogation.

Cooperation with the Plan

By accepting an Advance or by receiving the benefit of an Advance due to the payment of covered expenses, regardless of whether or not an Agreement has been executed, you and your Spouse and any of your Dependents must each agree:

- To reimburse the Plan for all amounts paid or payable to or on behalf of you or your Spouse or Dependent(s) by the Third Party or that Third Party's insurer for the entire Advance amount, and to hold any such amounts in constructive trust for the Plan until such time as they are reimbursed to the Plan;
- That the Plan has the first right of reimbursement from any judgment, settlement, or recovery;
- Not to do anything that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement rights or subrogation rights;
- Not to assign the right of recovery to any other person or entity without the specific consent of the Plan;
- To notify and consult with the Plan Administrator or its designee before starting any legal action or administrative proceeding against a Third Party alleged to be responsible for the Illness or Injury that resulted in the Advance, and before entering into any settlement Agreement with that Third Party or Third Party's insurer based on those allegations; and
- To inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings against the Third Party.

Subrogation

By accepting an Advance or by receiving the benefit of an Advance due to the payment of covered expenses, regardless of whether or not an Agreement has been executed, you and/or your Spouse or Dependent jointly agree that the Plan will be subrogated to your and/or your Spouse or Dependent's right of recovery from a Third Party or that Third Party's insurer for the entire Advance amount, regardless of any state or common law rule to the contrary, including without limitation, the so-called "collateral source rule" (that would have the effect of prohibiting the Plan from recovering any amount).

This means that, in any legal action against a Third Party who may have been responsible for the Illness or Injury that resulted in the Advance, the Plan may be substituted in place of you and/or your Spouse or Dependent(s), but only to the extent of the Advance amount. The Plan is subrogated in any and all actions against Third Parties for the portion of all recoveries to which the Plan is entitled.

In accordance with the Plan's subrogation rights, the Plan Administrator may, in its sole discretion:

- Start any legal action or administrative proceeding deemed necessary to protect the Plan's right to recover any Advance, and try or settle that action or proceeding in the name of, and with or without the full cooperation of, you and/or your Spouse or Dependent(s), but in doing so, the Plan will neither provide legal representation for you or your Spouse or Dependent(s) nor will it provide legal advice to you and/or your Spouse or Dependent(s) with respect to your damages or recovery that exceeds any Advance amount;
- Intervene in any claim, legal action, or administrative proceeding started by you or your Spouse or Dependent(s) against any Third Party or Third Party's insurer concerning the Illness or Injury that resulted in the Advance; or
- Compromise or reduce its lien if the Trustees determine it is in the best interests of the Plan.

Lien and Segregation of Recovery

By accepting the Advance, you and your Spouse and any of your Dependents agree that:

- The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment, or otherwise, by you or your Spouse or Dependent(s). The Plan's lien extends to any recovery from the Third Party, the Third Party's insurer, and/or the Third Party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance, or other benefits policy or plan. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.
- You and your Spouse or Dependent(s), and those acting on your behalf, hold in a constructive trust for the Plan that portion of the recovery to the extent of the Advance. You and your Spouse or Dependent(s), and those acting on your behalf, place and maintain such portion of any recovery in a separate, segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account, name of the custodian, if any, and the account number must be provided to the Plan.
- If you and/or your Spouse or Dependent(s), and those acting on your behalf, do not maintain this segregated account or comply with any of the Plan's reimbursement requirements, then you must stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

Additional Plan Remedies Available

In addition to the other remedies discussed, if you and/or your Spouse or Dependent(s), or those acting on your behalf, do not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

- Apply the amount not reimbursed to any future Plan benefits that may accrue or become payable on behalf of you or your Spouse or any of your Dependents whether or not the future Plan benefits are related to the original Plan benefits that were incurred as a result of the act or omission of a Third Party, which were excluded as work-related or otherwise excluded and subject to this provision;
- Exclude from coverage any future Plan benefits that may accrue or become payable on behalf of you or your Spouse or any of your Dependents that are related to the original Plan benefits that were incurred as a result of the act or omission of a Third Party, which were excluded as work-related or otherwise excluded and subject to this provision; or,

- Seek to obtain a judgment against you and/or your Spouse or Dependent(s) for the Advance amount not reimbursed and garnish or attach your and/or your Spouse or Dependent's wages or earnings.

CORONAVIRUS NATIONAL EMERGENCY

During the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak ("National Emergency"), pursuant to federal rules (85 Fed. Reg. 26351 – the "Coronavirus Rule), and not withstanding other Plan deadlines, the Plan will disregard the period from the earlier of: (a) one year from the date the individual was first eligible for relief (i.e., one year from their original deadline) or (b) 60 days after the announced end of the National Emergency, in determining the following periods and dates –

1) The period to request special enrollment,
2) The 60-day election period for COBRA Continuation Coverage,
3) The date for making COBRA premium payments,
4) The date for individuals to notify the Plan of a qualifying event or determination of disability,
5) The date within which individual may file a benefit claim under the Plan's claim procedure,
6) The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure.

All as required under ERISA, the Internal Revenue Code, and federal rules (and as specified by 85 Fed. Reg. 26351).

The Plan shall further conform to all lawful requirements of the Coronavirus Rule.

Privacy Policy

The information in this section was issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

DISCLOSURE OF SUMMARY HEALTH INFORMATION TO PLAN SPONSOR

In accordance with the Privacy Policy, the Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- Modifying, amending, or terminating the Plan.

Summary Health Information may be individually identifiable health information and it summarizes the claims history, claims expenses, or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

DISCLOSURE OF PHI TO PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

For the Plan Sponsor to receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in this Privacy Policy).
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization that meets the requirements of the Privacy Policy.
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for or that the Plan Sponsor becomes aware.
- Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524).
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526).
- Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528).
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq.).
- 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, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    - The following employees, or classes of employees, or other persons under control of the Plan Sponsor, will be given access to the PHI to be disclosed:
    - Trustees of the Local Union No. 9, IBEW and Outside Contractors Health and Welfare Trust Fund; and
    - Health and Welfare Fund Administrator Staff.

- The access to and use of PHI by the individuals described above will be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
    - In the event any of the individuals described above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Fund Administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay, and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

Plan Administration functions are activities that would meet the definitions of treatment, payment, and health care operations. Plan Administration functions include, but are not limited to, quality assurance, claims processing, auditing, monitoring, management, stop loss underwriting, stop loss claims filing, eligibility information requests, Medical Necessity reviews, appeal determinations, Utilization Management review, Case Management, and disease management. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the:

- Plan Documents have been amended to incorporate the above provisions; and
- Plan Sponsor agrees to comply with such provisions.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO PLAN SPONSOR

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the Privacy Policy.

PROTECTION AND SECURITY OF YOUR PHI

The Plan Sponsor will:

- 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;
- Ensure that the adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

BREACH NOTIFICATION RIGHTS FOR UNSECURED PROTECTED HEALTH INFORMATION UNDER HIPAA

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Fund Office to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Fund Office is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Fund Office to provide notification to the media.

If your unsecured PHI is breached, the Fund Office will notify you without unreasonable delay and in no case no later than 60 calendar days after discovery of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Plan up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Fund Office or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Fund Office has improperly followed the breach notification process.

PRIVACY NOTICE

This Privacy Notice describes how PHI may be used or disclosed by this Plan to carry out treatment, payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out this Plan's legal obligations concerning a Participant's PHI and describes a Participant's rights to access and control that PHI.

Protected Health Information (PHI) is individually identifiable health information, including demographic information, collected from a Participant or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to:

- A Participant's past, present, or future physical or mental health condition;
- The provision of health care to a Participant; or
- The past, present, or future payment for the provision of health care to a Participant.

This Notice has been drafted to be consistent with what is known as the HIPAA Privacy Rule, and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the policies and procedures described in the Notice or you want to obtain a copy of the Notice, please contact:

Fund Administrator
Local Union No. 9, IBEW and Outside Contractors
Active Employees Health and Welfare Plan
18670 Graphics Drive, Suite 201
Tinley Park, IL 60477
708-449-9004

Plan's Responsibilities

The Plan is required by law to maintain the privacy of a Participant's PHI. The Plan is obligated to provide you with a copy of this Notice of the Plan's legal duties and of its privacy practices with respect to PHI, and the Plan must abide by the terms of this Notice. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- Uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

Primary Uses and Disclosures of PHI

The following is a description of how the Plan is most likely to use and/or disclose a Participant's PHI.

- **Treatment, payment, and health care operations:** The Plan has the right to use and disclose a Participant's PHI for all activities that are included within the definitions of treatment, payment, and health care operations as described in the HIPAA Privacy Rule.
- **Treatment:** The Plan will use or disclose PHI so that a Participant may seek treatment. Treatment is the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of a Participant's providers. For example, the Plan may disclose to a treating specialist the name of a Participant's primary care Physician so that the specialist may request medical records from that primary care Physician.

This Privacy Notice describes how medical information about Participants may be used and disclosed and how Participants can get access to the information. Please review it carefully.

- **Payment:** The Plan will use or disclose PHI to pay claims for services provided to a Participant and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Participant's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was Medically Necessary.
- **Health care operations:** The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, the Plan may use or disclose PHI:
    - To provide a Participant with information about a disease management program;
    - To respond to a customer service inquiry from a Participant; or
    - In connection with fraud and abuse detection and compliance programs.
- Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, Utilization Management, subrogation, or pharmacy benefit management. Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization, and Utilization Management vendor.
- **Other covered entities:** The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance, and improvement activities or accreditation, certification, licensing, or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers to coordinate benefits, if a Participant has coverage through another carrier.
- **Plan Sponsor:** The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. Also, the Plan may use or disclose Summary Health Information to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. Summary Health Information summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

Potential Impact of State Law

The HIPAA Privacy Regulations generally do not preempt (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Other Possible Uses and Disclosures of PHI

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

- **Required by law:** The Plan may use or disclose PHI to the extent that federal law requires the use or disclosure. When used in this Notice, required by law is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.
- **Public health activities:** The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling Illness, Injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Health oversight activities:** The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as for audits, investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee:
    - The health care system;
    - Government benefit programs;
    - Other government regulatory programs; and
    - Compliance with civil rights laws.
- **Abuse or neglect:** The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Participant's PHI if there is reason to believe that the Participant has been a victim of abuse, neglect, or domestic violence.
- **Legal proceedings:** The Plan may disclose PHI in:
    - The course of any judicial or administrative proceeding;
    - Response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and
    - Response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.
- **Law enforcement:** Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but are not limited to:
    - Required by law or some other legal process;
    - Necessary to locate or identify a suspect, fugitive, material witness, or missing person; or
    - Necessary to provide evidence of a crime.

- **Coroners, medical examiners, funeral directors, and organ donation:** The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.
- **Research:** The Plan may disclose PHI to researchers when an institutional review board or privacy board has:
    - Reviewed the research proposal and established protocols to ensure the privacy of the information; and
    - Approved the research.
- **Prevent a serious threat to health or safety:** Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Military activity and national security, protective services:** Under certain conditions, the Plan may disclose PHI if Participants are, or were, armed forces personnel for activities deemed necessary by appropriate military command authorities. If Participants are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.
- **Inmates:** If a Participant is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for the:
    - Institution to provide health care to the Participant;
    - Participant's health and safety and the health and safety of others; or
    - Safety and security of the correctional institution.
- **Workers' compensation:** The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related Illnesses or Injuries.
- **Others involved in health care:** Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other authorized representative that the Participant identifies. Such use will be based on how involved the person is in the Participant's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.
- **Disaster relief:** The Plan may disclose PHI to an entity assisting in a disaster relief effort so that a Participant's family can be notified about his/her condition, status, and location.

If a Participant is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Participant's best interest.

Required Disclosures of PHI

The following is a description of disclosures that the Plan is required by law to make.

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services:** The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.
- **Disclosures to Participants:** The Plan is required to disclose to a Participant most of the PHI in a designated record set when that Participant requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Participant's health care benefits. The Plan also is required to provide, upon the Participant's request, an accounting of most disclosures of his/her PHI that are for reasons other than treatment, payment, and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Participant's PHI to an individual who has been designated by that Participant as his/her authorized representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Participant must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if the Participant designates an authorized representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Participant's authorized representative if a reasonable belief exists that:

- The Participant has been, or may be, subjected to domestic violence, abuse or neglect by such person;
- Treating such person as his/her authorized representative could endanger the Participant; or
- The Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Participant's authorized representative.

Other Uses and Disclosures of PHI

Other uses and disclosures of PHI that are not described previously will be made only with a Participant's written authorization. If the Participant provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

A Participant's Rights

The following is a description of a Participant's rights with respect to PHI:

- **Right to request a restriction:** A Participant has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment, or health care operations. The Plan is not required to agree to any restriction that a Participant may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide Emergency treatment.

  A Participant may request a restriction by contacting the Fund Office. It is important that the Participant direct his/her request for restriction to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

  The Plan will want to receive this information in writing and will instruct the Participant where to send the request when the Participant's call is received. In this request, it is important that the Participant states:

  - The information whose disclosure he/she wants to limit; and
  - How he/she wants to limit the Plan's use and/or disclosure of the information.

- **Right to request confidential communications:** If a Participant believes that a disclosure of all or part of his/her PHI may endanger him/her, that Participant may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Participant may ask that the Plan only contact the Participant at a work address or via the Participant's work e-mail.

  The Participant may request a restriction by contacting the individual or office referenced in the beginning of this Notice. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

  The Plan will want to receive this information in writing and will instruct the Participant where to send a written request upon receiving a call. This written request should inform the Plan that:

  - He/she wants the Plan to communicate his/her PHI in an alternative manner or at an alternative location; and
  - Disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Participant in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Participant's PHI could endanger that Participant. As permitted by the HIPAA Privacy Rule, reasonableness will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Participant's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Participant submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Participant may receive benefits (e.g., an Explanation of Benefits or EOB). Unless the Participant has made other payment arrangements, the EOB (in which a Participant's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within two business days or as soon as reasonably possible.

Before receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Participant contact the Plan at the number listed in this Notice as soon as the Participant determines the need to restrict disclosures of his/her PHI.

If the Participant terminates his/her request for confidential communications, the restriction will be removed for all of the Participant's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Participant should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

- **Right to inspect and copy:** A Participant has the right to inspect and copy PHI that is contained in a designated record set. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Participant's health care benefits. Documents in a designated record set may be in paper and electronic formats. However, the Participant may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

  To inspect and copy PHI that is contained in a designated record set, the Participant must submit a request by contacting the individual or office referenced in the beginning of this Notice. It is important that the Participant contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Participant requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing, or other supplies associated with that request.

  The Plan may deny a Participant's request to inspect and copy PHI in certain limited circumstances. If a Participant is denied access to information, he/she may request that the denial be reviewed. To request a review, the Participant must contact the individual or office referenced in the beginning of this Notice. A licensed health care professional chosen by the Plan will review the Participant's request and the denial. The person performing this review will not be the same one who denied the Participant's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Participant through the denial that the decision is not reviewable.

- **Right to amend:** If a Participant believes that his/her PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Participant may request that the Plan amend such information by contacting the individual or office referenced in the beginning of this Notice. Additionally, this request should include the reason the amendment is necessary. It is important that the Participant direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

  In certain cases, the Plan may deny the Participant's request for an amendment. For example, the Plan may deny the request if the information the Participant wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Participant has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

- **Right of an accounting:** The Participant has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Participant or his/her authorized representative. The Participant should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

  An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

  A Participant may request an accounting by submitting a request in writing to the individual or office referenced in the beginning of this Notice. It is important that the Participant direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

  A Participant's request may be for disclosures made up to six years before the date of the request. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Participant of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

- **Right to a paper copy of this notice:** The Participant has the right to a paper copy of this Notice, even if he/she has agreed to accept this Notice electronically.

Complaints

A Participant may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Participant may file a complaint with the Plan by contacting the individual or office referenced in the beginning of this Notice. A copy of a complaint form is available from this contact office.

A Participant also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must:

- Be in writing;
- Contain the name of the entity against which the complaint is lodged;
- Describe the relevant problems; and
- Be filed within 180 days of the time the Participant became or should have become aware of the problem.

Plan Information

PLAN NAME

Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan

PLAN NUMBER

501

PLAN IDENTIFICATION NUMBER

36-2261990

CALENDAR YEAR OR BENEFIT PLAN YEAR

January 1 through December 31. The Benefit Plan Year or Calendar Year is the period by which benefit limits, deductibles, out-of-pocket maximums are calculated.

PLAN YEAR OR FISCAL YEAR

November 1 through October 31. The Plan Year or Fiscal Year is the period used by the Plan for financial reporting and disclosure requirements for all Plan benefits, including the Health Reimbursement Arrangement (HRA).

PLAN TYPE

The Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan is a group health plan maintained for the purpose of providing comprehensive medical, prescription drug, dental, vision, disability, and death benefits for Participants who meet the eligibility requirements, as described in this book.

The Plan does not replace and is not affected by any requirement for coverage under workers' compensation, employer liability, occupational disease, or similar law. Benefits that would otherwise be payable under the provisions of such laws are not paid by the Plan.

ELIGIBILITY REQUIREMENTS

The Plan's requirements for eligibility for benefits are shown in this book. Circumstances that may cause you to lose eligibility are also explained. Your coverage under this Plan does not constitute a guarantee of your continued employment and you are not vested in the benefits described in this book. All Plan benefits are made available to you and your Spouse and Dependent children by the Plan as a privilege and not as a right.

LEGAL DOCUMENT

This book serves as the Summary Plan Description and the official legal Plan Document governing the Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan. All of your rights and benefits are governed by this official document, as it may be amended. If you misplace this book, you may examine a copy of it at the Fund Office, or obtain a copy for yourself from the Fund Administrator.

PLAN SPONSOR

The Plan is sponsored by the Board of Trustees of the Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan, consisting of Union and Employer representatives. If you wish to contact the Board of Trustees, you may use the following address and telephone:

Local Union No. 9, IBEW and Outside Contractors
Active Employees Health and Welfare Plan
18670 Graphics Drive, Suite 201
Tinley Park, Illinois, 60477
708-449-9004

The Trustees of this Plan are listed on the *Important Contact Information* insert to this book.

FUND ADMINISTRATOR

The Board of Trustees has named a Fund Administrator, whose responsibility it is to see that your questions are answered, that eligibility and Contribution records are maintained, that benefits are properly figured and paid promptly, and that the Plan is operated in accordance with the legal documents governing it. You may contact the Fund Administrator at the address shown for the Fund Office in this book. The Fund Administrator is listed on *the Important Contact Information* insert to this book.

The Board of Trustees has also delegated administrative responsibilities to specified administrators and insurance companies, as described on the *Important Contact Information* insert to this book.

AGENT FOR SERVICE OF LEGAL PROCESS

The Fund Administrator is the Plan's agent for service of legal process concerning the Plan. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Fund Administrator at the address of the Fund Office. However, such documents may also be served upon any individual Trustee at the address of the Fund Office.

PLAN FUNDING

Contributing Employers pay for the cost of the Plan by making Contributions to the Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan. Contributions are based on Covered Employment as described in the Collective Bargaining Agreement between your Employer and your Union, or are determined in accordance with a Participation Agreement between your Employer and the Plan. A copy of the Collective Bargaining Agreement under which you are covered is available, upon written request, from the Local Union No. 9 office and is available for examination at the Local Union No. 9 office. In addition, Participants may obtain, upon written request to the Fund Office, information as to the name and address of a particular employer and whether an employer is required to pay Contributions to the Plan.

Participant Self-Payments and COBRA Continuation Coverage Contributions are also used to fund the Plan. The Plan's benefits are self-funded from accumulated assets and are provided directly from the Trust Fund. Plan assets are also used to pay administrative expenses. A portion of Trust Fund assets is allocated for reserves to carry out the objectives of the Plan.

PLAN INTERPRETATION

The Board of Trustees, as the Plan Sponsor, has the authority to determine eligibility for benefits, to construe and interpret disputed or doubtful terms of, and to apply the provisions of, this Summary Plan Description/Plan Document, the Trust Agreement, and any and all other policies or procedures in its sole discretion. The Board of Trustees' decisions, interpretations, and conclusions will be final and binding. Although the Board of Trustees has retained an individual to act as the Fund Administrator and, although it has delegated to the Fund Administrator the authority to determine eligibility for benefits, to construe and interpret disputed or doubtful terms of, and to apply the provisions of, this Summary Plan Description/Plan Document, the Trust Agreement, and any and all other policies or procedures in the Fund Administrator's discretion, the Board retains its authority as outlined herein and as outlined in the section entitled ***Claims and Appeals***. Disputes between interpretations by the Fund Administrator and by the Board of Trustees will be resolved in favor of the Board of Trustees. Benefits under this Plan will be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them.

This book serves as the Plan's Summary Plan Description (SPD) and is the legal Plan Document (PD) as provided in Section 102 of the Employee Retirement Income Security Act of 1974. This SPD/PD book and supplemental documents, such as insurance certificates, HIPAA Privacy Rules, and COBRA notices, serve as the Plan's controlling legal documents.

PLAN AMENDMENT AND TERMINATION

The Board of Trustees expects that the Plan will be permanent. However, the Trustees have the authority and broad discretion to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan as they determine to be in the best interests of Plan Participants and beneficiaries. Any such amendment, which will be communicated in writing, will not affect valid claims that originated before the date of the amendment.

This Plan may be discontinued or terminated under certain circumstances, as described in the documents that establish this Plan. In such event, all coverage for Participants will end immediately. Any such discontinuation will not affect valid claims that originate before the termination date of the Plan as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets and benefit payments will be limited to the assets available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the documents governing this Plan.

BENEFITS ASSIGNMENT

This Plan is intended to pay benefits only for you and your Spouse and Dependent children. Payments generally are made directly to you, unless you assign benefits to the provider. Your benefits cannot be used as collateral for loans or assigned in any other way except in connection with Qualified Medical Child Support Orders. You will be notified if such an order is received with respect to your benefits.

YOUR ERISA RIGHTS

As a Participant in this 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 are entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, 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 (EBSA).
- Obtain upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description/Plan Document. The Fund Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, your Spouse, or Dependent children if there is a loss of coverage under the Plan because of a qualifying event. You or your Spouse or Dependents may have to pay for such coverage. Review this Summary Plan Description/Plan Document and other documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing condition limitations under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
    - You lose coverage under the Plan;
    - You become entitled to elect COBRA Continuation Coverage;

- Your COBRA Continuation Coverage ends.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for the 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. 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

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the 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. You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. If you are not satisfied with the reply, you feel you are unable to obtain a satisfactory answer, and if you want to take the matter further, you may wish to contact your lawyer or the Employee Benefits Security Administration of the U.S. Department of Labor to obtain further action.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the 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 Fund 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 Fund Administrator.

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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. You must file suit within three years of exhausting the Plan's claims and appeals procedures. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures.

If it should happen that the 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 courts 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

If you have any questions about your Plan, you should contact the Fund 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 Fund Administrator, you should contact the EBSA at:

National Office:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
866-444-3272

Nearest Regional Office:
Employee Benefits Security Administration
Chicago Regional Office
230 South Dearborn Street, Room 570
Chicago, IL 60604-1520
312-596-7010

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their Web site at www.dol.gov/ebsa.

Glossary of Terms

- **Allowable Charge** means:
  - With respect to a network provider, the Allowable Charge is the negotiated fee/rate set forth in the agreement with the participating network health and/or dental provider, facility, or organization and the Plan.
  - With respect to an out-of-network provider, the Allowable Charge means the amount as determined by the Board of Trustees for a particular service or supply. The Plan will not pay any Allowable Charge for out-of-network services or supplies that is determined by any provider, facility, or other person or organization, other than the Board of Trustees.
- **Ambulatory Surgical Facility** or **Ambulatory Surgical Treatment Center** means any non-Hospital facility at which a surgical procedure is performed.
- **Assistant Surgeon** means a Physician who is qualified and able to finish the procedure should circumstances require (for example, in the case of brain surgery, the surgeon and Assistant Surgeon must both be neurosurgeons). An Assistant Surgeon under the Plan is not a Nurse Practitioner (NP), Physician Assistant (PA), Certified Operating Room Technician (CORT), Registered Nurse (RN), Certified Surgical Assistant (CSA), or any other Non-Physician Medical Professional that is not qualified to continue an operation should the primary surgeon be unable to finish.
- **Association** means the Middle States Electrical Contractors Association of the City of Chicago.
- **Calendar Year** means the 12-month period starting on January 1 of any year and ending on December 31 of that year.
- **Case Management** or **Case Management Program** means a program of medical management typically utilized in situations involving extensive and ongoing medical treatment that provides a comprehensive and coordinated delivery of services under the oversight of a medically-responsible individual or agency. Such programs may provide benefits not normally covered under Plan provisions in lieu of Hospital Inpatient treatment.
- **Claims Administrator** is the entity providing consulting services to the Fund Administrator in connection with the operation of the Plan and performing other functions, including processing of claims. The Claims Administrator is listed in the Important Contact Information.
- **Coinsurance** means that portion of covered expenses that a Participant is responsible to pay. In most instances, the responsibility is for paying a percentage of the total covered expenses that are in excess of the Deductible.
- **Collective Bargaining Agreement** means a written agreement between the Union and the Association.
- **Contributing Employer** or **Employer** means:
  - Members of the Association;
  - An Employer that has an agreement with the Union to make Contributions to the Plan;
  - An Employer that does not have an agreement with the Union but that acknowledges the Union as the collective bargaining representative of Employees performing work of the type specified within the Collective Bargaining Agreement between the Union and the Association; and
  - The Union.
- **Contributions** mean payments made or due to the Plan by Employers, pursuant to the terms of the Trust Agreement, a Collective Bargaining Agreement, or a Participation Agreement on behalf of their Employees for work performed by such Employees.

- **Copayment** or **Copay** means a separate fixed dollar amount that a Participant is responsible to pay when incurring certain types of covered expenses. The Copayment is usually in addition to any Deductible and/or Coinsurance amounts that a Participant is responsible to pay.
- **Cosmetic Surgery** and/or **Treatment** means surgery or treatment that is intended to improve appearance or to preserve or restore a pleasing appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease (except when necessary to improve a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an accident or trauma, or disfiguring disease).

Reconstructive surgery covered under the Women's Health and Cancer Rights Act is not considered Cosmetic Surgery and/or Treatment and is covered under the Plan.

- **Covered Employment** means work performed by an Employee for an Employer for which Contributions are required to be made to this Plan.
- **Custodial Care** means services and supplies for care:
  - Furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; or
  - That can safely and adequately be provided by persons who do not have the technical skills of a covered practitioner.
  - Care that meets one of the conditions above is Custodial Care regardless of:
    - Who recommends, provides, or directs the care;
    - Where the care is provided; or
    - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- **Deductible** means the amount of covered expenses incurred in any Calendar Year that must be paid by a Participant before the Plan begins to pay benefits. The Deductible is usually in addition to any Copayment and/or Coinsurance amounts that a Participant is responsible to pay. However, some covered services are not subject to the Deductible, as noted in the ***Schedule of Benefits***.
- **Deliver**, **Delivered** and **Delivery** for purposes of submitting documents and monies to the Fund Office mean a U.S. postmark or postage stamp cancellation (postage meter dates are not considered since they can be altered at the time they are imprinted), common courier carrier date of acceptance for delivery, or date of hand delivery to the Fund Office.

The Plan requires proof of dependency for any person claimed to be a Dependent as it sees fit. Such proof of dependency may include a marriage certificate, birth certificate, or adoption papers. If you divorce, you may be required to submit a decree of divorce stating the name of the former Spouse and the date such marriage ended.

If you are not sure if your Spouse or child is eligible for coverage under the Plan, please contact the Fund Office for more information.

- **Dependents** include your:
  - Child, whether married or unmarried, who has not reached age 26; effective until October 31, 2014, adult dependent children who are eligible for any other employment-based health coverage, other than a parent's group health plan, will not be considered Dependents under the Plan.
  - Child includes your:
    - Natural born child (as evidenced by your name on the child's birth certificate);
    - Child you legally adopt or who is Placed for Adoption with you;

- Stepchild: To be eligible, the stepchild must be the natural-born or adopted child of your Spouse. Original birth certificates showing your Spouse as the parent are required to be submitted to the Fund. (The original county or state seal must be visible on the birth certificate.) Once the Fund Office processes your application, the original documents will be returned to you. If your Spouse's name on the birth certificate differs from that on the marriage license for you and your Spouse, then additional original, official documentation proving the succession of name changes will be required by the Fund Office as well.

- Child age 26 or older, who is unmarried and who is incapable of self-sustaining employment because of a Handicap, provided:
  - The child does not provide over one-half of his or her own support for the calendar year;
  - The child has the same principal place of abode as you for over half the year. Temporary absences for special circumstances, such as for school or vacation, are allowed; and
  - The Handicap began before age 26:
  - He or she remains Handicapped;
  - You remain an Eligible Employee;
  - You submit proof of the child's Handicap within 31 days of the date the child turns age 26; additional proof will be required from time to time.

  If your Handicapped child over age 26 otherwise meets the definition of Dependent but does not live with you, he or she will be an eligible Dependent child if the:
  - Child's parents are:
    - Divorced under a decree of divorce or separate maintenance;
    - Legally separated under a written separation agreement; or
    - Living apart at all times during the last six months of the calendar year;
  - Child's parents together provide over one-half of the child's support; and
  - Child is in the custody of one or both of his or her parents for more than one-half of the calendar year.
- Child who is named under a Qualified Medical Child Support Order or National Medical Support Notice.

A child is considered an eligible Dependent under this Plan while he or she is an Employee who is eligible for his or her own coverage under this Plan.

In the event of a divorce or legal separation, contact your attorney for information relating to whether or not a Qualified Medical Child Support Order is appropriate.

You must provide the Plan with any requested documentation relating to your Spouse or Dependents, including any documents required to prove dependency, such as a marriage certificate, birth certificate, or adoption papers. In addition, when an individual is no longer eligible as a Spouse or Dependent, you must provide any requested information, such as a divorce decree.

Durable Medical Equipment means equipment that:

- Can withstand repeated use;
- Is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Illness, Injury, or deformity; and
- Is not disposable or non-durable.

Elective Surgical Procedure means any non-Emergency surgical procedure that:

- May be scheduled at the Participant's convenience without jeopardizing the Participant's life or causing serious impairment to the Participant's bodily functions; and
- Is performed while the Participant is confined in a Hospital or in an Ambulatory Surgical Facility.

- **Employee** or **Eligible Employee** means a common law employee whose Employer is obligated to contribute to the Plan on his or her behalf under the terms of a Collective Bargaining Agreement between the Union and the Contributing Employer, or under the terms of a Participation Agreement.
- **Extended Care Facility** means a PPO network institution (or a distinct part of an institution) that:
    - Provides 24-hour nursing care and related services for Inpatients who require medical or nursing care or rehabilitation services for Ill or Injured persons;
    - Maintains and adheres to written policies developed with the advice of, approved by, and subject to review by a group of Physicians to cover nursing care and related services;
    - Requires a Physician, a registered professional nurse, or other qualified medical staff acting within the scope of their licensing be responsible for the execution of such policies;
    - Requires that every patient be under the care of a Physician and makes a Physician available to furnish medical care in case of Emergency;
    - Maintains clinical records on all patients and has appropriate methods for dispensing medicines and biologicals;
    - Requires that at least one registered professional nurse be on duty at all times;
    - Provides for periodic review of each patient by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay, and Medical Necessity of continuing confinement;
    - Is licensed or is approved pursuant to law by the appropriate authority as qualifying for licensing and is approved by Medicare; and
    - Is not primarily a place for the aged, drug addicts, alcoholics, mentally handicapped, or a place for rest, Custodial Care, educational care, or mental health care.

    See *General Plan Limitations and Exclusions* on page 36 for coverage limitations applicable to Extended Care Facilities.
- **ERISA** means the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.
- **Fund, Trust Fund,** or **Health and Welfare Fund** means the Local Union No. 9, IBEW and Outside Contractors Health and Welfare Trust Fund created pursuant to the Trust Agreement.
- **Fund Administrator**, **Administrator**, or **Plan Administrator** means the person designated by the Board of Trustees pursuant to its authority under the terms of Trust Agreement; however, if a person is not designated, the Board of Trustees, as the Plan Sponsor will act as the Fund Administrator.
- **Handicap** or **Handicapped** means the inability of a person to be self-sufficient as the result of a physical or mental condition, such as intellectual disability, cerebral palsy, epilepsy, or another neurological disorder, psychosis, or is otherwise totally disabled, provided the condition was diagnosed by a Physician and accepted by the Trustees as a permanent and continuing condition.
- **Hazardous Pursuit, Hobby,** or **Activity:** Services, supplies, care and/or treatment of an Injury or Sickness that results from engaging in a hazardous pursuit, hobby, or activity in an amateur or professional status, or in a reckless recreational manner. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the covered person's customary occupation or if it involves activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm, including but not limited to: cliff diving, hang gliding, skydiving, bungee/base jumping, cave diving, parasailing, white/black water rafting, scuba diving deeper than 30 meters, rock climbing, use of explosives, automobile, motorcycle, aircraft, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

- **Home Health Care Agency** means a public or private agency that is primarily engaged in providing skilled nursing and other therapeutic services that is:
    - Licensed or certified as a home health care agency by the governing jurisdiction; or
    - Certified as a home health care agency by Medicare.
- **Hospice** means a facility established to furnish terminally Ill patients a coordinated program of Inpatient and home care of a palliative and supportive nature. A Hospice must be approved as meeting established standards, including any legal licensing requirements.
- **Hospital** means an institution that:
    - Maintains permanent and full-time facilities for bed care of resident patients;
    - Has a Physician in regular attendance;
    - Continuously provides 24-hour-a-day nursing services by registered nurses;
    - Is primarily engaged in providing diagnostic and therapeutic services and facilities for medical and surgical care of Illness or Injury on a basis other than a rest home, nursing home, convalescent home, or a home for the aged;
    - Maintains facilities on the premises for surgery;
    - Operates lawfully as a hospital in the jurisdiction where it is located; and
    - Is accredited by The Joint Commission or similar organization as a hospital or is Medicare approved.

  In addition, Hospital means, as defined by Medicare, a psychiatric Hospital that is:
    - Qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; or
    - Licensed by the jurisdiction in which it operates and is accredited by The Joint Commission or similar organization.
- **Illness** means non-occupational sickness, disease, mental infirmity, or pregnancy requiring treatment by a Physician.
- **Injury** means a non-occupational bodily injury requiring treatment by a Physician.
- **Inpatient** means a Participant treated at a Hospital who incurs Room and Board Charges.
- **Intensive Care Unit** or **Cardiac Care Unit** means only a section, ward, or wing within the Hospital that is distinguishable from other Hospital facilities because it:
    - Is operated solely for the purpose of providing room and board and professional care and treatment for critically Ill patients, including constant observation and care by a registered nurse; and
    - Has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.
- **Investigative** or **Experimental** means procedures, drugs, devices, services, and/or supplies that are:
    - Provided or performed in a special setting for research purposes or under a controlled environment and that are being studied for safety, efficiency, and effectiveness;
    - Awaiting endorsement by the appropriate National Medical Specialty College or federal governmental agency for general use by the medical community at the time they are rendered; or
    - Specifically with regard to drugs, combination of drugs and/or devices, not finally approved by the Federal Drug Administration at the time used or administered.

Treatment (medicines, surgery, techniques, devices, and procedures) that is not generally recognized by professional medical peer groups, such as the American Medical Association, will be considered Experimental. Recognized treatment that is used in a non-routine manner, such as frequency or dosage, will be considered Experimental. If a particular form of medical treatment has been subject to a multiple phase set of clinical trials, such as developing cancer treatment, completion and publication of the results of the last phase of the clinical trials must occur before a treatment will be considered non-Experimental.

The Board of Trustees will use its discretion to determine if a particular procedure, drug, device, service, and/or supply is Investigative or Experimental based upon its review of the evidence presented. The Board reserves the right to consult independent experts from outside sources in an effort to aid it in reaching a determination. The Board may also examine the Centers for Medicare and Medicaid Services (CMS) coverage guidelines or Hayes ratings.

Since benefits under this Plan are for the treatment of accidental bodily Illness or Injury by generally recognized medicines, surgery, and other techniques, if the Board of Trustees, in its sole discretion, determines that a particular procedure, drug, device, service, and/or supply is Investigative or Experimental, such charges will not be considered covered expenses under this Plan.

- **Late Enrollment** means an enrollment that takes place other than during the first period during which an individual is eligible for coverage or other than during a period of Special Enrollment.
- **Lifetime** refers to the period while a person is covered under this Plan. It does not mean during the lifetime of the Participant.
- **Medical Emergency, Emergency Illness,** or **Emergency** is a sudden, unexpected, and severe onset of a medical condition manifesting itself by acute symptoms that are severe enough that the lack of immediate medical attention could reasonably be expected to result in:
  - Placing the Participant's health in serious jeopardy;
  - Seriously impairing bodily function;
  - Serious dysfunction of a bodily organ or part; or
  - Serious and permanent medical consequences; or
  - In the case of a mental health or substance abuse disorder, the patient harming himself or herself and/or other persons.
- **Medically Necessary** or **Medical Necessity** means health care services, supplies, or treatment that, in the judgment of the attending Physician:
  - Is appropriate and consistent with the diagnosis; and
  - In accordance with generally accepted medical standards, could not have been omitted without adversely affecting the Participant's condition or the quality of medical care rendered.
- **Medicare** means the Health Insurance for the Aged Program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97) and as such program is currently constituted and as it may be amended.
- **Non-Physician Medical Professional** means a licensed professional who is legally qualified to practice within the medical field at the time and place service is rendered within the scope of his or her licenses.
- **Office Visit** means a direct personal contact between a Physician or other health care practitioner and a Participant 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 coding. Neither a telephone discussion with a Physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is considered an Office Visit for the purposes of this Plan.
- **Outpatient** is a Participant who is treated at a Hospital and is not incurring Room and Board Charges.

- **Participant** means an Employee and Spouse and Dependent child eligible for coverage under this Plan.
- **Participation Agreement** means a written agreement between an Employer and the Board of Trustees obligating the Employer to make Contributions to the Plan on behalf of the Employer's Employees whether or not subject to the terms of a Collective Bargaining Agreement.
- **Physician** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is legally qualified and licensed without limitation to practice medicine at the time and place service is rendered. For services covered by this Plan and for no other purpose, a Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Podiatry, and Doctor of Chiropractic licensed to perform surgery are deemed to be a Physician when practicing within the scope of his or her license. See also Non-Physician Medical Professional for other eligible professional providers (except as such providers may be specifically excluded elsewhere by this Plan).
- **Placement for Adoption** or **Placed for Adoption** means the assumption and retention of a legal obligation for total or partial support in anticipation of adoption.
- **Plan** means the Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan, which is the program of benefits described in this document, including any other written document designated by the Trustees as constituting a part of the Plan, established, and as it may be from time to time amended, by the Board of Trustees pursuant to the provisions of the Trust Agreement.
- **Qualified Medical Child Support Order (QMCSO)** is a legal order requiring the coverage of specified child(ren) under an Employee's medical plan. If the Fund Administrator determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a legal QMCSO, you will be required to provide coverage for any child(ren) named in the QMCSO.

  If you do not enroll the child(ren), the Fund Administrator must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency, or Medicaid agency and can withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence to your Employer that the child support order is no longer in effect. The Plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). ERISA preemption of state laws does not apply to QMCSOs and provisions of state laws requiring medical child support.

  The Plan may not deny enrollment of a child under the health coverage of the child's parent on the grounds that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the applicable service area. Additional information concerning QMCSO procedures is available from the Fund Administrator at no charge upon request.
- **Qualifying Coronavirus Preventive Service** means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease (COVID-19) and that is, with respect to the individual involved:
  - An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force, or
  - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), which has been adopted by the Director of the CDC. This provision is in effect regardless of whether the immunization is recommended for routine use.

- **Room and Board Charges** means all charges made by a Hospital, Skilled Nursing Facility, Hospice facility, or treatment facility for alcoholism and/or drug addiction on its own behalf for room, board, general duty nursing, and any other charges that are regularly made by the Hospital or facility as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services of Physicians or private duty nurses. Such charges are based on a confinement or stay of 24 hours or any shorter period for which the Hospital or facility regularly charges a full day's room and board rate.
- **Second Surgical Opinion** means a written statement on the necessity for the performance of a covered surgical procedure. It must be given by a board-certified specialist who, by the nature of the Physician's specialty, qualifies the Physician to consider the surgical procedure being proposed and who is otherwise not associated with the surgeon who initially recommended the surgery.
- **Self-Payments** means payments made to the Plan by Employees, including retired Employees, for the purpose of maintaining eligibility for Plan benefits.
- **Skilled Nursing Facility** means a nursing facility that:
    - Is an institution, or a distinct part of an institution, that has in effect a transfer agreement with one or more Hospitals;
    - Is primarily engaged in providing Inpatient Skilled Nursing Facility care and related services for individuals who require medical or nursing care;
    - Is duly licensed by the appropriate governmental authorities;
    - Has one or more Physicians and one or more registered nurses responsible for the care of Inpatients;
    - Requires that every patient must be under the supervision of a Physician;
    - Maintains clinical records on all patients;
    - Provides 24-hour-a-day nursing services;
    - Provides appropriate methods and procedures for the dispensing and administering medicines and biologicals;
    - Has in effect a Case Management Program;
    - Is eligible to participate under Medicare; and
    - Is not an institution that is primarily for the care and treatment of mental diseases.
- **Special Enrollment** is an enrollment that takes place during the applicable time period following the date of the event that triggers the Special Enrollment period. The date of loss of coverage (see When Coverage Ends on page 3), the dates of marriage, birth, adoption or Placement for Adoption, initiate Special Enrollment periods.
- **Spouse** is your opposite-sex or same-sex spouse, provided you meet all the requirements of a valid marriage contract in the appropriate legal jurisdiction in which the marriage takes place. You will be required to furnish proof of marriage containing the original seal of the legal jurisdiction in which the marriage took or takes place.

Domestic partners, divorced spouses, legally separated spouses, or any other persons having relationships of any similar kind with the Employee are not Spouses or Dependents under the Plan.

- **Temporomandibular Joint (TMJ) Dysfunction** or **Temporomandibular Joint (TMJ) Syndrome** refers to a variety of symptoms often associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly) or ill-fitting dentures where the cause is not clearly established, including, but not limited to:
    - Severe aching pain in and about the TMJ (sometimes made worse by chewing);
    - Limitation of the joint;
    - Clicking sounds during chewing;
    - Tinnitus (ringing, roaring, or hissing in one or both ears); and/or
    - Hearing impairment.

TMJ means the temporomandibular (or craniomandibular) joint that connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible).

- **Trustee, Trustees,** or **Board of Trustees** means a person or persons designated by the Trust Agreement or appointed by a person or entity granted the authority by the Trust Agreement.
- **Trust Agreement** means the Agreement and Declaration of Trust that established the Local Union No. 9, IBEW and Outside Contractors Trust Fund including all amendments establishing the Trust Fund and its rules of operation.
- **Union** means the Local Union No. 9, International Brotherhood of Electrical Workers, AFL-CIO and any successors.
- **Utilization Management (UM)** is a process 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. The Plan requires that you pre-authorize organ transplants. See page 17 for more information about pre-authorizing treatment.
- **Waiting Period** is the first day of the Working Quarter during which an Employee accumulates enough hours to acquire initial eligibility for a Coverage Quarter as defined under the terms of the Plan. Any period before a Late Enrollment or Special Enrollment is not a Waiting Period.

Local Union No. 9, IBEW and Outside Contractors
Active Employees Health and Welfare Plan

18670 Graphics Drive, Suite 201
Tinley Park, Illinois, 60477
708-449-9004