January 1, 2025 Summary Plan Description Booklet
Wisconsin Electrical Employees Health and Welfare Plan

For More Information
Or Further Assistance Please Call the Plan Office At

1 (608) 276-9111 OR 1 (800) 422-2128

Or Write:

Wisconsin Electrical Employees
Health and Welfare Plan
2730 Dairy Drive, Suite 101 Madison, WI 53718
Business Hours: Monday through Friday 7:00 a.m. to 5:00 p.m. CST

The Board of Trustees is pleased to provide this summary of the benefits provided by the Wisconsin Electrical Employees Health and Welfare Plan ("Plan" or "Health and Welfare Plan Rules and Regulations") as of January 1, 2025 in a booklet that is easy to read and understand—one that provides you with the necessary information when you need it.

Note that this booklet refers to "you" throughout. Unless the context suggests otherwise (for example, the benefit is available to employees only), use of you includes your covered Dependents. As there have been several changes and clarifications to the Plan since the last booklet was printed, you should read this booklet carefully so you understand the eligibility and benefits of the Plan. This booklet is not a guarantee of benefits, but is an overview of your benefit package. Benefits are subject to review and approval upon receipt of the claim.

IMPORTANT INFORMATION:

1. You must submit proof of all claims within the following deadlines:

   - Short Term Disability Claims: within six months of the date
   - All other claims: within one year of the date the expenses are incurred.

   Claims not received by the Fund Office and date stamped within the filing deadline will be denied and no benefits will be paid.

2. You or your provider, should contact the Fund Office to verify eligibility and benefits. Providers can also contact Anthem directly.

3. Fill out the enrollment card that is enclosed in the middle of the booklet and return it to the Fund Office as soon as possible so we may update our records. Our service to you depends on the information only you can provide to us. Thank you for your cooperation.

Additional Information

The Board of Trustees establishes the Health and Welfare Plan Rules and Regulations. By majority vote, the Board of Trustees can amend, modify or delete the terms, conditions or benefits of the Plan or discontinue all or part of the Plan, whenever, in their sole discretion.

The Health and Welfare Plan Rules and Regulations, as amended or restated from time to time, is the controlling document. This booklet is intended only as a summary of the Health and Welfare Plan Rules and Regulations and is not meant to interpret, extend or change the provisions expressed in the Health and Welfare Plan Rules and Regulations in any way. If any of the terms of this booklet and the Health and Welfare Plan Rules and Regulations are in conflict or if there is a discrepancy between the wording here and the actual provisions of the Health and Welfare Plan Rules and Regulations, the terms of the Health and Welfare Plan Rules and Regulations shall be followed.

The Board of Trustees will be the sole judge of the interpretation of the Plan, this booklet, or any other provisions relating to the operation of the Plan. The Board of Trustees makes final decisions regarding any

questions or application of the Health and Welfare Plan Rules and Regulations unless otherwise specifically delegated. Decisions of the Trustees shall be final and binding on all persons dealing with the Plan, except to the extent that such decision may be ruled to be arbitrary or capricious. No agent, representative, officer or other individual from a Union or Employer has the authority to speak for the Trustees or to act contrary to the written terms of the Health and Welfare Plan Rules and Regulations.

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Introduction

The benefits described in this booklet are available to you through your participation in the Wisconsin Electrical Employees Health and Welfare Plan. These benefits are designed to provide you and your Dependents with protection and peace of mind when you need it most.

Together these benefits help:

1. Pay for Hospital, Physician and other medical or optional benefit bills.

2. Replace your paycheck when illness or injury prevents you from working.

3. Protect your family if you should die.

Please read the remainder of this booklet carefully, so that you and your family fully understand what is covered and how to receive benefits. Terms that are capitalized in this booklet have the special meaning set forth in the Definitions section.

Eligibility for Benefits

In order to be eligible for coverage you must be an Active Employee, which is a person who is actively employed by an Employer that makes contributions to the Plan on the employee's behalf. You may also be eligible under Self-Payment or Continuation of Coverage (COBRA) provisions of the Plan. An owner of an unincorporated entity, including a sole proprietor or a partner in a partnership, is not eligible for coverage under the Fund. If you were covered under the Plan as an Active Employee, you may also be eligible to continue coverage as a Retired Employee.

Benefits

Active Employees, including Self-Pay Active Employees, are covered for medical, Short Term Disability, Long Term Disability, Death and Accidental Death and Dismemberment Benefits. Optional Dental and Vision benefits are available if elected by your Union or your Employer.

Self-Pay Disabled Employees are covered for medical, Death and Accidental Death and Dismemberment Benefits. If you were covered under Optional Dental and/or Vision benefits while you were an Active Employee, you may continue to be covered for those benefits.

COBRA Participants may elect coverage for medical benefits only or medical benefits and all Optional Benefits they were covered under on the date of the Qualifying Event. Welfare benefits, including Short Term and Long Term Disability, death and Accidental Death and Dismemberment Benefits are not available to COBRA Participants.

Retired Employees are covered for medical and Death Benefits and may choose to enroll in the Optional Dental and/or Vision benefits.

Eligibility

Active Hourly Employees

Initial Eligibility

Standard Eligibility Rule

If you are a new hourly employee, you will become eligible on the first day of the calendar month following receipt by the Fund Office of Employer or reciprocity contributions for 300 work hours within a 12-consecutive month period.

Example: You begin working April 1st. Your Employer makes contributions to the Plan for 300 hours for the work months of April and May, which are received by the Fund Office in May and June. Your coverage under this Plan will begin on July 1st.

Alternate Eligibility Rule

As an alternative, Active Hourly Employees may elect to purchase initial eligibility when they first become employed in a position for which an Employer is required to contribute to the Plan. To be eligible for this Alternate Eligibility rule, your home local must be a participating Union in the Fund and you must have begun working for a participating Employer in a position for which the Employer is required to make contributions to the Plan on your behalf. You must pay the full two months of premiums no later than the 15th of the month prior to the effective date of coverage. The effective date for the purchased coverage depends on the date you begin working for the Employer:

- If you begin working before the 15th of the month, your coverage can be effective the first day of the next month.
- If you begin working the 15th of the month or later, your coverage can be effective the first day of the second month.

Example: You begin working with an Employer in a position for which contributions to the Plan are required on October 5th. You may elect to purchase initial eligibility effective November 1 by enrolling in the Plan and paying the full two months of premiums no later than October 15.

Example: You begin working with an Employer in a position for which contributions to the Plan are required on October 20th. You may elect to purchase initial eligibility effective December 1 by enrolling in the Plan and paying the full two months of premiums no later than November 15.

You must enroll in the Plan within 30 days of hire to qualify for this Alternate Eligibility rule. If you do not satisfy these requirements, timely enroll or timely pay the required premium, you will be eligible under the Standard Eligibility rule only. You have only one opportunity to establish eligibility under this Alternate Eligibility rule.

<u>Continued Eligibility – Dollar Bank</u>

The contributions received from Employers that you work for (either locally or on reciprocity) are applied to the second month of Plan coverage following the month the contribution is received by the Fund Office.

Example: You work in December, the contributions are received by the Fund Office in January and are applied to provide Plan coverage for March.

After becoming eligible for Plan coverage, the Plan will create a dollar bank account on your behalf. You will continue to be eligible as long as your dollar bank contains enough money to pay for 1 month's coverage. Whenever you are credited with more contributions than those needed to provide 1 month's coverage, excess money is added to your dollar bank accumulation. If contributions received during a given month are for less than amount needed for 1 month's coverage, excess credit in your dollar bank will be used to give you coverage.

Upon your death, any remaining amounts in your dollar bank will be transferred to your covered Dependents to continue coverage. If you have no spouse or Dependent child at the time of your death, any remaining funds in your dollar bank will be forfeited unless there is another Active Hourly Employee in the Plan who is your child or parent. In that case your dollar bank may be transferred to the surviving Active Hourly Employee.

The Plan will automatically forfeit a dollar bank after 36 consecutive months without any activity (no contributions into or payments from).

<u>Reinstatement of Eligibility</u>

Your dollar bank will not be forfeited as long as you are available for work and on the books located at your local Union office. If your dollar bank credits are cancelled due to termination of coverage and you return to Covered Employment within 12 months of termination, your cancelled dollar bank credits will be reinstated effective the first day of the calendar month following the month in which the Fund Office receives contributions from a participating Employer or through reciprocity for at least 150 hours in a 12-consecutive month period.

If your coverage is terminated and you are later reinstated, your Flexible Benefit Account (if any) will be reinstated on the same date that dollar bank credits are reinstated.

If you do not return to Covered Employment within 12 months of termination, your dollar bank credits and Flexible Benefit Account are permanently forfeited.

Reciprocity

The Fund is a participating trust fund in the Electrical Industry Health and Welfare Fund Reciprocal Agreement. If you are an Active Hourly Employee who leaves employment covered by the Plan for employment covered by another fund in the Reciprocal Agreement (a "reciprocal plan"), you may elect to continue Plan coverage. To do so, you must register in the Electronic Reciprocal Transfer System (ERTS) and inform the hiring hall of the local union where you are being referred for employment that you are registered in the ERTS system. You will then receive credit in your dollar bank for the contribution amount the Plan receives from the reciprocal plan. Your benefits are limited to those set forth in the applicable reciprocity agreement.

Active Employer Staff Employee

Active Employer Staff Employees employed by the Employer will become eligible on the first day of the calendar month following date of hire and payment of 2 months' contributions by the Employer before the month for which coverage is intended.

If you are covered by your spouse's employer sponsored group health insurance plan, under Medicare, under TRICARE or under VA health care, you may waive coverage with the Plan by completing and sending a Waiver Form and proof of the other coverage to the Fund Office within 30 days of becoming eligible. If you waive coverage you can elect to enroll in the Plan at a later date if any of the following requirements described below are satisfied. In such cases, the effective date of coverage will be the first day of the first calendar month following receipt of the written request and enrollment form.

1. You lose the other coverage, provided you submit a written request and completed enrollment form to the Fund Office within 30 days of the date the other coverage terminates.

2. You or your Dependent lose coverage under Medicaid or the State Children's Health Insurance Program ("SCHIP"), provided you submit a written request and completed enrollment form to the Fund Office within 60 days of the date the coverage terminates.

3. You or your Dependent become eligible for assistance through Medicaid or SCHIP for coverage under this Plan, provided you submit a written request and completed enrollment form to the Fund Office within 60 days of becoming eligible for such assistance.

Opt Out for Dependents Covered Under Other Plans

If your Dependent is covered under another group health plan, Medicare or TRICARE, they will have the option of opting out of coverage under the Plan, provided the Dependent supplies proof of other coverage to the Fund Office and signs the Plan opt-out form. The Dependent's coverage under this Plan will terminate at the end of the last day of the month during which a completed and signed election form is received by the Fund Office. No Flexible Benefit Account reimbursements can be made on the Dependent's behalf while they are opted out of coverage.

A Dependent who has opted out of this Plan's coverage will not be eligible for this Plan unless they have a special enrollment right.

Termination of Active Employee Coverage

Your coverage will terminate:

1. The date the Plan is discontinued;

2. 31 days after you enter the Military Service of the United States on full-time, active duty;

3. If you participate in, assist, or conceal any scheme, artifice, plan or conduct by an Employer intended to defraud the Plan by paying contributions less than those due, your eligibility and benefits will terminate on the last day of the month that your participation, assistance or concealment begins or is discovered, whichever is earlier. All amounts credited to your dollar bank and Flexible Benefit Account will be forfeited to the Plan when your eligibility terminates. If you have knowledge of such conduct, scheme or plan, or knowledge that an Employer is not paying all contributions due and do not report all known information to the Board of Trustees, you will lose eligibility under this provision. Contributions made after you lose eligibility will not be credited to your account, until you demonstrate, to the satisfaction of the Board of Trustees, that you are no longer participating in or assisting in any actions by an Employer to defraud the Plan and you have reported all information and knowledge of such to the Board of Trustees. Generally, this is not an event for which COBRA continuation coverage is available.

4. Death;

5. The date of a withdrawal as described on page 6. Your dollar bank and Flexible Benefit Account will also be forfeited at that time.

Active Hourly Employees

In addition to the termination events applicable to all Employees above, if you are an Active Hourly Employee, your coverage will terminate:

1. The last day of the month that your dollar bank account no longer contains enough credits to provide 1 month's coverage;

2. If you start work in Disqualifying Employment, your eligibility and benefits will terminate on the last day of the month that such employment is discovered or commences, if later.

3. If you continue work, of any kind, for a former contributing Employer that has dropped out of the Plan, and no longer obligated to contribute to the Plan under the terms of a written agreement or under the National Labor Relations Act during a period of bargaining, your eligibility and benefits will terminate on the last day of the month in which the Employer's obligation to make contributions ends.

If you lose eligibility under paragraph 2 or 3:

- You cannot self-pay as an Active Self-Pay Employee, Disabled Employee or Retiree.
- Your dollar bank and Flexible Benefit Account will be canceled and, unless you satisfy the requirements for reinstatement of eligibility, permanently forfeited after 12 months.
- You shall have the right to appeal your loss of eligibility. The Board of Trustees shall, under the appeal process, have discretion to make all findings of fact and conclusions.

Active Employer Staff Employees

In addition to the termination events applicable to all Employees above, if you are an Active Employer Staff Employee, your coverage will terminate:

1. The last day of the month following the month that your employment terminates;

2. The end of the last period for which any required contributions have been made on your behalf;

Self-Pay

Active Hourly Employee Self-Pay

If credit in your dollar bank is no longer sufficient to provide coverage, you may elect to continue coverage by making self-payments for coverage in effect at the time of termination of eligibility. This self-pay option is in place of COBRA and is available for 36 consecutive months as long as you remain available for work through the Local Union's referral system. To elect this self-pay option, you, your spouse, and any adult Dependents must waive coverage under COBRA. You will receive notice from the Fund Office of the contribution amounts due.

COBRA continuation coverage will also be offered, as described in more detail on pages 9-12.

Disabled Self-Pay

If you are an Active Employee and you become Totally and Permanently Disabled, you can continue coverage by self-payment after using up credits in your dollar bank account. You may elect medical, Death and Accidental Death and Dismemberment benefits, or medical, Death and Accidental Death and Dismemberment Benefits and all Optional Benefits that you were covered for on the date you became Totally and Permanently Disabled. Self-Pay Disabled employees are not entitled to Short Term Disability benefits. When you are age 55 or over and become covered under Medicare or when your spouse turns age 65, you will automatically be transferred to a Retiree class.

You will be deemed Totally and Permanently Disabled as follows:

1. Upon determination by the Social Security Administration that you are entitled to a Social Security Disability Award; or

2. Upon determination of the Board of Trustees, in accordance with standards consistently applied, as follows:

   (a) For the first two years, that you are fully incapable, due to a physical or mental impairment, of performing every duty of your regular and customary work;

   (b) After the first two-year period, that you are unable to perform any occupation or employment you are qualified for by education, training or experience.

   The Board of Trustees may require evidence of continued entitlement to such Social Security Disability Award or evidence of continued disability at your expense.

Surviving Dependents Continued Coverage and Self-Pay

If you die with a balance in your dollar bank account, the balance will be used by your surviving Dependent spouse and children to continue coverage. Once your dollar bank credits (or Flexible Benefit Account dollars, if you were an Early Retiree or Retiree at the time of death) are exhausted, your surviving Dependents can elect to continue coverage through self-pay. Your surviving Dependents may elect medical benefits only or medical and all Optional Benefits that you were covered for on the date of your death, except Death, Accidental Death and Dismemberment and Short Term Disability benefits.

Self-Payment Contribution Due Date

Self-payment contributions are due the 15th day of the month prior to the month for which coverage is intended (i.e., January self-payment is due December 15th), with a 5-day grace period. If self-payments are not received on time, coverage will be terminated as of the last day of the month for which contributions were timely made. If your self-pay contribution is returned due to non-sufficient funds, you will be charged a $30 penalty and must make the next six months' payments by guaranteed funds.

Termination of Self-Pay Coverage

Self-pay coverage will terminate on the earliest of the following dates:

1. The last day of the month for which the required timely self-payment has been made;

2. Death;

3. The date the Plan is discontinued;

4. The date of a withdrawal as described on page 6.

In addition, in the case of Surviving Dependents Self-Pay, your surviving Dependents will lose coverage as of the date a Dependent child's coverage would otherwise end, or the date the Dependent spouse remarries or

becomes covered under any other group health plan. Any unused amounts in the dollar bank will be forfeited to the Plan.

In addition, in the case of Active Employee Self-Pay, your coverage will end also on the last day of the month for which the self-pay period has been exhausted, the last day of the month you become covered as an employee under any other group health plan, or the date coverage would otherwise terminate.

In addition, in the case of a Disabled Self-Pay Employee, your coverage will also terminate on the last day of the month you are no longer Totally and Permanently Disabled, the last day of the month in which you become covered under another group health plan as an employee, the date you become entitled to Medicare or when your Dependent spouse turns age 65. In the event of termination of coverage due to entitlement to Medicare, you can make a one-time election to continue coverage under the Plan as a self-payment for retirees.

Withdrawal

A withdrawal occurs when an Employer's Collective Bargaining Agreement no longer requires contributions to the Plan for Active Employees or the Employer otherwise ceases to be required to make contributions to the Plan. A withdrawal also can occur when a local union negotiates health benefit coverage for a substantial number of its members from a source other than the Plan.

When a withdrawal occurs, all current and former Active Employees of that Employer and their Dependents, including individuals on self-pay, lose coverage under the Plan effective the last day of the second month after the month in which the last contribution was required and paid by the Employer. However, former Active Employees and their Dependents who are enrolled in COBRA will remain covered under the Plan unless the withdrawing Employer offers another group health plan to the former Participants or begins contributing to another multiemployer plan. COBRA and self-pay options are generally not available following an Employer withdrawal.

An Active Hourly Employee who continues to be employed by a withdrawing Employer is not eligible for self-pay after the date eligibility is terminated.

A withdrawal results in termination of eligibility for Plan benefits incurred on or after the date the withdrawal occurs and all dollar bank and Flexible Benefit Account amounts are forfeited to the Plan. However, the Trustees may, in their sole discretion, approve a transfer of amounts corresponding to a portion of an affected Participant's credit in his Dollar Bank Account to a successor trust fund established for the same purposes as the Plan, to the extent the reserves and Dollar Bank credits attributable to the affected withdrawing group exceeded the claims run off following the withdrawal date.

Prohibition of Rescissions

The Plan will not rescind the coverage of benefits provided under the medical and prescription drug components of the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan.

For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. However, the following examples of a retroactive cancellation or discontinuance of coverage are not considered rescissions:

1. A cancellation or discontinuance of coverage retroactive to the date an individual terminated employment if the cancellation or discontinuance is attributable to a delay in administrative recordkeeping and if the individual did not pay any premiums for the coverage after the date of termination.

2. A cancellation or discontinuance of coverage that is effective retroactively if the cancellation or discontinuance is attributable to an individual's failure to pay required premiums or contributions toward the cost of coverage.

3. A cancellation or discontinuance of coverage retroactive to the date of divorce if the employee or former spouse failed to timely pay the required COBRA premiums for the former spouse's coverage.

The Plan will provide each Participant who will be affected by a rescission at least 30 days' advanced written notice before Plan coverage can be rescinded.

Dollar Bank Transfers

If you are an Active Hourly Employee, you may voluntarily transfer a portion of your dollar bank credits to another participant subject to the rules described in this section.

Transferring Dollar Banks

You may transfer dollar bank credits one month at a time to a qualifying dollar bank transfer recipient, up to a lifetime maximum of three months to the same employee. Dollar bank transfers must be for a full month's payment.

In order to make a dollar bank transfer, you must have at least six months' eligibility left in your dollar bank after making a dollar bank transfer.

You must also complete and sign all necessary forms waiving all rights and claims arising out of the transfer of credits from your dollar bank and confirming you have not received, and will not receive, a payment or other consideration of any kind in exchange for the dollar bank transfer.

Recipients of Dollar Bank Transfers

An individual who meets the following requirements of (1) or (2) below may receive a dollar bank transfer:

1. At the time of the transfer, a potential recipient must:

    (a) have lost eligibility under the Fund as an Active Hourly Employee, Disabled Self-Pay Active Hourly Employee or an Active Staff Employee as a result of a catastrophic illness, and

    (b) for an Active Hourly Employee, have insufficient dollar bank credits to continue eligibility without making a self-payment or

2. At the time of the transfer, the potential recipient must be the child, parent or sibling of the transferring participant and must:

    (a) have lost eligibility under the Fund and

    (b) have insufficient dollar bank credits to continuing eligibility without making a self-payment

If you have lost coverage and had your dollar bank cancelled or forfeited, you cannot receive a dollar bank transfer.

For purposes of this provision, catastrophic illness means an injury or illness that the Trustees or their delegees determine, in their discretion, incapacitates the participant and creates a financial hardship, or an injury or illness that incapacitates a Dependent if it results in the participant being required to terminate employment or reduce his or her hours of employment for an extended period of time to care for the Dependent. The employee must submit medical proof or other documentation to evidence the catastrophic illness.

The recipient of dollar bank credits may receive a transfer of no more than one month's premium per month from all sources.

Dependents' Eligibility

Eligible Dependents

The following individuals qualify as eligible Dependents under the Plan:

1. Your spouse, pursuant to a marriage that was lawfully licensed and performed between two individuals, unless you and your spouse are legally separated under the terms of a legal separation agreement which does not require the Participant to provide health coverage to the spouse;

2. Your natural born child, legally adopted child and child placed for adoption from birth until the end of the calendar month in which the child attains age 26;

3. Your unmarried step-child, foster child or child whose custody is court-ordered from birth until the end of the calendar year in which such individual turns 19 or until the end of the calendar month in which the individual attains age 26 if attending a post-secondary school as a full-time student, provided either:

   (a) The child (1) is younger than you, (2) maintains a parent-child relationship with you, (3) does not provide more than half his or her financial support during the calendar year and (4) has the same residence as you for more than half the calendar year (except for temporary absences, such as attending school); or

   (b) You provide over one half of the child's support for the calendar year and the child is not your "qualifying child" (as defined under Internal Revenue Code section 152) or the "qualifying child" of another taxpayer.

   A "full-time student" means a person who is attending a post-secondary accredited college, university, graduate or vocational school on a full-time basis, as defined by such institution. Full-time student status must be submitted into the Plan annually. If your covered Dependent is eligible under this paragraph 3 and has full-time student status on the day before a medically necessary leave of absence from the post-secondary institution because of a serious injury or illness, Plan coverage will continue during the leave until the earlier of (1) the one-year anniversary of the date the medically necessary leave began or (2) the date the Dependent's coverage under the Plan would otherwise terminate (for example, the child turns age 26). To be eligible for this extended coverage, you must provide the Plan with written certification from the Dependent's treating physician that the leave of absence from school is medically necessary and is as a result of a serious illness or injury. Contact the Fund Office for additional information on coverage under this provision.

4. Your unmarried child who is incapable of self-sustaining employment because of Total and Permanent Disability) and who becomes Disabled prior to the date coverage would otherwise terminate. Your Disabled dependent child will continue to be covered beyond the limiting ages, provided the child is dependent upon you for over half the child's annual support and maintenance and has the same principal residence as you or is not considered a "qualifying child" or the employee of another taxpayer. Notification and satisfactory proof of the incapacity must be sent to the Fund Office within 31 days of the date the child's coverage would otherwise terminate and thereafter upon request.

Your adult child will cease being an eligible Dependent if the child is legally adopted on or after their eighteenth birthday and issued a new birth certificate that does not list a Participant as a parent.

Except for certain exceptions for an adopted child, the child must be a U.S. citizen or a resident of the U.S., Canada or Mexico.

If your child is also an Eligible Employee covered under this Plan or the plan of another employer, such child will not be considered your eligible Dependent. However, this rule does not apply to a natural or adopted child or a child placed for adoption. A Dependent who qualifies as an Active Employee will be considered a new Participant for purposes of the Plan's calendar year and specific benefit maximums, deductible and out-of-pocket expenses.

You must complete an enrollment card listing all Dependents to be covered by the Plan. As Dependents are added, a new enrollment card must be completed. No claims are considered for payment on a Dependent

until an enrollment card is on file. You are responsible for confirming that individuals are properly enrolled as Dependent children. Proof of dependency status may be required from time to time by the Board of Trustees.

Qualified Medical Child Support Orders (QMCSOs)

The Plan complies with all Qualified Medical Child Support Orders (QMCSOs) or National Medical Child Support Notices. A QMCSO is a court order, under family or child support laws, that may require a parent to enroll his or her children in his or her employer's medical plan. The QMCSO may also require benefits to be assigned to a child, to a custodial parent, or to a legal guardian. QMCSOs can be sent to the Plan Administrator listed on page 51. A Participant or Dependent can also request a copy of the Plan's QMCSO procedures from the Plan Administrator and receive a copy at no charge.

Termination of Dependent Eligibility

A Dependent will no longer be eligible for coverage under the Plan as of the earliest of the following:

1. The date your coverage ends,

2. The date the Dependent no longer meets the definition of an eligible Dependent as described above,

3. The date a Dependent step-child, foster child or child whose custody is court-ordered marries,

4. The date a Dependent enters full-time active duty with U.S. armed forces,

5. If you are an Early Retiree or a Retiree, the date you disenroll the Dependent from coverage.

Continuation Coverage

Self-Payment for COBRA

A federal law known as "COBRA" (Consolidated Omnibus Budget Reconciliation Act of 1985), requires that group health plans such as the Plan offer you and your covered Dependents continuation of coverage under the Plan in certain instances where coverage under the plan would otherwise end. To elect this continuation coverage, you must waive your right to self-payment under the Plan.

Important Definitions that apply for this COBRA section:

1. Qualified Beneficiary means you and your Dependents who were covered under the Plan on the day before a Qualifying Event. Qualified Beneficiary also includes any dependent child born or adopted by you while you are enrolled in COBRA continuation coverage.

2. Qualifying Event means one of the following events that causes you and/or your Dependent to lose coverage under the Plan:

   (a) Reduction in your hours of employment;

   (b) You terminate employment for reasons other than gross misconduct;

   (c) You and your spouse divorce;

   (d) Your Dependent child no longer meets the definition of a Dependent; or

   (e) You die.

   If you have a Dollar Bank account, you are considered to lose Plan coverage once your Dollar Bank is exhausted.

   Note that the COBRA rules provide for two other possible qualifying events: loss of coverage due to Medicare eligibility and loss of coverage due to an employer's bankruptcy (applicable to retired employees

only). However, these events do not cause you or your covered Dependents to lose coverage under the Plan and, as such, are not considered Qualifying Events.

Continuation Coverage

A Qualified Beneficiary may continue coverage for maximum coverage periods, by making election to do so with the Fund Office and making self-payment contributions.

Qualified Beneficiaries will be offered continuation coverage for all group health plan benefits in which they were enrolled as of the Qualifying Event. For example, if you were enrolled in medical, vision and the Flexible Benefit Account, you will be offered COBRA on those three benefits. Continuation coverage is not available for welfare benefits, such as Short Term Disability, Death Benefits or the SUB benefit.

All adult Qualified Beneficiaries will be offered continuation coverage; your spouse and each adult Dependent child who are Qualified Beneficiaries will have a separate right to elect it. You or your dependent spouse can elect to continue coverage for minor Dependent children.

How Much Will the Benefits Cost?

The amount of the monthly self-payment contribution is established by the Board of Trustees. In general, the cost is equal to the full cost of coverage under the Plan, including any share you now pay and the share your Employer pays, plus the additional administrative fees allowed under law.

Maximum Coverage Period

Eighteen (18) Month Continuation. The maximum coverage period for Qualified Beneficiaries who lose Plan coverage because of any of the following Qualifying Events is eighteen months:

- A reduction in your hours of employment; or
- Termination of your employment for reasons other than gross misconduct – note this includes when you retire.

Twenty-nine (29) Month Continuation. The maximum coverage period for Qualified Beneficiaries who lose Plan coverage because of any of the following Qualifying Events and who is or becomes disabled (as determined by the Social Security Administration) at any time during the first 60 days of continuation coverage is twenty-nine months:

- A reduction in your hours of employment; or
- Termination of your employment for reasons other than gross misconduct – note this includes when you retire.

These additional eleven months of continuation coverage are referred to as the disability extension and are intended to bridge the gap until a disabled individual can enroll in Medicare.

To qualify for the disability extension, you must notify the Fund Office within 60 days of the Social Security determination of disability and before the end of the initial 18-month period. If a disability ends within the disability extension, you must notify the Fund Office within 30 days of the date the disability ends. See "Procedures to Elect Continuation Coverage" below for detail on providing notice.

Thirty-Six (36) Month Continuation. The maximum coverage period for Qualified Beneficiaries who are your Dependents who lose Plan coverage due to any of the following Qualifying Events is thirty-six months:

- You and your spouse divorce;
- Your Dependent child no longer meets the definition of a Dependent; or
- You die.

If one of the above Qualifying Events occurs while the Qualified Beneficiary is covered under continuation coverage, the maximum coverage period will extend to thirty-six months. For example, if you and your family are on continuation coverage because you terminated employment, and your child turns age 26, your child

will be eligible for a total of thirty-six months of continuation coverage. In this example, you and your spouse would be eligible only for eighteen months of continuation coverage.

Termination of Continuation Coverage

Continuation coverage will terminate on the earliest of the following dates:

1. The first day of the month for which your required self-pay contribution is not paid on time;

2. The date the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing conditions the Qualified Beneficiary may have (note this applies to new coverage following the Qualified Beneficiary's continuation coverage election and this does not apply to TRICARE);

3. The date the Qualified Beneficiary becomes entitled to Medicare (note this applies to Medicare entitlement following the Qualified Beneficiary's continuation coverage election);

4. For Qualified Beneficiaries on the disability extension, the first of the month following the date the Qualified Beneficiary is found not disabled (note this terminates continuation coverage for all Qualified Beneficiaries on the disability extension);

5. The date coverage under the Plan would otherwise terminate due to acts of fraud or intentional misrepresentation; or

6. The date the Plan is terminated.

<u>Procedures to Elect Continuation Coverage.</u>

1. You must notify the Fund Office if you divorce your spouse, or your Dependent child no longer meets the definition of Dependent within 60 days of that Qualifying Event. If notice is not timely received, your Dependents will not be eligible for continuation coverage.

   The notice must be sent to the Plan Administrator at Wisconsin Electrical Employees Health and Welfare Plan, 2730 Dairy Drive, Suite 101, Madison, WI 53718.

   The notices must be in writing and must include sufficient information to enable the Plan Administrator to determine the Plan, the Qualified Beneficiaries, the Qualifying Event (or disability determination) and the date on which the Qualifying Event (or disability determination) occurred.

   A notice that does not contain all of the required information will not be considered sufficient notice. Failure to supplement the notice with the additional information necessary to meet the content requirements will result in the loss of the right to elect continuation coverage.

   For the remaining Qualifying Events, your Employer is obligated to notify the Fund Office.

2. After the Fund Office receives notice of a Qualifying Event, you will be sent an election form and other information regarding continuation coverage. You will have 60 days from the date your coverage terminates under the Plan, or, if later, 60 days from the date of the notice advising you of your election rights to make your decision.

3. If you or your Dependents choose to waive COBRA coverage, a waiver of COBRA coverage will be effective on the date sent to the Fund Office. Such waiver can be revoked at any time before the end of the election period. However, if the waiver is revoked, coverage will be effective on the date the revocation of waiver and election to continue is sent to the Fund Office.

4. The first payment (which must include contributions for all months since coverage terminated) must be received by the Fund Office within 45 days of the date COBRA coverage is elected.

   Example: Coverage terminates January 31st and you elect coverage March 15th, your first payment is due April 29th and must include payment for February, March and April coverage.

Each subsequent payment is due the 1st day of the month for which coverage is intended and will be considered timely if received prior to or on the last day of the month for which coverage is intended.

Example: Using the above example, the monthly payment for May coverage is due May 1st and must be received no later than May 31st.

If payment is not received in time, coverage will be terminated. No eligibility will be verified nor will claims be paid until the correct and timely payment is received. If payment is returned due to non-sufficient funds, replacement payment must be received within the contribution due period, and if not received within such period, regardless of reason, payment will be considered not paid on a timely manner, and coverage will be terminated, with no right of reinstatement.

If you have any questions, please feel free to contact the Fund Office.

In order to protect your family's rights, you must keep the Plan Administrator informed of the current addresses of all family members who are or may become Qualified Beneficiaries.

Self-Payment for USERRA

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may have the right to continue coverage under the Plan during periods of Military Leave by making the required self-payments. An election of continuation coverage under USERRA is treated by the Plan the same as an election under COBRA and continuation of coverage rights under COBRA are concurrent with your election to continue coverage under USERRA.

The procedures to elect and make self-payments for USERRA continuation coverage are the same as those for COBRA coverage and the available coverage will be the same as COBRA coverage. If the employee does not elect continuation coverage and does not submit payment for all amounts required to continue coverage within the applicable time frame, the employee will lose the right to continue coverage under this section and such right will not be reinstated.

Some provisions of COBRA provide more generous coverage rights that those available under USERRA (e.g., COBRA provides for coverage in excess of 24 months in some circumstances), and vice versa (e.g., USERRA does not allow for termination of coverage where a qualified beneficiary obtains other group health plan coverage after electing continuation coverage). An individual eligible for continuation coverage rights under both USERRA and COBRA shall be entitled to the most generous coverage provisions available under USERRA and COBRA during those periods during which the individual is eligible under both provisions.

Important Definitions for this USERRA section:

1. If you are an Active Employee who is performing Military Service and who has reemployment rights under USERRA, you will be considered to be on "Military Leave" effective as of the date you begin leave to perform Military Service.

2. "Military Service" means service on voluntary or involuntary basis in the Uniformed Services, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which you are absent from employment for purposes of a fitness for duty examination or certain funeral honors duties.

3. "Reemployment Requirements" means you have returned to employment as an Active Employee or made yourself available for employment following honorable discharge from Military Service.

4. "Uniformed Services" means the Armed Forces, Army National Guard, Air National Guard, commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Continuation Coverage

Military Service of Less Than 31 Days. If you are on Military Leave for Military Service of less than 31 days, coverage under the Plan will continue for you and your covered Dependents through the 30th day of the leave at no cost to you.

Military Service of 31 Days or More. If you are on Military Leave for Military Service of 31 days or more, coverage under the Plan will terminate as of the date of the Military Leave. You will be offered continuation coverage for a period of twenty-four months. You may elect to enroll in continuation coverage for yourself and/or your eligible Dependents.

If you fail to provide advance notice of Military Service, you will not be eligible to continue coverage beyond 31 days unless the failure to provide advance notice is excused by the Trustees, in their sole discretion.

Upon returning to employment as an Active Employee or making himself available for employment , you and your covered Dependents, shall be immediately entitled to benefits as if you had been continuously employed during the Military Service, regardless of whether you elected continuation coverage.

How Much Will the Benefits Cost?

The amount of the monthly self-payment contribution is established by the Board of Trustees. In general, the cost is equal to the full cost of coverage under the Plan, including any share you now pay and the share your Employer pays, plus the additional administrative fees allowed under law.

Effect on Dollar Bank and Staff Coverage

Any unused credits in your dollar bank or prepaid coverage (if you are an Employer Staff Employee) will be preserved until such time as you are discharged from Military Service if you have reemployment rights under USERRA. You must follow the Reemployment Requirements to have your dollar bank or prepaid coverage reinstated. If you fail to follow the Reemployment Requirements, your dollar bank or prepaid coverage will be forfeited to the Plan.

If, upon reinstatement to the Plan you have exhausted your Dollar Bank or prepaid account to pay for continuation coverage you will be required to make self-payments so that your Dollar Bank or prepaid account returns to a level sufficient to maintain eligibility under the Plan.

Termination of Continuation Coverage

Continuation coverage will terminate on the earliest of the following dates:

1. The end of the twenty-four month continuation period;

2. The date you reinstate coverage under the Plan;

3. The date you fail to timely make the required self-payment;

4. The date you fail to follow the Reemployment Requirements following Military Leave;

5. The date coverage under the Plan would otherwise terminate due to fraud or intentional misrepresentation; or

6. The date the Plan is terminated.

Family and Medical Leave Act ("FMLA")

Under the Family and Medical Leave Act of 1993 ("FMLA") you may be able to take up to 12 weeks of unpaid leave during any 12-month period for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child. You may take up to 26 weeks of unpaid leave during any 12-month period to care for a spouse, parent or child who was seriously injured or became ill in the line of duty while serving in the uniformed services as defined in USERRA.

During your leave, your health coverage under the Plan will continue until the end of your leave, as long as your Employer is subject to FMLA requirements, properly grants you FMLA leave and makes the required notifications and contributions to the Fund. If your Employer stops making contributions to the Fund or you exhaust your FMLA leave, you may be eligible to continue coverage under the Plan by election COBRA continuation coverage.

If you think that this law may apply to you, please contact your Employer. All disputes over eligibility and coverage under FMLA are between you and your Employer.

Death and Accidental Death and Dismemberment Benefit for Covered Employees Only

The Death Benefit and Accidental Death and Dismemberment Benefit are provided through a group insurance contract which sets forth the terms of this insurance coverage. You may examine or obtain a copy of the contracts by contacting the Fund Office. All benefits payable under the contract, limitations and exclusions and claims filing and appeals procedures are described in more detail in a separate booklet from the insurance company called a Certificate of Coverage. The Certificate of Coverage is available on the Fund's website or you can contact the Fund Office for a copy.

The following provides a summary of the benefits; if there are any inconsistencies between this summary and the Certificate of Coverage and/or policy, the Certificate of Coverage and/or policy controls. Contact the Fund Office for more information.

Death Benefit

If you are an Active Hourly Employee, Active Employer Staff Employee, Retiree or Early Retiree, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee, you are covered for Death Benefits by the Plan. Payment will be made to the person you designate as your Beneficiary. (see Beneficiary Designation section below.) If you die while still a Participant and prior to your 65th birthday, your Beneficiary will receive a lump sum payment of $10,000. If you die while still a Participant and between your 65th birthday and 70th birthday, your Beneficiary will receive a lump sum payment of $6,500. If you die while still a Participant on or after your 70th birthday, your Beneficiary will receive a lump sum payment of $5,000.

If you become terminally ill, meaning you have a life expectancy of six months or less, you may be eligible for an accelerated life insurance benefit of 50% of the Death Benefit.

If you become totally disabled, your coverage can continue until the policy terminates or your total disability terminates. "Totally disabled" for this purpose means your complete inability, due to injury or illness, to engage in any business, occupation or employment for which you are qualified, or becomes qualified by reason of education, training or experience, for pay, profit or compensation.

If your Death Benefit coverage terminates, you may convert the benefit to an individual life insurance policy without having to submit proof of insurability. The Plan will provide you notice of your right to convert your policy when applicable.

<u>Exclusions and Limitations</u>

- If you die by suicide, no benefit is payable unless your coverage has been in effect for at least two years.

Accidental Death and Dismemberment Benefit

If you are an Active Hourly Employee, Active Employer Staff Employee, Self-Pay Active Hourly Employee (under age 65) or Self-Pay Disabled Employee (under age 65) you are covered for Accidental Death and Dismemberment Benefits with the Plan. Upon retirement no Accidental Death and Dismemberment Benefits are available.

If you are an Eligible Employee and die or suffer Bodily Injury as a result of an Accident prior to your 65th birthday, or you are age 65 and over while working under a Collective Bargaining Agreement, you will be paid (in addition to any other amounts due under this Plan) in accordance with the following schedule:

		Under 65	65 – 69	70 and over
1.	Loss of Life	$10,000	$6,500	$5,000
2.	Loss of both hands, both feet, both eyes or any two such members	$10,000	$6,500	$5,000

3.	Quadriplegia	$10,000	$6,500	$5,000
4.	Loss of speech and hearing	$10,000	$6,500	$5,000
5.	Loss of one hand, one foot, one eye, or four or more fingers on one hand	$5,000	$3,250	$2,500
6.	Paraplegia or hemiplegia	$5,000	$3,250	$2,500
7.	Loss of speech or hearing	$5,000	$3,250	$2,500
8.	Loss of thumb and index finger	$2,500	$1,625	$1,250

Loss of a hand or foot means complete severance through or above the wrist or ankle joint and loss of eye means irrecoverable loss of the entire sight. If more than one type of loss occurs, the amount provided for the greatest loss will be paid. These benefits are payable for both work related and non-work related Injuries.

Exclusions and Limitations

No benefit will be paid for any loss caused directly or indirectly, in whole or in part, by any of the following:

- Bodily or mental illness or disease of any kind;
- Ptomaines or bacterial infections;
- Suicide or attempted suicide, while sane or insane;
- Intentional self-inflicted injury;
- Participation the commission of an assault, felony, riot, or civil commotion;
- War or act of war, declared or undeclared, or any act related to war or insurrection;
- Medical or surgical treatment of an illness or disease;
- Service in the armed forces of any country while such country is engaged in war;
- Police duty as a member of any military, naval or air organization
- Travel or flight as pilot or crew member in any kind of aircraft including, but not limited to, glider, seaplane or hang kite;
- Travel or flight in or descent from any kind of aircraft as a passenger, pilot, crew member or participant in training that is owned, operated, or leased by or on behalf of the plan, your Employer or the armed forces, or being operated for any training or instructional purposes;
- Parachuting, skydiving, bungee cord jumping, flying, ballooning, hang-gliding, parasailing or any other aeronautic activities except as a fare paying passenger on a commercial aircraft;
- Competing or practicing for competition in a car, motorcycle, moped, speed boat or other vehicular race;
- Intake of any drug, medication or sedative unless prescribed by a Doctor, or the intake of any alcohol in combination with any drug, medication or sedative;
- Use of alcohol, non-prescriptive drugs or controlled substances;
- Any poison or gas voluntarily taken, administered, absorbed, or inhaled; or
- Driving while intoxicated.

Beneficiary Designations

When you become eligible for the Plan, you will be given an opportunity to designate a beneficiary to receive any benefits that may be payable under the Death Benefit or Accidental Death and Dismemberment benefits. You can change your beneficiary at any time by contacting the Fund Office and requesting a new beneficiary designation form. If you and your spouse divorce, any beneficiary designation naming your spouse as your beneficiary will automatically become void. You must complete a new beneficiary designation following the date of divorce.

If you die without having designated a Beneficiary or if your designated Beneficiary has died, then any death benefit will be paid in equal shares to the first surviving class of the classes listed in order as follows:

1. your spouse,

2. your children,

3. your parents,

4. your siblings, and

5. your estate.

Short Term
Disability Benefits for Covered Employees Only

If you suffer a disability from a non-work related Injury or Illness, you can receive $500 per week for 26 weeks, or one-seventh of the weekly benefit for each day of disability. If you suffer a work-related Injury or Illness, you are eligible for the $500 per week disability payment only if you sign a Workman's Compensation Agreement and return it to the Fund Office. Please contact the Fund Office directly for this form. To qualify for the Short Term Disability benefit, you must be under the care of a licensed physician (M.D., D.C., D.P.M., or D.O.) and unable to work because of such Injury or Illness. If you are a disabled Employer Staff Employee you must also provide certification from an officer of your Employer that you are not receiving a salary while disabled.

If you are collecting unemployment compensation or collecting pay for attending school you are not eligible to collect the $500 per week Short Term Disability benefit at the same time.

Payments begin the 1st day in the event of an Injury or inpatient hospitalization and the 8th day in the event of Illness. This is taxable income and a W-2 will be mailed to you.

If you have consecutive disabilities, they will be treated as separate disabilities only if:

1. You are available to return to work after the first disability for at least 2 weeks of full-time employment; or

2. The two disabilities are due to entirely unrelated causes and you are available to resume work for at least one day.

You must file a claim within six months of the date the disability began. Disability forms may be obtained from the Fund Office or on our website at www.weebf.com. The Plan reserves the right to require your physician to provide documentation at least every four weeks to confirm you remain disabled, in order to continue to receive Short Term Disability benefits. No Short Term Disability benefits are payable for any period for which you fail to provide an acceptable physician certification of disability.

If you are a disabled Active Hourly Employee, premiums will be deducted monthly from your dollar bank account to provide coverage. In addition, 3 hours premium per day will be credited to your dollar bank account (disability credits), up to a maximum of 90 days during any one disability period.

If benefits are payable under Short Term Disability benefits and under a long-term disability or other source maintained by the Plan, any disability income benefits payable under Short Term Disability benefits shall be reduced (that is, offset) by the amount of any payments payable from the other sources. If any payment is made to or for you by the Plan under Short Term Disability benefits and also paid under another source, the Plan will have the right to suspend or withhold payment of incurred claims and to reduce any future payments due to you and/or your Dependents (including payments of medical benefits) by the amount of any overpaid disability amount and by an amount incurred by the Plan in pursuing the overpayment. The Plan will also have the right to reduce the amount of your dollar bank to recover any overpaid disability amount until the Plan has recovered the full amount.

Long Term Disability Benefit for Covered Employees Only

The Plan provides a disability benefit if you suffer a disability from a non-work related Injury or Illness and you exhaust your 26-week period of Short Term Disability Benefits under the Plan. You must have worked at least 450 hours in a 6-month period before becoming disabled in order to be eligible for this disability benefit. Subject to the terms of the insurance contract funding this benefit, benefits could continue for two years, or possibly longer, provided that the insurance company determines that you are disabled. A more detailed explanation of the benefit, its eligibility provisions, limitations and exclusions and claims filing and appeal procedures is found in a separate booklet that will be provided to you once you are eligible for the benefit and that is available upon request by contacting the Fund Office. The terms of this separate booklet and the insurance contract control in the event there are any inconsistencies between it and the above summary.

Medical Benefits

You and your Dependents are covered for Hospital, doctor and other medical benefits for accidental Bodily Injury or Illness. Payment is made for Covered Charges up to the maximum benefit amount allowed by the Plan, and only according to any other limitations that may apply. Payments based on the UCR amount shall constitute the Plan's full and final payment. Covered Charges in excess of UCR are the responsibility of the patient, except for Protected Services. All benefits are subject to the deductible and coinsurance unless otherwise stated.

PPO Network

The Plan utilizes a Preferred Provider Organization (PPO) network for care rendered at Hospitals and other facilities and performed by Physicians. The PPO negotiates with physicians, hospitals, clinics, etc. to provide medical care and services at a lower cost to you and to the Plan. While you are not required to use a PPO provider, use of a PPO provider should save you and the Plan money.

Visit www.Anthem.com/find-care to determine whether a Hospital, Physician or other provider participates in the PPO Network. Additionally you can review or request a list of PPO Hospitals, Physicians and other providers by calling the customer service number or by accessing the PPO website. The PPO name, address, and customer service information can be found on page 62.

It is very important that you (and your covered Dependents) show your I.D. card whenever you receive any type of health care. The I.D. card provides information on both the Plan and the PPO Network. If you need I.D. cards, contact the Fund Office at the number on page 62.

Precertification

You (or your Physician) must obtain precertification from the Plan's utilization review provider for the following services:

- All planned inpatient Hospital visits, including both surgical and non-surgical visits. However, precertification is not required for emergency or maternity admissions. Maternity admissions with complications must be reported to the utilization review service within 48 hours or the next business day. The Plan can limit the cost of coverage to an outpatient basis if precertification is not obtained and the utilization review service finds inpatient care not to be medically necessary.
- All gastric bypass surgeries.
- Any temporary or permanent implantable devices and all related charges,
- Inpatient and outpatient surgeries.
- Outpatient services performed in a hospital, licensed treatment facility or ambulatory surgical center.
- Gene therapy.

If a required precertification is not obtained, the Plan will reduce any Non-PPO Covered Charges by 20% and the reduction is not applied to your deductible or out-of-pocket maximum. The name and number for the current utilization review service is on page 62.

Deductible

The deductible amount is the dollar amount of Covered Charges you must pay out-of-pocket during a calendar year before the Plan pays benefits. The family deductible is satisfied when three members of your family have satisfied the individual deductible amount. PPO and Non-PPO Covered Charges are counted toward the same deductible.

The deductible does not apply to routine (well-baby) nursery care, routine physical exams, preventive care, hearing benefits, vision benefits or dental benefits.

Out-of-pocket Maximum

The out-of-pocket maximum is the maximum out-of-pocket expenses you are required to pay in a calendar year. After you satisfy the out-of-pocket maximum, the Plan will pay Covered Charges at 100% for the remainder of the calendar year. The family out-of-pocket maximum is satisfied when the cumulative individual out-of-pocket maximums of three or more family members is met. Only PPO Covered Charges and Covered Charges for Protected Services count toward the PPO out-of-pocket maximum.

The following expenses do <u>not</u> count toward the out-of-pocket maximum:

- Deductibles;
- Prescription drug expenses (these charges count toward the separate prescription drug out-of-pocket maximum);
- Expenses that do not qualify as Covered Charges (e.g., excluded services);
- Vision and dental expenses;
- Balance billed charges;
- Amounts in excess of a benefit maximum;
- Non-PPO charges, other than Protected Services.

Covered Charges

<u>Hospital Benefits</u>

1. Room and board up to the semi-private room rate charged by the Hospital for the level of care rendered.

2. Routine nursery care of a newborn child.

3. Hospital charges for confinement in an Intensive Care Unit.

4. Hospital miscellaneous charges for services and supplies provided during confinement as a registered bed inpatient, when room and board benefits payable, excluding charges for private duty nurse; anesthetics, but not including their administration; and whole blood or blood plasma, if not replaced, and the cost of its administration.

5. .

6. When confined as a registered inpatient for Mental Health Disorders, payment will be made for expenses incurred for Inpatient confinement, residential treatment facility, or partial hospitalization.

7. When confined as a registered inpatient for Substance Use Disorders, the Plan will cover expenses incurred for inpatient confinement, residential treatment facility, substance abuse treatment facility or for partial hospitalization.

Note: Partial hospitalization means continuous treatment of a Mental Health or Substance Use Disorder for at least 3 hours, but no more than 12 hours in a 24 hour period. Family counseling rendered by a Physician is covered during such hospitalization.

Ambulance Benefits

1. Professional ground ambulance services to and from a Hospital;

2. Professional ground ambulance call and corresponding services and supplies without transport to a Hospital in a Medical Emergency;

3. Professional air ambulance service for emergency transportation to a Hospital or for transferring between Hospitals, provided the Physician certifies that your condition requires specialized treatment at another Hospital and the condition requires transportation by air ambulance to the nearest Hospital that can provide the specialized treatment; and

4. Supplies and transport teams to the extent such charges would be covered if they had been covered in a clinical setting.

Limitation

Air ambulance transportation is limited to the continental limits of the United States, Canada and Mexico or within the geographical boundaries of Hawaii, Puerto Rico, and the Virgin Islands.

Skilled Nursing Facility Benefits

1. Room and board charges and charges for services in connection with room occupancy up to the average semi-private room rate.

2. Covered services:

   (a) Use of special treatment rooms;

   (b) x-rays and lab work;

   (c) Physical, Occupational or Speech Therapy;

   (d) oxygen and other gas therapy;

   (e) drugs, biological, solutions, dressings and casts, but no other supplies;

   (f) other Medically Necessary and Reasonable services and supplies charged and furnished by the Skilled Nursing Facility, excluding services of a private duty nurse or Physician.

3. Benefits are limited to 60 days during any one period of confinement provided:

   (a) Confinement follows at least 3 consecutive days of inpatient Hospital confinement, while covered under this Plan;

   (b) Confinement begins within 24 hours after Hospital discharge date; and

   (c) A Physician certifies confinement and services are necessary to the continued treatment by the Physicians of the Injury or Illness.

4. Successive confinements for the same condition will be considered 1 period of confinement unless separated by a period of at least 90 days during which the patient is not confined.

5. Benefits excluded on page 37 #10 are excluded under this section.

Hospital Outpatient Benefits

Hospital charges incurred for medical services or supplies provided by that Hospital during outpatient care, resulting from accidental Bodily Injury, surgery, or Medical Emergency. Services and supplies must be

rendered within 72 hours of the onset of the accidental Bodily Injury or Medical Emergency. Services of a private duty nurse or Physician and routine physical examinations are not covered hospital outpatient benefits.

Pregnancy Benefits

1. Charges incurred as a result of pregnancy, childbirth or a related medical condition, if the mother is covered by the Plan at the time of delivery.

2. Expenses for care received in a Hospital for treatment of childbirth.

3. The Plan will cover the obstetrical services, including pre-natal care, delivery and post-natal care, provided by a Midwife provided the Midwife is practicing in collaboration with an obstetrician who is available to assume responsibility at any time during the pregnancy, delivery or post-natal process.

The Plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the attending provider, after consulting with the mother, is allowed to discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable.) Providers are not required to obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours.)

Limitations

The Plan does not cover charges for home birth except in a Medical Emergency.

Surgery Benefits

Anesthesia

Covered Charges for surgical and anesthesia services. The maximum surgical amount payable will include the surgery charge and the charge for allowable follow-up care.

1. Surgeon charges.

2. Assistant surgeon charges at 25% of the allowable benefit for the surgeon.

3. Physician's assistant (P.A.) charges when acting in the stead of an assistant surgeon, and when an assistant surgeon is allowed, at 15% of the allowable benefit for the surgeon.

4. Anesthesiologist or nurse anesthetists.

Reconstructive Surgery

Reconstructive surgery following a mastectomy is covered under the Plan. Federal law (the Women's Health and Cancer Rights Act of 1998) requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy. Coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedemas (swelling associated with removal of lymph nodes).

Outpatient Surgery

Charges for medical services and supplies provided during Outpatient surgery are considered Covered Charges if the charges are made by a Licensed Ambulatory Surgical Center.

Oral Surgery

Covered Charges for oral surgery and anesthesia services. The maximum surgical amount payable will include the surgery charge and the charge for allowable follow-up care.

1. Repair or alleviation of damage to sound natural teeth caused by Injury sustained while covered by this Plan.

2. Removal of partially or completely unerupted impacted teeth.

3. Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when pathological examination requires.

4. Removal of apex of tooth root, “apicoectomy”, not including root canal.

5. Removal of exostoses, “growth of the jaw and hard palate”.

6. Treatment of fractures of facial bones.

7. External incision and drainage of cellulitis.

8. Incision of accessory sinuses, salivary glands, or ducts.

9. Surgical treatment for the correction of temporomandibular joint dysfunction (TMJ/TMD), including post-surgical therapy necessary for recovery.

10. Gingivectomy, excision of loose gum tissue to eliminate infection.

11. Alveolectomy, the leveling of structures supporting teeth for the purpose of fitting dentures.

12. Frenectomy, the cutting of the tissue in the middle of the tongue (frenulum), which is usually done to prevent tongue tie conditions.

13. Osseous surgery.

Gastric Bypass Surgery

Covered Charges for gastric bypass surgery as a direct result of Morbid Obesity will be covered up to a maximum of one such surgery per lifetime when all of the Plan’s requirements are satisfied. Gastric bypass surgery must be precertified.

Morbid Obesity means, for purposes of this benefit, that you meet all of the following conditions:

- You are at least twice your ideal weight and have a body mass index (BMI) of at least 40 or a BMI of at least 35 with at least one life-threatening co-morbid condition;
- You have demonstrated to the reasonable satisfaction of the Plan that you are unable to control your weight over a period of five consecutive years;
- You suffer from a separate condition that is aggravated by your obesity, as documented by a Physician;
- You must be psychiatrically stable;
- You must have demonstrated that you have participated in three medically supervised weight loss programs, which have all failed;
- You are at least 21 years old;
- Your Physician confirms in writing that you have tried in good faith to lose weight for at least 12 consecutive months; and
- You have demonstrated the ability to modify your eating patterns by losing at least 5% of your weight during the 12-consecutive months preceding your request for treatment.

The lifetime maximum applies to all direct or indirect charges you incur on account of the gastric bypass surgery, including but not limited to, charges made by a Hospital, the surgical fees for the performance of the procedure, presurgical psychological examination performed in connection with the surgery, pre and postoperative visits, anesthesia services, and treatment of health issues and complications that may arise from the surgery.

Radiotherapy

The Plan will pay Covered Charges for radiotherapy, including the use of x-ray, radium, cobalt and other radioactive substances.

Diagnostic X-Ray and Laboratory

The Plan will pay Covered Charges for necessary x-ray and laboratory examination for diagnosis of an accidental Bodily Injury or Illness, including allergy testing, basal metabolism determination, audiograms, electrocardiograms, and initial diagnostic testing.

Asbestosis Screening

The Plan will pay Covered Charges for one breathing test and x-ray analysis for detection of asbestosis per Eligible Employee or Retiree per lifetime.

Medical Services

1. Daily Physician visits when confined in a Hospital or Skilled Nursing Facility as an inpatient, and when room and board benefits are payable.

2. Daily Physician visits for Substance Use Disorder when confined in a Substance Use Disorder Treatment Facility as an inpatient, and when room and board benefits are payable.

3. Office visits and consultations and Physician visits at other covered locations.

4. Telehealth and virtual visits.

5. Outpatient treatment of Mental Health and Substance Disorders, including family counseling

6. Physician's charges for treatment of an accidental Bodily Injury or Medical Emergency, provided treatment is rendered within 72 hours of the onset.

7. Gene therapy if prescribed by a Physician and approved by the Federal Food and Drug Administration for the use for which it is prescribed at the time treatment is provided. All phases of the gene therapy treatment, including genetic testing, services, supplies and medicines provided in connection with an admission, the extraction of cells, the administration of the gene therapy and any follow up care are also covered. Precertification is required.

8. Gender affirming services consistent with the guidelines of the Plan's utilization review provider.

Durable Medical Equipment, and Appliances

1. Rental of a wheelchair, hospital bed, oxygen equipment and other similar durable medical equipment required for therapeutic use and not normally utilized for everyday use. The Board of Trustees may authorize purchase instead of rental. Like all covered charges, rental of equipment is subject to determination of Medical Necessity and rental of some equipment may not be covered even though prescribed by a Physician.

2. Prosthetic devices and replacement or repair, including artificial arms, legs and accessories, artificial eyes, initial prosthetic implants due to malignancy or benign tumor removal. Benefits are payable for fitting, adjusting and repair, but not for maintenance of the prosthetic's hardware. Coverage is limited to one such prosthetic device per limb per 60-month period plus any adjustments. Coverage is excluded for implantable and/or inflatable prostheses and replacement of breast implants unless the breast implant

is provided in conjunction with the reconstruction of a breast on which a mastectomy has been performed (see page 20).

3. Casts, splints, trusses, braces, crutches and surgical dressings.

4. Custom fitted orthotics, leg braces including attached shoes, arm and back braces, and cervical collars prescribed by a Physician, for a diagnosis not excluded by the Plan, if cast impressions and range of motion testing performed. Subject to the limits described in the Schedule of Benefits.

5. Custom-fitted orthotics prescribed by a Physician for treatment of a chronic conditions of the foot that are otherwise excluded by the Plan (for example, plantar fasciitis) are covered if cast impressions and range of motion testing are performed. Replacement or repair of the orthotic device is covered once every five years. Subject to the limits described in the Schedule of Benefits.

6. Oxygen.

7. Insulin pumps every 3-5 years as Medically Necessary provided that other more conservative and less costly alternatives have been exhausted and failed. Precertification is required.

8. Implantable devices, either temporary or permanent, and their installation are covered if other more conservative and less costly alternatives have been exhausted and failed. Precertification is required.

Nursing Care

The Plan will pay for Covered Charges of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) on a part-time or intermittent basis. However, services for a nurse that ordinarily lives in your home or in your Dependent's home or is a member of your immediate family will not be covered.

Home Health Care

At times it may be more appropriate to receive medical care at a private residence (not necessarily your own residence) by or through a Home Health Care Agency. Under certain conditions, home health care expenses will be paid by the Plan. Your Physician must establish a home health care treatment plan, which must be reviewed every 2 months by your Physician; however, a longer interval may be acceptable if approved by your Physician and this Plan.

The Physician must certify that inpatient confinement in a Hospital or Skilled Nursing Facility would be required if home health care is not provided. Also, the Physician must certify that the care cannot be provided by any other properly trained person of the household without endangering your life or impairing your condition.

The following expenses will be covered under a home health care plan that meets the necessary requirements:

1. Home health care visits up to 4 hours per day if the maximum weekly benefit is less than the weekly cost of care in a Skilled Nursing Facility.

2. The evaluation of the need for and development of a plan by a registered nurse (RN), medical social worker (MSW) or the attending Physician.

3. Part-time or intermittent care by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN) or licensed physiotherapist.

4. Part-time or intermittent care of a home health aide, under the supervision of a registered nurse (RN) or a medical social worker (MSW).

5. Physical, Respiratory, Occupational, Rehabilitation, or Speech therapy.

6. Medical supplies or services provided by or through the Home Health Agency, drugs and medication prescribed by a Physician, and laboratory services by or on behalf of a Hospital, if necessary, to the extent the items would have been covered if the patient had been inpatient confined.

7. Nutrition counseling provided by or under the supervision of a registered dietician where such services are Medically Necessary and Reasonable as part of the home health care plan.

The Plan will not pay benefits for:

1. Massage therapy, personal training or other general fitness services.

2. Routine housekeeping chores, which are not necessary to prevent or postpone hospitalization, or similar services which would increase the amount of time required for the visit.

3. Services or supplies that would not be paid if confined as an inpatient in a Hospital or Skilled Nursing Facility.

4. Personal custodial care that can be provided by a family member or relative.

Hospice Care

The Plan will pay for expenses for Hospice Care if your attending Physician certifies that you or your Dependent has a life expectancy of less than 6 months. The Hospice must be an organization, agency or facility licensed by the state in which it is headquartered or accredited by a national accrediting organization or recognized as a hospice program by the U.S. Department of Health and Human Services and meets the certification requirements of Medicare.

The Plan will pay Covered Charges for:

1. Hospice Care, not to exceed Hospital benefits, for Inpatient confinement.

2. Home Hospice Care furnished in a private residence (not necessarily your residence), including:

   (a) home health aide;

   (b) registered nurse (RN) or licensed practical nurse (LPN);

   (c) physical and respiratory therapy;

   (d) nutrition counseling and special meals; and

   (e) licensed or certified social worker for medical social services rendered for a maximum of 6 visits.

3. The Plan will pay for 8 days of inpatient care for Respite Care per lifetime. Respite Care is care furnished when confined as an inpatient so your family may have relief from the stress of care at home.

Occupational, Physical and Speech Therapy

The Plan will pay for Occupational, Physical and Speech Therapy by a Physician or other properly licensed therapist when prescribed by your Physician and when significant improvement can be obtained. The Plan will initially allow up to 3 consecutive months of therapy, and any additional need for therapy must be certified by your attending Physician to be Medically Necessary. The Plan will not pay for expenses to maintain functions at the current level or when no further significant practical improvement can be expected or when it is prescribed instead of non-medical treatment, such as exercise or an excluded diagnosis. Speech Therapy will be covered to restore patient's functional ability to prior levels.

Virtual Physical Therapy

The Plan also covers virtual physical therapy through Sword Health for you and your Dependents age 13 and older. Through the Sword Health program, you will receive a tablet, motion sensors and access to a digital physical therapy program with support from a real physical therapist. You can use this program for treatment of all musculoskeletal issues, including back, shoulder, neck, hip, knee, elbow, ankle and wrist issues. To get started contact the Fund Office or visit Help@swordhealth.com

Transplants

The Plan will cover transplant expenses for you or your covered Dependent who is the recipient of a cornea, kidney/pancreas, liver, autologous or allogenic bone marrow, kidney, heart, or a heart/lung human-to-human transplant. The transplant and all phases of related transplant care, including, but not limited to, treatments, procedures, services, supplies and medicines provided in connection with admission, surgery and post-transplant care, must be performed at a provider that participates in the Plan's Transplant Network at the time such transplant care is rendered. The Transplant Network differs from the PPO Network. **No benefits are payable for transplants performed outside the Transplant Network.** However, pre-transplant evaluation may be performed at a PPO Network provider or outside the Transplant Network provided that such evaluation is monitored by and coordinated with the Plan's utilization review service.

The Plan will cover up to $5,000 for a transplant recipient's travel expenses per lifetime. No benefits are payable for donor expenses as set forth as part of an all-inclusive discounted case rate charged by a provider in the Transplant Network where such expenses do not increase the case rate. Travel expenses for the transplant recipient only to and from a provider participating in the Transplant Network in conjunction with the transplant will be covered under this provision up to a maximum of $5,000 per lifetime. Travel expenses means ambulance, air ambulance or other professional transportation for the transplant recipient, including the recipient's travel by regularly scheduled airline or railroad to and from the Transplant Network provider. Some portion of the travel expenses may be taxable to you. You should consult your tax advisor with any questions.

No benefits are payable for donor expenses, except for available coverage for donor expenses as set forth as part of an all-inclusive discounted case rate charged by a provider in the Transplant Network retained by the Trustees where such expenses do not increase the case rate.

Contact the Fund Office if you require more information on this transplant benefit. Prior authorization of any transplant procedure is recommended.

Chiropractic Services

Benefits are limited to the following services and maximums for the treatment of spinal maladjustments:

1. Initial office visit including routine examination, patient history (new patient or new condition)

2. Follow-up visit-manipulation, one per visit

3. Follow-up visit-one therapy per visit

4. Diagnostic X-ray—one per calendar year

The maximum number of follow-up visits will be 30 per calendar year.

If a registered physical therapist (RPT) is employed with, by, associated with, or in the same office with a chiropractor and renders spinal adjustment services, these are payable under the above chiropractic benefits and not under the therapies benefit of the Plan. The number of visits to the registered physical therapist for spinal adjustment services will count toward the 30 follow-up visits maximum.

Benefit Exclusions

The Plan does not cover:

1. Chiropractic services for Dependent children under age 10;

2. Visits in excess of the annual maximum

Routine Physical Examination and Preventive Care; Immunizations

The Plan covers items or services with an A or B rating as recommended by the U.S. Preventive Service Task Force, immunizations recommended by the Advisory Committee on Immunization Practices and adopted by the Centers for Disease Control, preventive care and screenings for infants, children and adolescents

supported by the Health Resources and Services Administration (HRSA) and screenings for women supported by HRSA (collectively referred to as "ACA Preventive Care"), subject to the following:

1. Breast pumps — one per childbirth.

2. Routine mammogram — either 2D or 3D but not both.

3. Routine colonoscopy or one Cologuard Kit.

4. Four tobacco counseling sessions of 10 minutes from a PPO Provider per calendar year in conjunction with a maximum of 2 calendar year smoking cessation attempts. Tobacco cessation drugs and medications are covered under the Prescription Drug benefit.

5. To the extent not covered as ACA Preventive Care, the Plan also covers the following preventive care services:

   (a) physician's charges for complete history and physical examination,

   (b) well-child expenses for a Dependent child including charges for routine immunizations,

   (c) x-ray and laboratory charges such as electrocardiogram,

   (d) blood count, and

   (e) chest x-ray.

For additional information on ACA Preventive Care services you can visit the website: www.healthcare.gov/ or contact the Fund Office.

Physical exams for employment (such as a commercial driver's license or hazmat services) or recreational activity such as a pilot's license are not covered by this benefit.

Hearing Benefits

The Plan covers hearing exams, hearing aids, hearing aid batteries and repairs up to the maximums described in the Schedule of Benefits.

Alternative Care

The Trustees reserve the right to approve payment of benefits for alternative treatment on a case-by-case basis in accordance with guidelines adopted by the Trustees.

Nutritional Counseling

The Plan covers nutritional counseling provided by or under the supervision of a registered dietician or other appropriately licensed provider, subject to the limits in the Schedule of Benefits.

Prescription Drug Expense Benefits

Pharmacy Network

The Plan provides a Pharmacy Network. When you have a prescription drug or medicine filled at a pharmacy participating in the Network, you must use the separate prescription drug I.D. card. Call the Pharmacy Network for information about participating pharmacies in your area. Contact information for the Pharmacy Network is found on page 62.

In the event you lose your Pharmacy Network I.D. card or have a question as to whether a prescription drug is covered, you should contact the Fund Office or Pharmacy Network.

If you go to an Out-of-Network pharmacy or do not present your I.D. card at a Network pharmacy, you must pay for the entire cost of the prescription at the pharmacy and submit your receipt along with a claim form to the Pharmacy Network. Claim forms can be obtained by contacting the Pharmacy Network.

Co-payment and Out-of-Pocket Maximum

You must pay the pharmacist a co-payment for covered prescription drugs or medicines. The Plan will pay the remainder of the cost of covered prescription drugs and medicines up to $10,000. Once the Plan has paid $10,000 in prescription drug costs, the Plan will pay 50% of future covered prescription drug costs until the prescription out-of-pocket maximum is satisfied.

If you choose a brand name prescription drug when a generic equivalent is available, you must pay the difference in cost between the generic prescription drug and the brand name prescription drug in addition to the co-payment for the brand name drug. This rule does not apply if your treating Physician provides a written letter of Medical Necessity requiring use of the brand name medication.

The prescription drug out-of-pocket maximum are the expenses you are required to pay for prescription drugs in a calendar year and is separate from the out-of-pocket maximum that apples to the medical benefit. Even though you may have other medical expenses paid by the Plan at 100% after satisfying the deductible and out-of-pocket maximum, you must continue to pay the prescription drug co-payment when a prescription is filled until the separate prescription drug out-of-pocket maximum is satisfied. The copayments you pay will count toward the prescription drug out-of-pocket maximum only.

The following expenses do not count toward the out-of-pocket maximum:

- Medical, dental or vision expenses;
- Expenses that do not qualify as Covered Charges (e.g., excluded services);
- Balance billed charges;
- Amounts in excess of a benefit maximum;
- Prescription drug manufacturer coupons, to the extent permitted by law.

You will be automatically enrolled in a manufacturer coupon program if your prescription is covered by the program. Use of the coupon results in a lower cost to you and the Plan. The list of medications with coupons available can be changed from time to time.

Covered Expenses

A covered prescription drug or medicine is one that requires a Physician's written prescription, whether for a pill, a liquid or an injectable substance (including birth control pills and contraceptive devices). It must be prescribed in accordance with and for a medical condition for which the U.S. Food and Drug Administration (FDA) has authorized its use. In order for an injectable drug or medicine to be covered, it must be one that would be covered under the Plan's medical benefits if administered by a physician or registered nurse. If a drug is not covered, you must pay the entire cost.

- Retail **-** You may receive up to a 30-day supply of medication from your local Network Pharmacy.
- Mail Order **-** You may receive up to a 90-day supply from the Sav-Rx Mail Order for maintenance medications. Remember, you must have your physician write the prescription for a 90-day supply to take advantage of this benefit.
- "Walk-In" Mail Order Available at Walgreens - You may receive up to a 60-day supply of maintenance medications at your local Walgreens. Remember, you must have your physician write the prescription for a 60-day supply to take advantage of this benefit.

<u>Smoking Cessation</u>

The Plan provides a calendar year maximum of two 90-day supplies of smoking cessation medications, provided you have a prescription from a Physician and the medications are purchased at a Network Pharmacy.

The Plan first provides a 90-day trial period of over-the-counter smoking cessation products, such as nicotine patch, lozenge or gum, used singly or in combination. A 90-day approval of generic prescription smoking

cessation products, such as Buproban and generic Zyban, is available following failure, intolerance, allergy, or contraindication to the over-the-counter products. A 90-day approval of brand name prescription smoking cessation products, such as Chantix and Nicotrol, following demonstrated intolerance and/or allergic reaction to over-the-counter and generic prescription products.

Specialty Drugs

The Plan will cover specialty drugs and medications for uses or diagnoses for which the drug or medication has been approved by the FDA. Specialty drugs must be precertified by the Pharmacy Network provider. If you fail to have a specialty drug precertified, the Plan will not cover the drug and you must pay the full cost.

The Plan utilizes various programs to help with the rising cost of certain specialty drugs. The High Impact Advocacy Program and Patient Assistance Programs utilize pharmaceutical manufacturer coupons and other assistance to reduce or eliminate your out-of-pocket expense. If you are taking a prescription drug that qualifies for one of these programs, you will receive additional information from the Plan's Pharmacy Network provider. Note that the drugs included in these programs can change from time to time without notice.

Exclusions

In addition to the general exclusions identified on pages 36-39, the Plan does not cover the following drugs, items or services under the Prescription Drug benefit:

1. Drugs that are not FDA approved;

2. Drugs prescribed for a non-FDA approved use;

3. Non-legend patent or propriety drugs;

4. Drugs not requiring a prescription (except for ACA Preventive Care drugs);

5. Vitamins (except for vitamins that qualify as ACA Preventive Care);

6. Canes, crutches, walkers, wheelchairs or any means of conveyance;

7. Braces, splints, dressings, bandages, heat lamps or similar items;

8. Abdominal supports, trusses, support hosiery, hypodermic syringes/needles, oxygen; and

9. Drugs dispensed by a Hospital or other institution.

Peer Review

The Board of Trustees has the right to submit claims to peer review to determine appropriateness of treatment for the diagnosis, to determine if charges are Medically Necessary, and determine if charges are Usual, Customary and Reasonable. Medical charges can be denied if the peer review process and appeal to the Board of Trustees determine the charges are unreasonable or for services which are not Medically Necessary or accepted as Usual, Customary and Reasonable for the condition.

Optional Benefits

The Plan provides Optional Benefits for Preventive Dental, Comprehensive Dental and Vision Care, Supplemental Unemployment, or a Flexible Benefit Account, which must be elected under the collective bargaining agreement. Optional Benefits, other than the Flexible Benefit Account program, are not available to Retirees or Early Retirees or their Dependents. The following is a summary of Optional Benefits that you may receive, if elected through your collective bargaining agreement.

The Trustees have determined that the Optional Benefits qualify as "excepted benefits" for all purposes under ERISA, including, but not limited to, HIPAA, ACA, Mental Health Parity and Addiction Equity Act, and Consolidated Appropriations Act, 2021.

Optional Benefits will terminate on the earliest of the following dates:

1. The date coverage would otherwise terminate under the Plan;

2. The date you become covered as a Retiree or Early Retiree (except Flexible Benefit Account benefits); or

3. The date the Employer or Union terminates participation in the Optional Benefit.

Optional Benefits are subject to the General Exclusions and Limitations and Coordination of Benefits provisions of the Plan.

Optional Preventive Dental Benefits

The Plan will cover:

1. Oral exams including cleaning and scaling—no more than twice in a calendar year (generally 6-month checkups).

2. Cleaning—oral prophylaxis up to twice in a calendar year—one topical fluoride treatment and one application of tooth sealants per back molars for Dependents under age 16 each calendar year.

3. X-rays limited to one set of bite-wing x-rays in a 6-month period, one set of full-mouth x-rays in a 36-month period and one set of panoramic x-rays in a 60-month period.

4. Certain space maintainers (fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth for Dependent children under age 19.

Limitations and Exclusions

In addition to the General Exclusions and Limitations of the Plan, no benefits are payable under Optional Preventive Dental for:

1. Services and supplies not listed above;

2. Expenses for services or supplies that are not necessary according to or do not meet accepted standards of dental practice; and

3. Treatment by other than a legally qualified dentist (D.D.S. or D.M.D.), except charges for cleaning performed by a licensed dental hygienist under the supervision and direction of a dentist.

Optional Comprehensive Dental Benefits

The Plan provides preventive, basic, major and orthodontic dental services under the Optional Comprehensive Dental Benefit.

Preventive

1. Oral exams including cleaning and scaling—no more than twice in a calendar year (generally 6-month checkups).

2. Cleaning—oral prophylaxis up to twice in a calendar year—one topical fluoride treatment and one application of tooth sealants per back molars for Dependents under age 16 each calendar year.

3. X-rays limited to one set of bite-wing x-rays in a 6-month period, one set of full-mouth x-rays in a 36-month period and one set of panoramic x-rays in a 60-month period.

4. Certain space maintainers (fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth for Dependent children under age 19.

Basic

1. Periodontal

2. Oral surgery or extractions

3. Restorative or fillings

4. Endodontic treatment, including root canal therapy

5. Local anesthetic (e.g., Novocain), and when Medically Necessary and administered in connection with oral or dental surgery, general anesthetics

6. Repair or recementing of crowns, inlays, onlays, bridgework or dentures

7. Relining or rebasing of dentures more than 6 months after installation or replacement, but not more than once every 36 months

8. Intra-Oral x-rays

Limitations to Basic Services are:

1. Veneers posterior to maxillary first molars or mandibular second bicuspids are considered optional and are not considered covered services.

Major

1. Cast restorations—gold restorations; crowns and jackets when teeth cannot be restored with other materials.

2. Prosthodontics—construction, placement or repair of fixed bridges, partial and complete dentures.

    (a) Initial installation of fixed bridgework to replace missing natural teeth (including inlays and crowns as abutments, except periodontal splinting).

    (b) Initial installation (including precision attachments and adjustment during the 6-month period following installation) of partial or full removable dentures.

    (c) Replacement of existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

        (i) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or

        (ii) the existing denture or bridgework was installed at least 5 years prior to its replacement under this Plan or any other group plan, unless no payment was received and the existing denture or bridgework cannot be made serviceable; or

        (iii) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

    (d) Inlays, implements, onlays, fillings, or crown restorations to restore diseased teeth and implants.

Limitations to Major Services are:

1. If adequate retention and aesthetics can be obtained using only gold for a crown, payment will be made toward the cost of a more extensive procedure at the gold rate.

2. Porcelain gold, porcelain veneer and acrylic veneer precious metal crown over vital teeth are not covered for children under age 12.

3. Veneers on crown posterior to maxillary first molars or mandibular second bicuspids are optional, and are not covered.

4. Appliances for the replacement of the same natural teeth are a benefit only once in a 5 year period.

5. Temporary partial dentures are a benefit only when anterior teeth are missing.

6. Specialized techniques, precious metals for removable appliances, precision attachments, personalization and characterization are optional, and are not covered. Allowance for standard procedures will be made toward the cost of a more complex procedure.

7. Fixed bridges and/or cast partials are not a benefit for children under age 16.

8. A posterior fixed bridge is not covered when done in connection with a removable appliance in the same arch.

9. Oral surgery is not covered under the Dental Coverage of your Plan, it is covered under the Medical Coverage shown on page 21.

Orthodontic

Orthodontic procedures and treatment consisting of appliance therapy and surgical therapy (the surgical repositioning of the jaw, facial bones and/or teeth to correct malocclusion).

The maximum amount payable for expenses for orthodontic treatment will not exceed $100 for a person whose initial expense for treatment is incurred less than 3 months prior to the date of termination of coverage.

Limitations and Exclusions

In addition to the General Exclusions and Limitations of the Plan, no benefits are payable under Optional Comprehensive Dental for:

1. Services and supplies not listed above;

2. Expenses for services or supplies that are not necessary according to or do not meet accepted standards of dental practice;

3. Treatment by other than a legally qualified dentist (D.D.S. or D.M.D.), except charges for cleaning performed by a licensed dental hygienist under the supervision and direction of a dentist;

4. Treatment due to injury to natural teeth as a result of an accident—benefits are paid under Medical Benefits;

5. Correction of congenital, developmental or acquired malformations;

6. Treatment for temporomandibular joint dysfunction (TMJ/TMD);

7. Procedures necessary to alter occlusion or vertical dimension or restoration of tooth structure lost through attrition;

8. Hypnosis;

9. Pre-medication;

10. Treatment solely for cosmetic reasons;

11. Prescription drugs;

12. Hospital charges, including Hospital visits;

13. Charges for completion of forms;

14. Charges for lost or stolen appliances; and

15. Experimental treatment and services.

Extended Dental Benefits

No benefits are payable for any covered dental expenses incurred after termination of coverage, except as follows:

1. Expenses for a prosthetic device, including bridgework, will be covered only if the impressions were taken and abutment teeth fully prepared while covered under this Plan, provided the prosthetic device is installed or delivered to the person within 2 calendar months following termination of coverage.

2. Expenses for a crown will be covered only if the tooth was prepared for the crown while covered under this Plan, and the crown is installed within 2 calendar months following termination of coverage.

3. Expenses for root canal therapy will be covered if the tooth was opened while covered under this Plan, and treatment is completed within 2 months following termination of coverage.

Optional Vision Benefits

The Plan covers the following under the Optional Vision Benefit:

1. vision exam,

2. glasses,

3. frames,

4. corrective lenses,

5. charges in connection with radial keratotomy,

6. LASIK surgery and other surgical procedures to correct refractive errors of the eyes.

Exclusions

in addition to the General Exclusions and Limitations, no benefits are payable under the Optional Vision Benefit for:

1. orthoptics or vision training;

2. subnormal vision aids;

3. plano (non-prescription) lenses;

4. Medical or surgical treatment of the eyes;

5. Any eye examination required by an Employer as a condition of employment; and

6. Swimming or skiing goggles.

Flexible Benefit Account Reimbursement Program

The purpose for the Flexible Benefit Account is to provide Participants with a tax-free source for paying deductibles, co-payments, self-payments and a number of other medical expenses that are not covered under the regular Plan provisions or by any other source. The Flexible Benefit Account is a health reimbursement arrangement.

The Plan will establish an individual Flexible Benefit Account for each Participant. A Participant's account will be funded from the Employer's contributions made to the Plan on behalf of the Participant. (If a Participant is working under a reciprocity agreement, the first $1.00 of each hourly reciprocal contribution will be allocated to the Participant's Flexible Benefit Account.)

Expenses Eligible for Reimbursement

Flexible Benefit Account payments are available to reimburse a Participant for out-of-pocket expenses, *i.e.*, co-payments and deductibles. A Participant may also apply assets in his Flexible Benefit Account to continue Plan coverage if there are insufficient credits in his dollar bank. Further, a Participant may obtain reimbursement from his Flexible Benefit Account for any medical service or item that meets the Internal Revenue Code definition of medical expense, including the following:

- vision and dental benefits not covered by the Plan's vision or dental programs (even if the Participant does not participate in the Plan's vision or dental programs);
- medical expenses that are only partially covered by the Plan's major medical expense program (or that are listed below) but not expenses for which reimbursement can be made from another source, such as spousal coverage, other Health Reimbursement Accounts ("HRAs"), Veterans Affairs ("VA"), Medicare, other medical assistance, and HSAs;
- acupuncture;
- guide dogs for blind or deaf persons;
- smoking cessation programs;
- hearing examinations and hearing aids;
- surgery or laser treatments to correct vision;
- weight loss programs, but not food or dietary supplements nor health club memberships or expenses;
- over-the-counter medications (except insulin).

Flexible Benefit Account benefits will be paid by deducting assets from a Participant's Flexible Benefit Account. Benefits will only be available to the extent of the assets in a Participant's Flexible Benefit Account.

Filing Procedure

To receive reimbursement from your Flexible Benefit Account, you must submit a claim form along with evidence identifying the reimbursement amount (e.g., an explanation of benefit form or receipt). All evidence must be submitted when filing for benefits from the Flexible Benefit Account. You must submit the form and evidence within 12 months of the date the claim was incurred. Only claims incurred after you are eligible for the Flexible Benefit Account may be submitted. You may submit your claim form to the Fund Office via hardcopy or through the Fund's website.

A charge is incurred at the time the service is rendered or the item is purchased. In addition, a charge is deemed incurred when an advance payment is made for orthodontic services, provided satisfactory substantiation of the payment is provided to the Fund Office to the extent permitted by applicable law. Except where an individual's Flexible Benefit Account is forfeited as described below, a former or retired Participant with an Account balance is eligible to use his or her Account for reimbursable expenses. You do not need to be eligible for regular Plan benefits when the expense is incurred, the reimbursement request is submitted or received or when the check is issued.

The total amount of claims submitted at one time must equal at least $100. The Plan will issue Flexible Benefit reimbursement checks weekly or as soon as administratively feasible. The Plan will annually reimburse Participants whose claims do not exceed $100. The Flexible Benefit Account will not issue partial payments. Amounts not spent in a calendar year remain available in later years.

Forfeiture of Flexible Benefit Account

Your Flexible Benefit Account will be forfeited to the Plan in the following circumstances:

1. Upon your death. Upon your death, the entire balance of your Account will become available to your eligible Dependents. Your eligible Dependents may request reimbursement from the Account until the Account balance is zero, the Account is forfeited for the reasons below, or the Plan ends. If you have no surviving Dependents, the balance will be forfeited to the Plan.

2. Forfeiture of Inactive Account. Your Flexible Benefit Account will be forfeited if no contributions are made to or benefits paid from your Account for five consecutive calendar years or for accounts holding $400 or less an entire calendar year.

3. When your dollar bank is forfeited. Your Account will be terminated and forfeited to the Plan if your Dollar Bank is forfeited. However, if you return to covered employment with an Employer your Flexible Benefit Account will be reinstated on the same date dollar bank credits are reinstated. See pages 2-3 for more detail.

Opting-Out of the Flexible Benefit Account

You will be given an opportunity to opt-out of the Flexible Benefit Account and waive future reimbursements from the Account at the following times:

- Annually, while you remain covered under the Plan;
- Upon termination of eligibility for Plan coverage;
- Upon becoming eligible for Retiree coverage; and
- Upon notification you sign up for a subsidized plan under the ACA marketplace.

Additionally, upon your death, your eligible Dependents will be given an opportunity to opt-out of Flexible Benefit Account coverage and waive future reimbursements from your Account.

If you or, upon your death, your eligible Dependents elect to opt-out of your Flexible Benefit Account, any amounts remaining in the Account will be frozen. Any contributions to the Flexible Benefit Account received on your behalf after you opt-out will be forfeited to the Plan. A frozen Flexible Benefit Account will be reinstated the earlier of:

1. The January 1 following the 12-month period to which the opt-out applied, unless you or your Dependent elects to opt-out for a subsequent 12-month period; or

2. Your death;

3. Loss of coverage under another group health plan due to loss of eligibility or termination of the plan (applicable to Retirees and Dependents only).

If you opt-out of your Flexible Benefit Account upon loss of plan eligibility, your account will be reinstated on the date you regain eligibility under the Plan.

The forfeiture rule for inactive accounts will apply during the period the Flexible Benefit Account is frozen.

Coordination of Benefits

For purposes of coordination of benefits, the Flexible Benefit Account is not considered a group health plan and will not be taken into account when determining other benefits payable under this Plan or any other plan, except for Medicare. The use of benefits under the Flexible Benefit Account program may be restricted under some circumstances for active Employees or their Dependents who are enrolled in Medicare.

Supplemental Unemployment Benefits ("SUB") for Covered Employees Only

The Plan's SUB feature is intended to provide you with a $250 weekly benefit during a period in which you have involuntarily terminated employment qualify for unemployment benefits. SUB payments are subject to state and federal income tax withholding.

SUB benefits are available only if included in the collective bargaining agreement applicable to you.

Eligibility

To qualify for a SUB payment during the first six weeks of unemployment, you must submit a state unemployment compensation receipt to the Plan within 30 days after you receive it.

After the sixth week of unemployment, you must timely submit both a state unemployment receipt. ***and*** evidence that you have signed Book One or taken other action to obtain employment through your Local Union's employment referral process. SUB payments may also be available following exhaustion of state unemployment benefits in certain situations.

You must elect SUB pay as soon as you qualify for payments. If you qualify to receive SUB benefits but fail to submit a request for benefits, you will still be subject to taxation on the amount that would have been paid if you had requested benefits at the time you qualified.

Funding

The SUB account is funded with Employer Contributions up to a maximum of $4,500.

All earnings on your SUB account assets will be credited to your account (reduced by expenses the Plan incurs administering the SUB program). The Plan will pay you a single $300 holiday benefit after October for any calendar year in which your SUB account exceeds $5,500.

Benefit Duration

Weekly benefits will be paid to you until there is less than $250 in your SUB account.

Death and Retirement

Upon retirement, any amounts remaining in your SUB account will be transferred to your Flexible Benefit Account. If you die before your SUB account is exhausted and you have surviving covered Dependents, the assets remaining in the SUB account will be transferred to your Flexible Benefit Account or, if you do not have a Flexible Benefit Account your dollar bank. Any asset that cannot be transferred following death will be forfeited.

The Plan will forfeit the SUB account of an inactive Participant. You are considered inactive if no contribution is made to the Plan on your behalf for 24 consecutive months. The forfeiture will occur after two consecutive Plan Years. If you are inactive, the Plan will transfer any remaining SUB account assets to your Flexible Benefit Account or if not maintained, your dollar bank at the time the forfeiture would otherwise occur.

The SUB is not a pension benefit; the benefit does not vest.

Termination

In the event that SUB contributions are no longer required by a Local Union due to modification of the Collective Bargaining Agreement, the assets in the SUB accounts maintained for Participants in that Local Union will be transferred to the Participants' Vacation Benefit Program account.

Vacation Benefits for Covered Employees Only

The Plan's Vacation Benefit feature is intended to provide you with an annual vacation benefit of up to $2,500. Vacation Benefit payments are subject to state and federal income tax withholding.

Vacation Benefits are available only if included in the collective bargaining agreement applicable to you or if your SUB Account was transferred into a Vacation Benefit account.

Funding

The Vacation Benefit is funded solely with Employer contributions. No earnings will be credited to your Vacation Benefit Account.

Benefit Payment

If you have a Vacation Benefit account balance on December 31 of each year, you will receive a distribution of the lesser of $2,500 or your account balance, less a deduction of administrative expenses. Benefits will be distributed annually by mail as soon as administratively feasible after December 31.

Death and Retirement

Upon your death, any balance in your Vacation Benefit Account will be distributed to your designated beneficiary. If you have not designated beneficiary or your designated beneficiary has not survived you, then the benefit will be paid in equal shares to the first surviving class of the classes listed in order as follows: (1) your spouse, (2) your children, (3) your parents, (4) your siblings, and (5) your estate.

General Exclusions and Limitations

The General Exclusions and Limitations apply to all Plan benefits, including Optional Benefits. If any services or supplies are not particularly addressed in this booklet, whether as an exclusion or covered expense, you should not assume that such services or supplies are covered under this Plan.

The Plan shall not provide benefits for any expenses directly or indirectly related to the following:

1. If, with respect to an accidental Bodily Injury or Illness, you are entitled, or could have been entitled if proper application had been made, to any medical benefits paid by, reimbursed by or provided by or under the authority of any government or any governmental agency, such benefit shall discharge the obligation of this Plan as though and to the extent such benefit had been paid hereunder, but no claim will be denied solely because treatment or services are rendered in a Hospital owned or operated by a State or political subdivision thereof;

2. Any charge under more than one type of coverage, unless specifically provided otherwise;

3. If you are not obligated to pay, is not billed or would not have been billed except for the fact that the person was covered under this Plan; however, to the extent required by law the Plan will reimburse a Veterans Administration Hospital for care of a non-military service connected disability;

4. Medical services or supplies unless such service or supply is provided for the treatment or diagnosis of an accidental Bodily Injury or Illness and is prescribed by, or made at the direction of a Physician, except when such charges are provided as a benefit under the Plan (e.g., routine physical examinations and related charges);

5. Accidental Bodily Injury or Illness resulting from and arising out of or occurring in the course of any employment or occupation for wages, compensation or profit, including work performed outside the your regular trade for an employer who should have been covered under Workers' Compensation except for Death Benefit and Accidental Death and Dismemberment Benefits;

6. Hearing aid or the fitting thereof except as described on page 26;

7. Eye examination or refractions, eye glasses, contact lenses or fitting of eye glasses or contact lenses, except as provided in Optional Vision Benefits;

8. Medical benefits for dental services and supplies, except for oral surgery as described on page 21, and Optional Preventive Dental Benefits and Optional Comprehensive Dental Benefits;

9. Cosmetic, plastic or reconstructive surgery for developmental malformations, or as the result of earlier cosmetic, plastic or reconstructive surgery except for the following is covered:

   (a) initial plastic, cosmetic or reconstructive surgery due to a condition caused by a malignancy or removal of a benign tumor;

   (b) a surgery that is Necessary for the repair or alleviation of damage resulting from a Bodily Injury you sustained and the charges are incurred within 1 year of the Bodily Injury or, if the charges are incurred beyond 1 year, your Physician provides support for the delayed procedure;

   (c) the surgery is necessary because of a congenital disease or anomaly of a Dependent child that has resulted in a functional defect; or

   (d) following a mastectomy, as set forth on page 20.

10. Custodial Care, medical care or treatment and services or supplies for which charges are made by a nursing home, rest home, convalescent home, or similar establishment;

11. Accidental Bodily Injury or Illness resulting from any act of war, armed invasion or aggression occurring after the effective date of coverage;

12. Accidental Bodily Injury or Illness incurred while in service in the Armed Forces of any country;

13. Accidental Bodily Injury or Illness resulting from any release of nuclear energy, except when being used solely for medical treatment of your Illness or Bodily Injury under direction and prescription of a Physician;

14. Accidental Bodily Injury or Illness you sustain that result from or occur during the commission or attempted commission of a criminal act, except that losses resulting from acts of domestic violence will be covered;

15. Replacement or repair of any prosthetic device or orthotic, except once in a 5-year period, unless due to the patient's pathological changes or normal growth and is Medically Necessary;

16. Recreational therapy;

17. Naprapathy therapy;

18. Orthopedic shoes, or supportive devices for the feet, such as arch supports, heel lifts, orthotics, except for the benefit for orthotics on page 23;

19. Confinement, treatment, services, medications or prescription drugs provided for or in connection with:

   (a) a surrogate pregnancy, except as required by law or

   (b) infertility, restoration of fertility or the promotion of conception, including, but not limited to artificial insemination, in-vitro fertilization, gamete intra fallopian tube procedures or revision of surgically induced infertility;

20. Over-the-counter birth control pills and contraceptive devices, except as required by the ACA,

21. Genetic counseling or confinements,

22. Treatment, services, medications, or prescription drugs for sexual impotency.

23. Rental and/or purchase of humidifiers, air conditioners, exercise equipment, whirlpools, hot tubs, health spa or club, athletic club, or swimming pools, whether or not prescribed by a Physician;

24. Charges incurred prior to the individual's effective date of coverage;

25. Private duty nursing care, medical care or treatment, performance of surgical procedures, or physical therapy, when those services are rendered by a professional that ordinarily resides in your home or who is a member of your immediate family;

26. Callus or corn paring, toenail trimming or excision for toenail trimming, treatment of chronic conditions of the foot, such as weak or fallen arches, flat or pronated foot metatarsalgia (plantar fasciitis) or foot strain;

27. Weight loss or physical fitness programs, weight loss clinics, Cardiac Rehab Phase III, or obesity, except as described on pages 21-22;

28. Non-surgical treatment or services rendered in connection with disturbance of the temporomandibular joint (TMJ/TMD dysfunction/pain syndrome) except as specifically noted;

29. Marital counseling;

30. Orthoptics or vision training;

31. Speech Therapy that is not for correction of a pathological functional disorder;

32. Laetrile, enzymes and food supplements;

33. Chelation therapy;

34. Experimental and investigative treatment procedures, facility, equipment, supplies or drugs, including prescription drugs that are not approved by the FDA for the use for which the drug is prescribed, except that, to the extent required by the ACA, the Plan will not deny any Qualified Individual the right to participate in an Approved Clinical Trial; deny, limit or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished with participation in the Approved Clinical Trial and will not discriminate against a Qualified Individual who participates in such Clinical Trial. Qualified Individuals must use a PPO Provider if the PPO Provider is participating in an Approved Clinical Trial. Contact the Fund Office if you have questions on the Plan's coverage of Approved Clinical Trials.

35. Blood pressure kits, monitoring devices and other similar devices, other than pacemakers, which can be permanently implanted;

36. Travel expenses, except as provided for transplant recipient;

37. Preparing medical reports or itemized bills;

38. Telephone consultations;

39. Wigs, artificial hairpieces;

40. Acupuncture;

41. Elective procedures (*e.g.*, mastectomies, abortions);

42. Personal convenience items, education materials, etc.

43. Expenses for grandchildren or children of Dependent children;

44. Court ordered classes or treatments;

45. Lamaze classes;

46. Vocation rehabilitation;

47. All transplants, except those listed on page 25.

48. Donor expenses related to transplants, except for available coverage as part of an inclusive case rate provided in the transplant network;

49. Non-surgical treatment of hemorrhoids (obliteration);

50. Drug testing required by an employer for employment;

51. Stop smoking substances and devices, programs and clinics regardless of whether prescribed by a Physician unless otherwise covered under the preventive care services or the Prescription Drug Benefit section;

52. Massage therapy, self-help and stress management, and exercise stress testing and perceptual therapy;

53. Occupational Therapy which retrains an individual for a job or career;

54. Biofeedback;

55. Hypnosis;

56. For or relating to any special education. This limitation applies regardless of the type of education, the purposes of the education, the recommendation of the attending physician or the qualifications of the individual(s) rendering the special education;

57. Sales taxes;

58. Virtual colonoscopies;

59. For and relating to programs for monitoring and management of pain unless determined by the Plan, in consultation with its medical review firm as necessary, to be the appropriate prescribed course of treatment for the diagnosis rendered and Medically Necessary and Reasonable; and

60. If you are a Michigan resident, a Bodily Injury or Illness that results from a motor vehicle accident.

Coordination of Benefits

Your Plan is designed to provide reimbursement for covered medical, dental and vision expenses up to the allowed amounts under This Plan. If you are also covered under another health Plan, you may not recover more than what This Plan would have paid.

Important Definitions for this Coordination of Benefits section:

1. **"Plan"** means any plan providing benefits or services for medical, dental or vision benefits and includes any of the following:

   (a) Group, blanket, franchise coverage plans or any other plan covering individuals or members as a group;

   (b) Group practice and other group prepayment coverage;

   (c) Group service plans;

   (d) Coverage under a labor management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;

   (e) Coverage under governmental programs (excluding Medicare);

(f) coverage required or provided by any statute, including any motor vehicle no fault coverage required by statute;

(g) coverage under an automobile insurance policy; and

(h) any other insured or self-insured group health plan.

The term Plan does not include:

(a) Medicare;

(b) any individual policy or contract; or

(c) school accident type coverage, whether on a blanket, group or franchise basis.

2. **"This Plan"** means the Wisconsin Electrical Employees Health and Welfare Plan subject to these coordination rules.

3. **"Allowable Expense"** means a Covered Charge, subject to This Plan's maximums and equal to the amount This Plan would have paid in the absence of coverage under another Plan. This Plan will not consider charges as Allowable Expenses if the charges would have been covered under an HMO (Health Maintenance Organization) program had the individual used the participating providers and required HMO procedures for receiving treatment.

If you or your covered Dependents have coverage under This Plan and another Plan, This Plan will coordinate benefits as follows:

1. If the other Plan does not have a coordination of benefits provision, then the other Plan will pay first up to its allowable limits and This Plan will pay second.

2. The Plan covering you as an employee pays first and the Plan covering you as a former employee or as a dependent pays second (note special rules will apply if you are enrolled in Medicare – contact the Fund Office for more information).

3. The Plan covering you as an employee or dependent of an employee will pay before the Plan covering you under COBRA or other right of continuation coverage.

4. In the case of children whose parents are married, the Plan covering the parent whose birthday occurs earlier in the calendar year pays first.

5. In the case of children whose parents are divorced or legally separated, the following order of benefit determination will apply:

   (a) The Plan covering the child as a dependent of the natural parent who has responsibility for health care under a court order will be the primary plan and will pay first.

   (b) If there is no court order, the order of benefit determination is as follows:

      (i) The Plan covering the child as a dependent of the natural parent who has custody or, if joint custody, primary physical placement of the child pays before the Plan of the non-custodial/non-primary placement parent and the Plan of any stepparent .

      (ii) If the parent with custody or primary physical placement has remarried, the Plan covering the child as a dependent of the stepparent will pay before the Plan of the non-custodial/non-primary placement parent.

When none of the above rules establish an order of benefit determination, the Plan covering you for the longer period of time will pay first. This Plan's Order of Determination will be followed, regardless of another Plan's compliance, and This Plan will be secondary in all cases where its Order of Determination specifies it is secondary. If the Plans do not agree on Order of Determination, This Plan will subrogate benefits with any payments received from the other Plan when This Plan determines it is secondary.

This Plan will disregard any attempt by another Plan to disregard industry-wide coordination of benefit provisions by adopting a provision that excludes or limits the other Plan's benefits to a person covered by This Plan. This Plan will coordinate its benefits with the benefits that would have been provided by the other Plan as if that provision did not exist.

In the event this Plan makes an overpayment due to your failure to report other coverage or for any other reasons, the Trustees have the right to recover the amount of the overpayment from you.

Special Rule for No-Fault Automobile Insurance

Benefits will be coordinated with no-fault automobile insurance coverages, including minimum coverage required under any no-fault statute or law. The Plan will not pay any benefits to the extent of the minimum benefits required by a no-fault statute or law. No benefits are payable for Michigan residents involved in a motor vehicle accident. Note this special rule does not apply to a passenger, non-owner operator, or pedestrian if they are not covered by the no-fault automobile insurance.

Coordination With Medicare

This Plan will be primary over Medicare for Active Employees and Active Employees' Spouses who are age 65 or older.

This Plan will be primary over Medicare for disabled individuals who are Active Employees or their Dependents, under age 65, and entitled or potentially entitled to Medicare as a disabled beneficiary other than as an ESRD beneficiary.

This Plan will be primary over Medicare if you are entitled to Medicare as an ESRD (End Stage Renal Disease) beneficiary for the first 30 months since the earliest of the following:

1. The fourth month after you began a regular course of renal dialysis (or the first month of dialysis if you have taken a course in self-dialysis training before the third month of dialysis and expects to give himself dialysis treatments);

2. The month you received a kidney transplant;

3. The month you were admitted to the Hospital in anticipation of a kidney transplant that was performed within the next 2 months; or

4. The second month before the month the kidney transplant was performed, if performed more than 2 months after admission.

This Plan will be secondary to Medicare in all other cases and Allowable Expenses shall be reduced so the sum of benefits paid between this Plan and Medicare shall not exceed the total amount of the Allowable Expense. The term "Allowable Expense" for this purpose is the Usual, Customary and Reasonable charge as determined by the Plan, for a Covered Charge this is also covered by Medicare. Charges made by Physicians who do not accept assignment of benefits from Medicare may not exceed the limiting charge provided for under federal law.

You are responsible for enrolling in Part A and Part B of Medicare when eligible. If fail to enroll, This Plan will coordinate with Medicare benefits as if you had enrolled. If you need information about Medicare enrollment, contact the local Social Security office (at least two months before your 65th birthday, if possible).

Subrogation and Reimbursement

The Plan is not designed to pay expenses covered by another person or party who may have caused harm to you or your Dependents. Examples of this type of situation include an automobile accident or a product liability case. If such a situation arises, call the Fund Office.

The Plan shall be subrogated to all rights of recovery of a Participant, his or her parent(s) and dependent(s) or a representative, guardian or trustee of the Participant, his or her parent(s) and Dependent(s) (collectively the "Claimant"), relating to any claim paid or obliged to be paid by the Plan. The subrogation right applies on a priority, first dollar basis to any recovery received by or payable to or on behalf of the Claimant by suit,

settlement or otherwise. This right applies to any recovery, regardless of whether it is a partial or full recovery or whether the Claimant is made whole, from any source making a payment for the injury, illness or conditions relating to the claim. It further applies, regardless of whether the source admits it is liable. Possible sources include, but are not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, financial responsibility, uninsured or underinsured insurance coverages, as well as medical reimbursement coverage purchased by the Claimant or by any responsible party.

In addition to its subrogation rights, the Plan is granted a right of reimbursement from any recovery from any source, including a partial or full recovery, and regardless of whether it is by suit, settlement or otherwise or whether the Claimant is made whole. Consistent with this right, the Claimant shall first reimburse the Plan on a priority basis for the full amount of all payments the Plan made or may be obliged to make for the claim. This means, for example, that if a covered person has claims, such as medical or Short Term Disability, as a result of an accident for which the Plan pays or would pay benefits, the Plan is entitled to be reimbursed in full first from any recovery the covered person makes from any source relating to the accident. Once the Plan makes or is obligated to make payments on behalf of the Claimant, the Plan is granted, and the Claimant consents to, an equitable lien by agreement or constructive trust on the proceeds of any payment, settlement or judgment received by the Claimant from any source.

The Plan disavows any claims the Claimant may make under the common fund doctrine. This means the Plan will not be responsible for any of the Claimant's attorneys' fees or costs incurred in seeking a recovery unless the Plan has agreed, in writing, to pay such fees or costs.

In situations where a Claimant has been asked to complete a Subrogation and Reimbursement Agreement in a form acceptable to the Trustees, the Fund Office may suspend the processing and payment of any claims that relate to the incident or condition to which the Plan relates until the signed Subrogation and Reimbursement Agreement is received by the Fund Office. In accepting benefits from the Plan, the Claimant agrees that any and all amounts recovered will be applied first to reimburse the Plan. In addition, if requested in writing by the Trustees or the Plan's representatives, the Claimant or the Claimant's authorized representative shall take action as necessary or appropriate to recover any and all payments the Plan made or is obliged to make. If the Claimant does not, the Plan will be entitled to exercise its rights in the Claimant's name.

The Claimant shall not do anything to impair, release, discharge or prejudice the Plan's rights to subrogation and reimbursement. The Claimant shall assist and cooperate with the Plan's representatives and shall do everything needed to allow the Plan to enforce these rights. The Claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source which is due for any claim paid or obliged to be paid by the Plan. The Claimant shall reimburse the Plan immediately upon recovery.

The Claimant must provide the Plan with a copy of any judgment, settlement agreement or other document obtained in connection with the recovery. Any claim that is first received by the Plan after a recovery, regardless of when a claim is incurred, is the Claimant's responsibility and is paid by the Claimant and not the Plan to the extent of the Claimant's net recovery. If the Plan inadvertently provides benefits for such a claim, the Claimant is obligated to repay the Plan to the extent of the Claimant's net recovery.

If you or your agent receive a recovery from any source but do not reimburse the Plan, the Plan shall have the right to reduce future benefits on the claims you and your eligible dependents submit or reduce the amount of the dollar bank until the Plan has recovered the full amount allowed under the Plan's subrogation and reimbursement provision. The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests through any appropriate legal or equitable remedy, including but not limited to the initiation of a collection action under ERISA or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any Claimant for recovery from any reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Trustees of the Plan may waive the above right to subrogation and reimbursement if they determine that doing so is in the best interest of the Plan and its Participants.

Work-Related Injury or Sickness

The Plan does not provide benefits for Short Term Disability or medical care for work-related injuries or sickness. If you suffer a work-related injury or illness, you should apply for payment of benefits from Workers'

Compensation and, if denied, appeal the denial. If the appeal results in a determination that the injury or sickness was not work-related, you should submit any claims to the Plan along with a copy of the appeal denial letter. During a Workers Compensation appeal, the Plan may advance payment of benefit on an interim basis provided you agree in writing to repay 100% of these benefits from any recovery.

Claim Filing and Appeal Procedures

General Provisions

Claims for fully insured benefits will be decided by the insurer as described in the insurance policy (not the Board of Trustees). You should review the insurance certificates for detail on filing claims and appeals for these benefits. The procedures described in this section apply only to those self-funded benefits decided by the Board of Trustees.

The Plan and Board of Trustees, in making decisions on claims and on appeal, will apply the terms of the Plan and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with these documents, and where appropriate, applied consistently with respect to similarly situated claimants. Also, the Plan and Trustees will take into account all information you submit in making decisions on claims and on appeal. The Trustees will review all claims and appeals impartially and without conflicts of interest.

You may name a representative to act on your behalf. To do so, you must notify the Plan in writing of the representative's name, address and telephone number.

If you request a copy of an explanation of benefits ("EOB") noting the amount paid on a specific charge, other than the EOB automatically provided when payment is made, you will be charged for the copy.

Exhaustion is required. You must follow and fully exhaust the terms of this claim and appeal procedure before you may file any judicial or administrative proceedings.

Important Definitions for this Claim and Appeal section:

1. An **"Adverse Benefit Determination"** means a denial of a Claim, in whole or in part, and a final Adverse Benefit Determination means a denial of Claim on appeal, in whole or in part. A rescission of coverage is also treated as an Adverse Benefit Determination for purposes of these procedures.

2. A **"Claim"** is a request for Plan benefits made by a Claimant in accordance with this section. Inquiries about eligibility, casual inquiries about benefits and a request for prior approval of a benefit when prior approval is not required by the terms of the Plan are not Claims.

3. A **"Claimant"** is you or your duly authorized representative who requests a benefit under the Plan and files a Claim.

4. A **"Concurrent Care Claim"** is a Health Care Claim to extend an ongoing course of treatment beyond the period of time or number of treatments authorized by the Plan.

5. A **"Disability Claim"** means a Claim for a Short-Term Disability benefit.

6. A **"Health Care Claim"** means a Claim for a medical, prescription drug, dental or vision benefit.

7. A **"Post-service Claim"** is a Health Care Claim that is not a Pre-service Claim, Urgent Care Claim or Concurrent Care Claim.

8. A **"Pre-service Claim"** is a Health Care Claim for which you are required to obtain prior approval under the terms of the Plan.

9. A document, record or other information is **"Relevant"** to a Claim if it:

   (a) Was relied upon in making the benefit determination;

(b) Was submitted, considered or generated in the review, regardless of whether it was relied upon in making the benefit determination;

(c) Demonstrates compliance with the Claims processing requirements; or

(d) Constitutes a statement of policy or guidance concerning the denied treatment option or benefit for the Claimant's diagnosis, regardless of whether the statement or policy was relied upon in making the benefit determination.

10. An **"Urgent Care Claim"** is a subset of Pre-service Claims that, if delayed:

(a) could seriously jeopardize the Claimant's life, health or the ability to regain maximum function; or

(b) in the opinion of a Physician who has knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or medical treatment for which the Claimant is filing the claim.

Terms for Filing a Claim and Payment of Claims

Disability claims must be filed within 6 months of the date the disability began. All other claims must be filed within one year of the date the expenses are incurred. No benefits will be paid on bills or claims received (Plan Office date stamped) more than one year after the date the expense was incurred.

The Plan will pay benefits directly to you, unless the Fund Office receives a signed and dated authorization to pay benefits to the provider of the service or another individual or entity with the claim. The Trustees reserve the right to make payments directly to you without regard to a signed authorization or assignment directing payment to the provider. Claims may be paid directly to a spouse, blood relative or institution that is entitled to receive payment if you are unable to execute a valid receipt, or if you are deceased before all claims have been paid, and there is no appointed guardian to act on your behalf.

You must complete and file all claim forms and furnish all pertinent information and documents requested by the Trustees, including enrollment materials, required to properly process and pay claims before a payment is made on your behalf.

All claims submitted must be honest, accurate and as complete as possible. If the Trustees find there has been intentional falsification or any document submitted in support of a claim by forgery or intentionally inaccurate information or any other fraudulent means whatsoever, coverage for you and your Dependents can be terminated and/or the claim may be denied.

Claims must be filed at the Fund Office at the address on page 62.

Denial of Claims

Timing of Decision

The length of time required to process the Claim depends upon the type of Claim:

For an **Urgent Care Claim**, the Plan will notify you of an Adverse Benefit Determination within 72 hours of the date the Claim was properly filed with the Plan. The Plan's decision may be made orally initially, but will be followed up in writing.

For a **Pre-service Claim** the Plan will notify you of an Adverse Benefit Determination within 15 days of the date the Claim was properly filed with the Plan.

For a **Post-service Claim** the Plan will notify you of an Adverse Benefit Determination within 30 days of the date the Claim was properly filed with the Plan.

For a **Concurrent Care claim –** If the Plan determines that a course of treatment will be stopped or reduced before the previously approved number of treatments or period of time expires, you will be notified within a sufficient amount of time to allow an appeal before the Plan stops or reduces coverage for the ongoing treatment. If you request that a Concurrent Care treatment be extended beyond the initially determined time,

your claim will be decided no later than 24 hours after your claim is received by the Plan (if you make the claim at least 24 hours before the period or number of treatments expires).

For a **Disability Claim** the Plan will notify you of an Adverse Benefit Determination within 45 days of the date the Claim was properly filed with the Plan.

For **SUB and Vacation Claims**, the Plan will notify you of an Adverse Benefit Determination within 90 days of the date the Claim was properly filed with the Plan.

Extensions of time

Pre- and Post-service Claims: If the Plan determines that an extension of this time is necessary, the Plan may take one 15-day extension. Prior to the expiration of the initial 15- or 30-day notification period, as applicable, you will be notified of the need for an extension, the reasons why the extension is needed and the date by which the Plan expects to make a decision on the Claim. If the Plan needs more information from you to process the Claim, the notice will also specifically describe the necessary information and you will have 45 days to provide the needed information to the Plan. The time period for making a decision on your Claim is suspended until the date you respond or the 45 day period expires, if earlier. If you do not provide the information requested, your claim will be denied. If you provide the requested information, the Plan will issue its decision within the 15-day extension period.

Short-Term Disability Claims: If the Plan determines that additional time is required due to reasons beyond the Plan's control, the Plan may extend the decision-making period for up to an additional 30-days. Prior to the expiration of the initial 45-day period, you will be notified in writing of the reason for the delay and the date that the Plan expects to issue a final decision. If the Plan needs more information from you to process the Claim, the notice will also specifically describe the necessary information and you will have at least 45 days to provide the information to the Plan. A decision will be made with respect to the claim within 30 days of the deadline or the date that you respond. If circumstances warrant, a second extension of up to 30 days may be utilized.

SUB and Vacation Claims: If the Plan determines that special circumstances exist that require an extension of time, the Plan may take one 90-day extension. Prior to the expiration of the initial 90-day period, you will be notified in writing of the reason for the delay and the date the Plan expects to issue a final decision. If the Plan needs more information from you to process the Claim, the notice will also specifically describe the necessary information.

Notice of Claim Denial

If all or part of your Claim is denied, you will receive a written explanation that includes:

- the specific reason for the denial,
- the specific provisions of the Plan document on which the decision was based,
- any additional information necessary to reconsider your claim (and the reasons why that information is necessary), and
- a description of the Plan’s appeal procedures and the time limits for use of those procedures, including a statement of your right to bring an action under ERISA.

The written explanation will include additional information if your Claim is a Health Claim or a Disability Claim:

- If the Plan relied on an internal rule, guideline or protocol in making the decision, a copy of the rule, etc., a statement that it was relied upon and is available upon request and free of charge, or a statement that it does not exist, and
- if the Plan based its decision on medical necessity, experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment related to your condition or a statement that such an explanation is available upon request and free of charge.
- If the Claim is a medical or prescription drug Health Claim:
    - information sufficient to identify your Claim ,
    - the denial code and its corresponding meaning,

- a provision stating that diagnosis and treatment codes (as well as their corresponding meanings) are available upon request ,
- For certain medical and prescription drug Health Claims only, your right to request an external review by an independent review organization if you decide to appeal and your appeal is denied,

- If the Claim is a Disability Claim, a discussion of the decision, including the basis for disagreeing with or not following:
  - the view of a health care professional treating the Claimant or vocational professional who evaluated the Claimant,
  - the view of a medical or vocational expert whose advise was solicited by the Plan in connection with the Claim, or
  - a disability determination by the Social Security Administration regarding the Claim.

Appeal Procedure

You (or your authorized representative) may request a review of your Claim denial by writing to the Board of Trustees within 180 days of the date of your Adverse Benefit Determination. If you are appealing an Urgent Care Claim denial, you may do so orally by calling the Fund Office at 1-800-422-2128 or 1-608-276-9111 or in writing.

Your written appeal should state the reason for your appeal. You may submit any documents, records or other information relating to your appeal. You (or your authorized representative) may receive, upon request and free of charge, reasonable access to and copies of any documents Relevant to your claim and may submit issues and comments in writing. In addition, for medical and prescription drug Health Claims and Disability Claims, you shall receive copies of any new or additional information considered, relied upon, or generated during the appeal as well as any new or additional rationale for the denial, if any. If the new or additional information for a Health Claim is received so late that you will not have a reasonable opportunity to respond within the prescribed timeframe, the time period for the Plan to issue a final Adverse Benefit Determination will be suspended to provide you an opportunity to respond.

The Plan will provide for a full and fair review of your Claim on appeal. The review will take into account all comments, documents, records and other information you submit. The Board of Trustees, or delegated committee, is the named fiduciary and will be the assigned decision maker for all appeals except for appeals relating to fully insured benefits. The Plan will consult with appropriate health care professionals in deciding appealed Health and Disability Claims that involve medical judgment, including determination of Medical Necessity and Experiment or Investigational. Such health care professionals will have appropriate training and experience in the field of medicine involved in the medical judgment and will not be the same professional consulted as part of the initial Claim review, nor a subordinate of such person. You may request the identify of any medical or vocational expert consulted in connection with your Claim, upon request.

Timing of Decision

The amount of time the Trustees have to issue a decision after receiving your appeal will depend on the type of Claim:

For a **Pre-service Claim** the Plan will notify you of a final Adverse Benefit Determination within 30 days after the date the appeal was properly filed with the Plan.

For an **Urgent Care Claim** the Plan will notify you of a final Adverse Benefit Determination within 72 hours after the date the appeal was properly filed with the Plan. The decision may initially be made orally, followed by a written decision.

Appeals of **Concurrent Care Claims** are governed by the provisions above for Urgent Care, Pre-service or Post-service Claims, whichever applies to the particular claim.

The Trustees meet quarterly to decide all other claims, including **Post-service Claims** and **Disability Claims.** Properly filed appeals will be decided at the next quarterly meeting of the Trustees immediately following the receipt of your appeal unless your appeal was received by the Trustees within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will receive a decision no later than the third quarterly meeting, and you will be notified in writing of the need for the

extension, why the extension is needed, and when a decision is expected. The Plan will notify you of a final Adverse Benefit Determination within 5 days of the decision.

Notice of Appeal Denial

If all or part of your Claim is denied on appeal, you will receive a written explanation that includes the following:

- the specific reason for the denial,
- the specific provisions of the Plan document on which the decision was based,
- notice that you may receive on request access to and free copies of documents and records Relevant to your claim, and
- a statement of your right to bring an action under ERISA.

The written explanation will include additional information if your Claim is a Health Claim or a Disability Claim:

- If the Trustees relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, guideline or protocol, a statement that it is available upon request and free of charge, or a statement that it does not exist;
- If the Trustees based their decision on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment related to your condition or a statement that such an explanation is available upon request and free of charge.
- If the Claim is a medical or prescription drug claim:
  - a discussion of the Trustees' decision ,
  - information sufficient to identify the Claim ,
  - the specific reason for the denial (including the denial codes and their corresponding meanings),
  - a provision stating that diagnosis and treatment codes (and their corresponding meanings) are available upon request ,
  - a statement of your right to request an external review by an independent review organization.
- If the Claim is a Disability Claim:
  - a discussion of the decision, including the basis for disagreeing with or not following:
    - the view of a health care professional treating the Claimant or vocational professional who evaluated the Claimant,
    - the view of a medical or vocational expert whose advise was solicited by the Plan in connection with the Claim, or
    - a disability determination by the Social Security Administration regarding the Claim.
  - The date by which any action brought under ERISA must be filed.

External Review Procedure

If your medical or prescription drug Health Claim appeal is denied, in whole or in part, and the decision involved medical judgment or the balance billing protections of the No Surprises Act or if your coverage is being rescinded, you have the right to have the decision reviewed by an independent review organization. The Plan offers this right in accordance with and to the extent required by available guidance issued by the Departments of Labor and Health & Human Services and the Internal Revenue Service. You (or your authorized representative) may, within 4 months from receipt of the final Adverse Benefit Determination, request an external review from an independent review organization by writing to the Board of Trustees. Your written request should state the reason for your request. You may submit copies of evidence supporting your request for review.

You may request an expedited external review in the following circumstances:

1. Your Claim involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function

and you have filed a request for an expedited internal appeal. You may request this expedited external review at the same time as you request the expedited internal appeal.

2. Your Claim involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

3. Your Claim concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency services, but you have not yet been discharged from a facility.

Time Limit For Filing Lawsuits

No lawsuit or other action against the Plan or Trustees may be filed after 12 months from the date you receive the final Adverse Benefit Determination.

Overpayment of Benefits

In the event any payment is made by the Plan to or for an individual (e.g., a Participant, Dependent or provider) who is not entitled to such payment or the full amount of such payment, the Plan can suspend or withhold payment of claims and reduce future payments due to such person and/or, if applicable, his dependents by the amount of any erroneous payment and by the amount incurred by the Plan in pursuing the overpayment. The Plan and Trustees in their sole judgment, may take other actions to recover the erroneous payments and other amounts, including, but not limited to, commencing a restitution action under ERISA or reducing the amount of the Participant's dollar bank until the Plan has recovered the full amount.

Submission of Falsified or Fraudulent Claims

All claims, enrollment forms and any other information submitted or provided to the Fund, directly or indirectly, shall be accurate and complete. If the Board of Trustees finds, at any time, that false or inaccurate information has been submitted or provided to the Fund, directly or indirectly, in support of a claim, the claim shall be denied. The Trustees shall have the right to offset an amount improperly paid as discussed above and/or to terminate your coverage.

Retiree Benefits

Important Note: Retiree Benefits are not considered an accrued benefit and can be modified or terminated by the Board of Trustees at any time in its sole discretion.

Eligibility for Benefits

In order to be eligible for retiree coverage you must be, or have previously been, actively employed by an Employer that makes contributions to the Plan on your behalf. You may also be eligible under Self-Payment provisions of the Plan. If you are covered by the Plan under COBRA Continuation Coverage, you must become eligible again for coverage as an Active Employee.

To qualify as an Early Retiree, you must be covered by the Plan as an Active Employee, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee, be at least 55 years of age, cease from working in the industry, and advise the Fund Office in writing that you are an Early Retiree.

To qualify as a Retiree you must be covered by the Plan as an Active Employee or Self-Pay Active Hourly Employee, be at least 65 years of age, cease from working in the industry, and advise the Fund Office in writing that you are a Retiree. A Self-Pay Disabled Employee will be eligible as a Retiree upon the Employee's entitlement to Medicare Parts A and B. An Early Retiree will be eligible as a Retiree upon attaining age 65.

IMPORTANT: You must enroll in Medicare Parts A and B and fully complete the insurance enrollment forms to be eligible for Plan benefits after age 65. If you do not enroll in Medicare Part A and B <u>and</u> submit the enrollment forms, you and your Dependents will lose coverage under the Plan.

Individuals retiring should contact the Social Security Administration at least 90 days in advance of their 65th birthday. Participants should notify the Fund Office at 1(800) 422-2128 prior to the effective date of their retirement.

You may remove a Dependent upon enrolling in Retiree coverage. Your Dependent will not be eligible for Plan coverage unless they have a special enrollment qualifying event.

Waiver and Reinstatement

You have a one-time option to waive or terminate Plan coverage if you provide documentation that you are enrolled in another employer-sponsored group health plan (such as through your spouse's employer) or individual Medicare Advantage policy with prescription drug coverage (a "MAPD"). You must also sign a waiver form certifying such coverage. The waiver will be effective the first of the month following the date the Fund Office receives a properly completed waiver form and proof of other coverage.

If you have properly waived coverage, you will have a one-time opportunity to reinstate Retiree coverage following termination of coverage under other employer-sponsored group health plan or MAPD. You must submit an enrollment form to the Plan Office within sixty days following the termination of coverage under the other plan along with proof that you and your eligible Dependents were continuously covered under the other plan following the waiver of coverage. Coverage will become effective on the first day of the month following the date the Fund Office receives a properly completed enrollment form, proof of continuous coverage and applicable self-payment. Note that if you were enrolled in a MAPD, reinstatement is contingent on the Plan's MAPD carrier accepting you for coverage.

Retiree Self-Pay

To continue coverage under the Retiree Benefit you must make the required self-payments. You can elect to have self-payments automatically deducted from your Flexible Benefit Account or your checking account.

When you notify the Fund Office that you are an Early Retiree or Retiree, any eligibility credits you have remaining in your dollar bank will automatically be transferred to your Flexible Benefit Account. If your Flexible Benefit Account is inactive, the Fund Office shall reinstate the Account. If you were an Early Retiree or Retiree with an existing dollar bank account balance on September 1, 2022, your dollar bank credits were automatically transferred to your Flexible Benefit Account. If you return to Covered Employment, contributions will again be credited to your dollar bank.

Self-Payment Contribution Due Date

Self-payment contributions are due the 15th day of the month prior to the month for which coverage is intended (for example, the January self-payment is due December 15th), with a 5 day grace period. If self-payments are not received on time, coverage will be terminated as of the last day of the month for which contributions were timely made.

Termination of Self-Pay Coverage

Subject to a Dependent’s eligibility to continue coverage under the Surviving Dependents Self-Pay Plan or under COBRA, the coverage under the Retiree Self-Pay Program will terminate on the earliest of the following dates:

1. The last day of the month for which the required timely self-payment has been made;

2. Death;

3. The date the Plan is discontinued;

4. Withdrawal as described on page 6.

In addition, if your Dependent is covered, coverage for the Dependent will also terminate on one of the dates described on page 9.

Retiree Benefits

Medical Benefits

Early Retiree medical benefits are the same as the medical benefits described for all other Plan Participants.

Retiree medical benefits are provided through the Plan's insured Medicare Advantage program ("MAPD"). The MAPD is a fully insured program offered through an insurance carrier that includes medical services, hospital stays, and prescription drug coverage and are described in the separate MAPD booklet, which is available on the Fund Office website www.weebf.com.

Prescription Drug Benefits

Early Retiree prescription drug benefits are the same as the benefits described for all other Plan Participants.

Retiree prescription drug benefits are provided through the MAPD and described in the separate MAPD booklet.

Death Benefits

If you are a Retiree or Early Retiree, you are covered for Death Benefits with the Plan. If you die while still a Participant your Beneficiary will receive a lump sum payment equal to:

If you die prior to your 65th birthday	$10,000
If you die on or after your 65th birthday but before your 70th birthday	$6,500
If you die on or after your 70th birthday	$5,000

If you die without having designated a Beneficiary or if your designated beneficiary has died, then the benefit will be paid in equal shares to the first surviving class of the classes listed in the following order: (1) your spouse, (2) your children, (3) your parents, (4) your siblings, and (5) your estate.

Accidental Death & Dismemberment Benefits

Accidental Death and Dismemberment Benefits are not available to Early Retirees or Retired Participants.

Optional Dental and Vision Benefits

Optional Dental and Vision benefits are not available to Early Retirees, Retirees, or their Dependents.

Important Information About the Plan

Name of Plan. Wisconsin Electrical Employees Health and Welfare Plan.

Type of Plan. This multiemployer group health plan is maintained for the purpose of providing health and welfare benefits, including medical, Short Term Disability, Long Term Disability, Death, Accidental Death and Dismemberment, optional preventive dental, optional comprehensive dental and optional vision benefits.

Plan Sponsor and Plan Administrator. A Board of Trustees is the Plan Sponsor and the Plan Administrator and the Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of an equal number of employer and employee representatives, selected by the Employers and the Unions which have entered into Collective Bargaining Agreements that relate to the Plan.

As of January 2025, the Trustees of the Plan are:

Employee Trustees

Jonathan Chermack	Sean Frank	Chris Gulbrandson
IBEW Local Union 14	IBEW Local Union 127	IBEW Local Union 430
9480 Highway 53	3030 39th Avenue	1840 Sycamore Avenue

Fall Creek, WI 54742	Kenosha, WI 53144	Racine, WI 53406
Jesse Jacques IBEW Local Union 158 2970 Greenbriar Road Green Bay, WI 54311	Michael Killian IBEW Local Union 159 5303 Fen Oak Drive Madison, WI 53718	Dean Miller IBEW Local Union 388 5224 Heffron Court Stevens Point, WI 54481
Benjamin Myers IBEW Local Union 890 1900 Reuther Way Janesville, WI 53546	Thomas Schlender IBEW Local Union 577 1024 South Lawe Street Appleton, WI 54915	

Employer Trustees

Jim Eland II Eland Electric Corp. 3154 Holmgren Way Green Bay, WI 54302	Bryan Gawlik E-Con Electric 4610 Plover Road Wisconsin Rapids, WI 54494	John Gerlach NEI Electric 605 Industrial Parkway St. Croix Falls, WI 54024
Jeff Hanson ECI of Wisconsin 6402 32nd Avenue Kenosha, WI 53142	Todd Javoroski CR Meyer 895 West 20th Avenue Oshkosh, WI 54902	Darren Johnson Wisconsin Chapter NECA 2200 Kilgust Road Madison, WI 53713
John Westphal Westphal & Company, Inc. 14 March Court Madison, WI 53718	Daniel Zurawik Westphal & Company, Inc. 14 Marsh Court Madison, WI 53718	

Trustee Address and Telephone Numbers. If you wish to contact the Board of Trustees, you may use the address and telephone numbers below:

Board of Trustees
Wisconsin Electrical Employees Health and Welfare Plan
2730 Dairy Drive, Suite 101
Madison, Wisconsin 53718
(608) 276-9111 or (800) 422-2128
Monday through Friday 7:00 a.m. to 5:00 p.m. CST

A complete list of the employers and employee organizations sponsoring the Plan may be examined at this address. A Plan Participant or beneficiary may obtain a copy of this list for a reasonable charge by writing to the Trustees at this address. In addition, upon written request to the Trustees at this address, a Plan Participant or beneficiary may obtain information as to whether a particular employer or employee organization is a sponsor including the sponsor's address.

Type of Administration. The Board of Trustees has delegated administrative responsibilities to the Plan's Administrative Office or Fund Office. The Administrative Manager is the Chief Executive Officer of the Wisconsin Electrical Health and Welfare Fund Office, LLC.

Wisconsin Electrical Employees Health and Welfare Plan
2730 Dairy Drive, Suite 101
Madison, WI 53718
(608) 276-9111 or (800) 422-2128
Monday through Friday 7:00 a.m. to 5:00 p.m.

Agent for Service of Legal Process. The Plan's Administrative Manager has been designated as the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal document should be served upon the Plan at the following address:

Wisconsin Electrical Employees Health and Welfare Plan
c/o Administrative Manager
2730 Dairy Drive, Suite 101
Madison, WI 53718

In addition, service of legal process may be made upon any member of the Board of Trustees listed above at the address of the Wisconsin Electrical Employees Health and Welfare Plan or such documents may also be served upon any individual Trustee.

Identification Numbers. The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 39-1651543. The Plan Number assigned by the Board of Trustees is 501.

Plan Year. For purposes of maintaining the Plan's records, the fiscal year of the Plan ends on the last day of December each and every year.

Collective Bargaining Agreements. This Plan is maintained pursuant to one or more Collective Bargaining Agreements. Plan Participants and beneficiaries may examine these Collective Bargaining Agreements at the Plan Administrative Office address listed above and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees.

Funding Medium. Benefits are provided from the Plan's assets, which are accumulated under the provisions of the Collective Bargaining Agreement, Participation Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses.

Medical, prescription drug, Short Term Disability, optional Dental, Optional Vision, Supplemental Unemployment Benefits (SUB), Vacation Benefits and Flexible Benefit Account benefits are provided directly by the Plan. The Plan has entered into a contract with Union Labor Life Insurance Company to provide death and accidental death and dismemberment benefits, with Northwestern Mutual Life Insurance Company (NML) to provide Long Term Disability Benefits, and UnitedHealthcare to provide Medicare Advantage and Prescription Drug plan benefits. The Plan has entered into a contract with the Union Labor Life Insurance Company to provide excess stop-loss coverage for certain claims.

The complete Wisconsin Electrical Employees Health and Welfare Plan and copies of the insurance contracts are available for review, upon request, at the Plan Administrative Office.

Rights to Trust Assets. No employee shall have any right to, or interest in, any assets of the Plan upon termination of his employment or otherwise, except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such employee out of the assets of the Plan. All payments of benefits as provided for in this Plan shall be made solely out of the assets of the Plan and none of the fiduciaries shall be liable therefor in any manner.

Disclaimer. None of the benefits provided by the Health and Welfare Plan Rules and Regulations other than Death, Accidental Death and Dismemberment Benefits, Long Term Disability, and Medicare Advantage and Prescription Drug plan benefits are insured by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amounts in the Plan collected and available for such purpose.

Contribution Source. Contributions to the Plan are made by Employers in accordance with Collective Bargaining Agreements between the Union and the Employer, Participation Agreements between the Employer and the Plan in accordance with the Trust Agreement, and in some instances by direct employee and/or beneficiary payments. The amount of the Employer contribution is determined by the provisions of the Collective Bargaining Agreement or Participation Agreement.

Plan Termination. The Board of Trustees intends to continue the Health and Welfare Plan indefinitely. However, in the event the obligations of all Employers to make contributions to the Plan shall terminate or the Plan otherwise terminates, the Trustees shall determine the disposition of any assets in the Trust remaining after all expenses of the Plan have been paid; provided that any such distribution shall be made only for the benefit of former Participants and for the purposes set forth in the Plan.

Amendment. In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program of benefits for all Eligible Employees, the Board of Trustees expressly reserves the right, in its sole

discretion at any time and from time to time, by majority vote to increase, decrease, change or eliminate benefits, eligibility, rules or other Plan provisions as necessary.

Non-Guarantee of Employment. Nothing contained in this Plan shall be construed as a contract of employment between any Employer and any employee, or as a right of any employee to be continued in the employment of any Employer, or as a limitation of the right of any Employer to discharge any of its employees, with or without cause.

Board of Trustees' Discretion and Authority

Under the documents creating the Plan, the Trustees have sole and absolute discretion and authority to make final determinations regarding any application for benefits, including eligibility for participation, or other benefits available under the Plan, the interpretation of the Plan, Summary Plan Description and Agreement and Declaration of Trust, and any administrative rules adopted by the Trustees. To the extent any such duties are delegated to others, the Trustees retain the right to ultimately decide all appeals of self-funded benefits, in the Trustees' sole and absolute discretion. Benefits under this Plan will be paid only if and when the Board of Trustees or persons to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, decide the participant or beneficiary is entitled to benefits under the terms of the Plan. Any exercise by the Trustees of their discretionary authority with respect to construction and interpretation of the Plan, the Summary Plan Description, and the Trust or eligibility for benefits are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. All questions or controversies of whatsoever character arising in any manner or between any parties or persons in connection with the Plan or Summary Plan Description or its operation, whether as to any claim for benefits, as to the construction of the language of the Plan or this Summary Plan Description or any rules and regulations adopted by the Trustees, or as to any writing, decision, instrument, or account in connection with the operation of the Plan or the Summary Plan Description or otherwise, shall be submitted to the Board of Trustees for decision. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner and the Trustees' decisions will be awarded judicial deference in any subsequent court or administrative proceedings.

The Board of Trustees determines the benefits provided in accordance with all Plan provisions. Any required self-payment contributions may vary depending on the benefits provided and other factors.

The Trustees have the authority and retain the right, by written amendment to the Plan, to change, add, or delete benefits, self-payment contribution rates, eligibility rules, or any other provisions relating to the operation of the Fund or discontinue all or part of this Plan whenever, in their sole discretion, conditions so warrant. If the SPD is materially amended or modified, you will be notified in writing.

Prohibition Against Assignment to Providers

You may not assign any right under the Plan or statutory right under applicable law to a provider of services or supplies. You may not designate a provider of services or supplies as a Beneficiary under the Plan. The prohibition against assignment of such rights includes, but is not limited to, the right to:

- Claim benefits in accordance with Plan procedures and/or federal law;
- Commence legal action against the Plan, Trustees, Fund, its agents, or employees;
- Request Plan documents or other instruments under which the Plan is established or operated;
- Request any other information that you may be entitled to receive upon written request to the Plan Administrator; and
- Any and all other rights afforded to you under the Plan, Trust Agreement, federal law, and/or state law.

This provision does not:

- Prohibit a properly appointed authorized representative from acting on your behalf; or
- Prohibit the claims administrator or the Trustees from mailing payment of benefits under the Plan directly to a provider of services or supplies, to any organization or to any person as is needed to properly carry out the provisions of the Plan.

Your Rights and Protections Under ERISA

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

Receive Information About the Plan and Benefits

1. Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all Plan documents, including Health and Welfare Plan Rules and Regulations, insurance contracts, collective bargaining agreements, participation 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.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for such copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions 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, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit fund. The people who operate the 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 benefits under the Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for welfare benefits is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the rights listed above. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which 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. 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 court may order the person you

have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds you claim is frivolous.

Assistance with your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (866-444-3272).

Definitions

Defined terms are capitalized in this booklet. While the official definitions are set forth in the Health and Welfare Plan Rules and Regulations, the following provides a summary of the definitions. Some definitions are also included within the rules described elsewhere in this booklet. In the event of any conflict between the definition in this booklet and the Rules and Regulations, the definition in the Rules and Regulations will control.

1. **"Accident"** means a sudden and unforeseen event or occurrence that results in injury or death.

2. **"Active Employee"** means a person actively employed by an Employer and on whose behalf the Employer is required to contribute to the Plan and who is eligible for coverage under the Plan. The term Active Employee also includes Active Hourly Employee and Active Employer Staff Employee.

3. **"Active Employer Staff Employee"** means a person working in the state of Wisconsin on whose behalf an Employer is required to contribute to the Plan under a participation agreement and who is eligible for coverage under the Plan.

4. **"Active Hourly Employee"** means a person on whose behalf an Employer is required to contribute to the Plan under the terms of a collective bargaining agreement and who is eligible for coverage under the Plan.

5.

6. **"Beneficiary"** means a person designated by a Participant to receive any Death and/or Accidental Death and Dismemberment benefits under the Plan.

7. **"Covered Charges"** or **"Covered Service"** means Medically Necessary services or supplies provided for your care for which benefits are provided under the Plan.

8. **"Covered Employment"** means employment for an Employer for which the Employer is required to make contributions to the Plan under a collective bargaining agreement or other written agreement with the Plan.

9. **"Dependent"** is defined on page 8.

10. **"Disqualifying Employment"** means employment with a non-contributing employer

    (a) in the same "trade or craft" and "industry" in which Participants are engaged and that would have generated a contribution to the Plan if the employment had been performed with an Employer or

    (b) that would otherwise have been performed by an Employer and its employees.

11. **"Early Retiree"** means a Retiree who is under age 65 and not yet eligible for Medicare.

12. **"Eligible Employee"** means an Active Employee, Self-Pay Active Hourly Employee, Self-Pay Disabled Employee, Early Retiree and Retiree. Eligible Employee's surviving spouses are also considered Eligible Employees.

13. **"Emergency"** or **"Medical Emergency"** means a sudden and unexpected Illness or Injury manifested by acute symptoms, including severe pain, that are severe enough that a prudent person could reasonably expect that lack of immediate medical attention would result in the patient's health being placed in serious jeopardy, serious impairment of bodily function, or serious dysfunction of a bodily organ or part.

14. **"Emergency Services**" shall mean services for or in response to an Emergency, including any medical examination and treatment necessary to evaluate and stabilize the patient and post-stabilization services rendered to a patient admitted through a Hospital emergency department or Freestanding Emergency Center.

    Emergency Services generally include all services that are part of the same visit in which the Emergency is treated. However, post-stabilization services that meet all of the following conditions shall not be considered Emergency Services:

    (a) the attending physician determines the patient is able to travel using nonmedical or nonemergency medical transportation to an available participating provider or facility located within a reasonable distance, taking into account the patient's medical condition;

    (b) the provider or facility furnishing the services or items satisfies the notice and consent requirements under the No Surprises Act;

    (c) the patient (or a person authorized by law to provide consent on behalf of the patient) is in a condition to receive the required notice under the No Surprises Act and provide informed consent; and

    (d) the provider or facility satisfies any additional requirements or prohibitions required by state law.

15. **"Employer**" means a company that has entered into a collective bargaining agreement or other written agreement with a Union or the Trustees that requires contributions to the Plan. The term Employer includes the National Electrical Contractors Association, Inc. Wisconsin Chapter; a Union; the Plan (or any wholly owned subsidiary thereof); and any other jointly administered employee benefit plan that is required to contribute to the Plan pursuant to a participation agreement.**"Freestanding Emergency Center"** means any facility that is geographically distinct and licensed separately from a Hospital and that is licensed under state law to provide Emergency Services, regardless of how the facility is classified.**"Home Health Care Agency"** means either a certified rehabilitation agency or a non-profit public home care service or agency, approved by Medicare or otherwise properly licensed by the appropriate licensing authority. **"Hospital**" means an institution that is duly licensed as a hospital, is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis and meets the requirements of the Plan for hospitals. Such requirements include, but are not limited to, the institution provides 24-hour a day nursing services; has a staff or one or more licensed Physicians available at all times; and is not primarily a clinic, nursing facility, rest facility convalescent facility, facility for the aged, or extended care facility.

19. **"Illness**" means a disease, disorder, or condition that requires treatment from a Physician, including pregnancy and Mental Health and Substance Use Disorders.

20. **"Injury"** or **"Bodily Injury**" means physical damage caused by purely accidental means, independent of all other causes.

21. **"Medically Necessary**" or **"Necessary"** means a service or supply that is appropriate and consistent with the diagnosis of your particular condition and that meets the following requirements:

    (a) Is appropriate and necessary for your symptoms;

    (b) Is provided for the diagnosis or direct care and treatment of an Illness or Injury;

    (c) Is within the standards of good medical practice within the medical community;

(d) Is not primarily for your convenience or the convenience of the Physician; and

(e) Is the most appropriate level of services or supplies that can be safely provided.

22. **"Mental Health Disorder"** means any nervous, psychoneurosis, psychopathy, psychosis or mental or emotional disease of any kind regardless of whether such disease or disorder is organic or functional, including bulimia, anorexia nervosa and similar disorders.

23. **"Midwife"** means a certified midwife, a certified nurse midwife or a certified professional midwife licensed by the state in which services were provided and who is acting in accordance with that license.

24. **"No Surprises Act"** shall mean the No Surprises Act that is part of the federal Consolidated Appropriations Act, 2021, its implementing regulations and other underlying guidance.

25. **"Non-PPO**" or **"Non-PPO Provider"** means a Physician or facility that does not participate in the Plan's PPO network.

26. **"Occupational Therapy"** means the use of educational, vocational and rehabilitative techniques to restore a patient's functional ability to previous levels or to live independently.

27. **"Participant**" means an Eligible Employee covered under the Plan.

28. **"Physical Therapy"** means the use of physical agents to treat a disability resulting from disease or injury to restore a patient's functional ability to previous levels. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.

29. **"Physician**" means an individual properly licensed under state law to provide medical services. The term Physician includes medical doctor (M.D.), doctor of osteopathic medicine (D.O.), doctor of dental surgery (D.D.S.), doctor of dental medicine (D.M.D.), doctor of optometry (O.D.), podiatrist (D.P.M.), chiropractor (D.C.), licensed clinical psychologist (Ph.D.) as well as any other practitioner who is licensed under state law to perform a Covered Service and who is acting within the scope of that license.

30. **"PPO**" means Physicians and facilities that are included in the network approved by the Trustees. PPO Providers or PPO facilities are sometimes referred to as "in-network." The Plan's PPO provider is listed on page 62.

31. **"Protected Services**" means Emergency Services provided by a Non-PPO Provider, Non-PPO air ambulance services, and other items and services provided by a Non-PPO Provider at a PPO facility.

32. **"Retiree**" means an Active Employee, Active Employer Staff Employee, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee who has retired under the Plan and elects to continue Plan coverage. Important: you must file the required paperwork with the Fund Office to be considered a Retiree. Being retired for purposes of drawing your retirement plan benefits does not automatically make you a Retiree. See pages 48-50 for more detail.

33. **"Self-Pay Active Hourly Employee**" means an Active Hourly Employee who elects to continue coverage under the self-payment provisions of the Plan.

34. **"Self-Pay Disabled Employee**" means an Active Hourly Employee, Active Employer Staff Employee or a Self-Pay Active Hourly Employee who becomes Totally and Permanently Disabled and elects to continue coverage under the self-payment provisions of the Plan.

35. **"Skilled Nursing Facility**" means a facility for the care and treatment of patients convalescing from an Injury or Illness that meets the Plan's specific requirements and is not, other than incidentally, a rest home or home for custodial care. Such requirements include, but are not limited to, maintenance of permanent facilities for bed care of at least three patients, has a Physician or registered nurse on full-time duty, and has a registered nurse or licensed practical nurse on duty at all times.

36. **"Speech Therapy"** means services used for diagnosis and treatment of speech and language disorders to restore the patient's functional ability to previous levels.

37. **"Substance Use Disorder"** means alcohol or drug use resulting in the need for treatment.

38. **"Totally and Permanently Disabled**" or **"Disabled"** means the complete inability to perform your regular and customary work due to an Illness or Injury. For Dependent children, the term Totally and Permanently Disabled means their complete inability to engage in the normal activities of a person in good health of the same sex and age due to Illness or Injury.

39. **"Union"** means the locals of the International Brotherhood of Electrical Workers AFL-CIO that have adopted the Trust or signed a participation agreement for participation in the Plan.

40. **"Usual, Customary and Reasonable**" or **"UCR"** means:

    (a) For PPO Services: the lesser of the prearranged fee established under the PPO Provider agreement or the actual billed charge;

    (b) For Non-PPO Services: the charge for services and supplies provided by other health care providers in the same geographic area where your services were rendered, as determined by the Plan's PPO Provider;

    (c) For Protected Services: the amount determined in accordance with the No Surprises Act.

To Receive More Information

We hope this booklet has answered your questions regarding the benefits provided by the Health and Welfare Plan. If you have any questions, we invite you to call us. We will be available to answer your questions during normal business hours on Monday through Friday 7:00 a.m. to 5:00 p.m. CST. Our phone numbers are: (800) 422-2128 or (608) 276-9111.

If you wish to write to the Trustees, write to:

Board of Trustees
Wisconsin Electrical Employees Health and Welfare Plan
2730 Dairy Drive, Suite 101
Madison, WI 53718

Schedule of Benefits Life Insurance – Death Benefit

Employees and Retirees	
Under age 65	$10,000
Ages 65-69	$6,500
Age 70+	$5,000

Accidental Death and Dismemberment – Eligible Employees only

For Loss Of:	**The Benefit Is:**		
	Under age 65	**Ages 65-69**	**Age 70+**
Life, 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, speech and hearing, quadriplegia	$10,000	$6,500	$5,000
One hand, one foot, sight of one eye, four or more fingers on one hand, paraplegia, hemiplegia, speech, hearing	$5,000	$3,250	$2,500
Thumb and index finger	$2,500	$1,625	$1,250

Disability Benefits – Eligible Employees Only

Short-Term Disability	$500 per week for 26 weeks
Long-Term Disability (Transitional)	$100 minimum/$2,000 maximum per month

Medical Benefits (refer to pages 17-26 for detail on Covered Medical Charges)

	PPO	**Non-PPO**
Calendar Year Deductible		
Individual	$500	
Family	$1,500	
➢ *PPO and Non-PPO Covered Charges apply to a single calendar year deductible.*		
➢ *Does not apply to PPO ACA Preventive Care services, routine well-baby nursery care, routine physical examinations, prescription drug expenses, or dental or vision benefits*		
Annual Out-of-pocket Maximum		
Individual	$1,350	Unlimited
Family	$4,050	Unlimited
➢ *Only PPO charges and Protected Services are applied to the PPO out-of-pocket maximum*		
➢ *Does not include calendar year deductible, prescription drug expenses, dental or vision expenses, excluded services, amounts in excess of any maximums or balance billed charges.*		
Coinsurance Amount (applicable to all covered medical benefits unless otherwise specified)		
Plan pays	90%	70%
You pay	10%	30%
Special Benefit Provisions/Limitations		
Virtual Benefits		
LiveHealth Online visit for medical, Mental Health and Substance Use Disorders	Plan pays 100%	Not covered

	PPO	Non-PPO
Sword Health virtual physical therapy	Plan pays 100%	Not covered
ACA Preventive Care Services	Plan pays 100%	Plan pays 100% up to $450 per year, then 10%
Emergency Room	Plan pays 90%	Plan pays 90%
Protected Services	Plan pays 90%	Plan pays 90%
Ambulance – ground or air	Plan pays 90%	Plan pays 90%
Nutritional Counseling	Plan pays 90%	Plan pays 70%
	Limited to 6 visits per person per year (visit limit does not apply to mental health or substance use disorder conditions)	
Orthotics		
Covered Charges up to $10,000 per person per lifetime	Plan pays 90%	Plan pays 70%
Covered Charges in excess of $10,000 per person per lifetime	Plan pays 50%	Plan pays 50%
For chronic conditions of the foot otherwise excluded by the Plan	Plan pays 90%	Plan pays 70%
	Limited to $500 per person every 5 years	
Hearing Benefit	Plan pays 100% up to maximum of $1,500 per person every 3 years	
Transplant Benefit – must use Transplant Network	Plan pays 90%	Not covered

Prescription Drug Benefits

Copayment	**PPO**	**Non-PPO**
Generic Drugs		
30-day fill	You pay $10	You pay $10
61 to 90-day fill	You pay $15	You pay $15
Brand Drugs		
30-day fill	You pay $50	You pay $50
61 to 90-day fill	You pay $75	You pay $75
Maintenance Drugs		
Generic up to 60-day fill	You pay $10	You pay $10
Generic 61 to 90-day fill	You pay $15	You pay $15
Brand up to 60-day fill	You pay $50	You pay $50
Brand 61 to 90-day fill	You pay $75	You pay $75
ACA Preventive Care services – including smoking cessation drugs and vaccines	No charge	No charge
Diabetic supplies and insulin	You pay 20%	You pay 20%
Specialty drugs	You pay the generic or brand drug copay, as applicable	

- *If you fill a prescription at a Non-PPO Pharmacy, you must pay the full cost of the drug and then submit a refund request to the Fund Office.*
- *If you choose a brand drug when a generic equivalent is available, the Plan will pay only the amount it would have paid for the generic drug. You will pay the brand drug copay plus the difference in cost from the generic drug. This rule does not apply if your Physician provides a letter of Medical Necessity.*
- *You may be required to participate in the High Impact Advocacy Program or a Patient Assistance Program for your specialty drugs.*

Annual Out-of-Pocket Maximum

Individual	$7,350	Unlimited
Family	$12,850	Unlimited

- *Only drugs filled at a PPO pharmacy are applied to the PPO out-of-pocket maximum*
- *Does not include medical benefits, brand drugs that have a generic equivalent, excluded drugs or balance billed charges*

Annual Maximum	$10,000, then the Plan pays 50% up to the annual out-of-pocket maximum

- *Does not apply to diabetic supplies and insulin or injectable drugs purchased at a PPO Provider and administered at home*

Optional Dental Benefits (refer to pages 29-32 for detail on Covered Dental Charges)

Preventive Dental Benefits	
Deductible	None
Coinsurance	Plan pays 100%
Comprehensive Dental Benefits	
Deductible	None
Annual Maximum	$1,700
Coinsurance	
Preventive services	None
Basic and Major Services	Plan pays 80%
Orthodontia	
Coinsurance	Plan pays 50% of the first $1,400 in Covered Charges and 100% of the next $1,800 in Covered Charges
Lifetime maximum	$2,500

Optional Vision Benefits (refer to pages 32-33 for detail on Covered Vision Charges)

Deductible	None
Coinsurance	Plan pays 100% up to annual maximum
Annual Maximum	$400

Important Addresses and Telephone Numbers

Fund Office

Wisconsin Electrical Employees Benefit Fund LLC
2730 Dairy Drive, Suite 101
Madison, WI 53718
(608) 276-9111 or (800) 422-2128
www.weebf.com

PPO/Medical Network Provider

Anthem Blue Cross Blue Shield
P.O. Box 951254
Cleveland, OH 44193
Provider Locator: (800) 810-BLUE
Provider Eligibility/Benefits: (800) 676-BLUE
Member Eligibility/Benefits: (800) 422-2128
24/7 Nurse Line: (866) 670-1565
www.anthem.com

Prescription Drug Network Provider

SAV-RX
224 N. Park Avenue
Fremont, NE 68025
(800) 228-3108

Telehealth Provider

Anthem — Live Health Online
www.livehealthonline.com
(855) 603-7985

Employee Assistance Plan

Northwestern Mutual
Phone 888-893-6585
answers@healthadvocate.com
https://www.healthadvocate.com/NM3

Virtual Physical Therapy

Sword Health
13937 Sprague Lane Suite 100
Draper UT 84020
Phone 888-492-1860
help@swordhealth.com
join.swordhealth.com/WEEBF

Medicare Advantage Plan Insurer

UnitedHealthCare
Retiree Advocate at Retiree First
Phone 833-550-1678

Long-Term Disability Insurer

Northwestern Mutual Life Insurance Company
PO Box 2177
Portland OR 97208-2177
Phone 800-378-4665

Utilization Review

Conifer Health Solutions
9200 Shelbyville Rd., Ste. 400
Louisville, KY 40222
Precertification: (866) 850-4932
Facsimile: (866) 315-6314

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