ELECTRICAL WORKERS LOCAL 369

BENEFIT FUND

SUMMARY PLAN DESCRIPTION
2022 EDITION

For Inside Wireman, Market Recovery Agreement (MRA) Program and Construction Wireman/Construction Electrician (CW/CE) Employees

Electrical Workers Local 369 Benefit Fund

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This booklet, which replaces and supersedes any prior Summary Plan Description, contains only highlights of certain features of the Electrical Workers Local 369 Benefit Fund, including highlights of the Electrical Workers Local 369 Benefit Plan affecting only Market Recovery Agreement (MRA) Employees and Construction Workers/Construction Electrician (CW/CE) Employees. Full details are contained in the Plan document that establishes the Plan provisions. If there is a discrepancy between the wording here and the document that establishes the Plan, the Plan document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

To Our Participants:

The Electrical Workers Local 369 Benefit Fund offers you a wide range of benefits, including:

- Medical;
- Prescription Drug;
- Dental;
- Vision;
- Hearing;
- Weekly Disability;
- Death; and
- Accidental Death and Dismemberment (AD&D).

This Summary Plan Description for the Electrical Workers Local 369 Benefit Fund Plan outlines benefits, effective as of July 1, 2022, available to you and your eligible dependents, if applicable, based on your status under the Plan (Active Employee, Disabled Employee, Retired Employee, Surviving Spouse, or Eligible Dependent). This booklet replaces and supersedes any prior booklet.

The Plan is funded by Employer contributions and, under certain circumstances, self-payment contributions; it is **not** insured by an insurance company. In some instances, the Board of Trustees of the Plan has delegated administrative responsibilities to other organizations, but all benefits are paid from the Fund's assets.

In this booklet, we have tried to describe your benefits as completely as possible and in everyday language. We have also tried to organize the booklet in a way that will be useful to you. This booklet includes:

- A summary of the coverages provided by the Plan (see the *Summary of Benefits* insert for the Program under which you are covered);
- A listing of important contact information (see the *Important Contact Information* insert);
- A life events section designed to show you how your benefits work and how they fit into the different stages of your life;
- Information about when you and your dependents, if applicable, are eligible for coverage under the Plan;
- An explanation about your coverage under each benefit program;
- Information about how to file claims;
- General Plan administrative information; and
- A glossary of important terms.

We urge you to read the booklet and, if you are married, to share it with your spouse. We recommend that you keep this booklet with your important papers so you can refer to it when needed.

Sincerely,

Board of Trustees

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Notice of Grandfathered Health Plan Status

The Electrical Workers Local 369 Benefit Fund believes its entire plan of benefits, including the retiree option provided therein, is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage already in effect before the law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plan must comply with certain other consumer protections in the Affordable Care Act (for example, eliminating lifetime limits on benefits).

You can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You can reach the EBSA by phone at 866-444-3272 or by accessing their website at www.dol.gov/ebsa/healthreform, where you can see a chart summarizing the protections that do and do not apply to grandfathered health plans. You may also contact the Plan Administrator with your questions by calling 502-635-2611 or 800-427-2495.

PLAN PARTICIPATION

The Plan provides coverage to eligible Employees (including Active and Disabled Employees). Coverage for Eligible Dependents, Surviving Spouses and their Eligible Dependents, and Retired Employees depends on the Active or Disabled Employee's classification. This section describes the eligibility requirements for Active Employees and defines dependents eligible for coverage under the Plan. For more information on:

- Disabled Employee eligibility, see page 8;
- Retired Employee eligibility, see page 9; or
- Surviving Spouse eligibility, see page 10.

Generally, you are eligible for benefits from the Fund if you work for an Employer that contributes on your behalf. When you are eligible, coverage for Eligible Dependents of Inside Wireman and Construction Workers/Construction Electricians (CW/CE) Employees is automatic. However, upon becoming initially eligible for benefits, you will need to complete an enrollment card for you and your Eligible Dependents. You will also be asked to provide appropriate documentation, such as a marriage certificate, birth certificate, or divorce decree, as applicable. Market Recovery Agreement (MRA) Employees may cover Eligible Dependents provided you elect family coverage and pay the required monthly self-payment amount.

Initial Eligibility

You will be initially eligible and your coverage will begin on the first day of the second month following the month in which at least $1,950 in Employer contributions have been made to the Fund on your behalf during a 12-consecutive month period. If you are an MRA or CW/CE Employee, your Employer must have signed an Agreement agreeing to cover your Employee classification.

When at least $1,300 in contributions have been made on your behalf in a 12-consecutive month period, you may be eligible and coverage may begin sooner if you:

- Have (or have had within the immediately preceding 30 days) medical coverage as an employee (not as a dependent);
- Provide proof of your prior coverage; and
- Are working in Covered Employment at the time of enrollment in the Plan.

If you meet the above requirements, your coverage will begin not less than 30 days or more than 59 days after your eligibility ends in your prior health care plan.

Initial Eligibility Example

Pat began working for an employer on April 1. By July 31, the Fund had received $2,275 in Employer contributions on his behalf. Since Pat's contributions exceed $1,950, Pat is eligible for coverage as of September 1, the first day of the second month following the month in which sufficient contributions were received on his behalf. The additional $325 ($2,275 minus $1,950) of contributions made is credited to Pat's Dollar Bank (see page 2).

Initial Eligibility for Certain Groups

Certain groups have contracted with the Fund under different Eligibility Rules. Employers of these groups make the required monthly contribution to the Fund on the Employee's behalf in one month and the Employee becomes initially eligible on the first day of the following month. For Employees of these groups, the Benefit Month is the month following the month the contribution was made and is not governed by the Work Month and corresponding Benefit Month, shown in the chart below. If you are an Employee of one of these groups, your eligibility will continue on a monthly basis as long as your Employer makes contributions to the Plan. You may not make self-payment contributions while your Employer contributes on your behalf.

Continuing Eligibility

Eligibility for coverage continues on a month-by-month basis. As long as you are working in Covered Employment and have sufficient contributions made on your behalf to cover the monthly cost of coverage, your benefits will continue.

Continuing eligibility is based on Work Months and Benefit Months. A Work Month is a calendar month during which Employer contributions are made to the Fund on your behalf for the hours you worked in that month. A Benefit Month is a calendar month during which you are eligible for benefits based on the Employer contributions made on your behalf during the corresponding Work Month.

For your coverage to continue for the next Benefit Month, you must continue to work in Covered Employment and your Employer must make sufficient contributions on your behalf in the corresponding Work Month to cover the monthly cost of coverage.

Work Month Work performed during:	Benefit Month Determines your eligibility for:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

The monthly cost of coverage is determined by the Trustees based on the actual cost of providing benefits. The Trustees, in their sole discretion, reserve the right to modify this amount periodically. You will be notified of any change in the monthly cost of coverage.

If contributions made on your behalf in a Work Month are:

- Less than the monthly cost of coverage for the corresponding Benefit Month, the additional amount needed will be deducted from your Dollar Bank, if available; or
- More than the monthly cost of coverage for the corresponding Benefit Month, the additional amount will be credited to your Dollar Bank.

Continuing Eligibility Example

In June, Dana, who is an Inside Wireman employee and is currently eligible for coverage, has only $768.75 in Employer contributions made on her behalf and, therefore, needs $296.25 more to be eligible for coverage in August. Since Dana has a credit of $1,565 in her Dollar Bank, the additional amount is deducted from Dana's Dollar Bank, leaving her with a balance of $1,268.75 in her Dollar Bank.

Dollar Bank

The Dollar Bank program is designed so that the more you work, the more your Dollar Bank may grow. Contributions that your Employer makes on your behalf are based on the number of hours you work each month and are credited to your Dollar Bank. You may accumulate a maximum balance of 12 months of coverage in your Dollar Bank (currently $12,780 for Inside Wireman Employees, $9,480 for CW/CE Employees and $6,840 for MRA Employees, based on a monthly cost of coverage of $1,065 for Inside Wireman Employees, $790 for CW/CE Employees and $570 for MRA Employees).

If contributions made on your behalf in a Work Month are less than the monthly cost of coverage for the corresponding Benefit Month, the additional amount needed will be deducted from your Dollar Bank, if available. If the amount credited to your Dollar Bank does not cover the monthly cost of coverage, you may be eligible to make self-payment contributions for the difference.

If you are an MRA Employee, the Dollar Bank program is only for you and is used to pay your cost of coverage. You cannot use your Dollar Bank to pay for family coverage. When you retire, you will continue participating in the plan for active MRA Employees until the depletion of your Dollar Bank. At that time, you must enroll in the Retired Employee Program to maintain coverage under the Plan (see page 9). Once you enroll in the Retired Employee Program, you cannot enroll again in the Active Employee Program even if you return to work in the electrical trade.

Continued Eligibility If You Become Disabled

If you become disabled due to a non-occupational Sickness or Injury and are entitled to Weekly Disability Benefit payments or if you receive payments under a Workers' Compensation or Occupational Disease law, you will remain eligible for the remainder of the benefit month during which you became disabled. You will be awarded contributions to your Dollar Bank for each full or partial week that you are entitled to the Weekly Disability Benefit, Workers' Compensation or Occupational Disease payments, subject to a maximum of 13 weeks for Weekly Disability Benefits, a maximum of six weeks (traditional delivery) or eight weeks (Cesarean section) for Weekly Maternity Benefits for Female Active Employees, or a maximum of 12 months for Workers' Compensation or Occupational Disease. If you have been awarded the maximum amount to your dollar bank but your disability continues, you will be required to make self-contributions to continue eligibility for you and your Eligible Dependents, if applicable.

No contributions will be made to your Dollar Bank if the Fund discovers that you are working in the electrical industry or otherwise during your period of disability. The Fund Office will send you written notification of the termination of contributions. You will have the right to appeal this decision (see page 27).

Reciprocal Hours

If you are working outside the jurisdiction of the Plan for an employer that is contributing to a fund other than this Fund, you may maintain your eligibility under this Plan by having those contributions transferred to this Fund. Contributions may be transferred if:

- The fund to which the contributions have been made has a reciprocal agreement with this Fund;
- You have been eligible for benefits under this Fund at least once during the preceding six years;
- You are not eligible for benefits under the other fund; and
- You are registered on the IBEW/NECA Electronic Reciprocal Transfer System (ERTS).

Contributions will continue to be transferred until you notify the other fund to cease the transfer. To stop the transfer, you must use the IBEW/NECA ERTS. Contact your Local Union or the Fund Office for more information about ERTS.

Dependent Eligibility

Your Eligible Dependents become eligible for coverage on the same date you become eligible, or if later, on the date you acquire an Eligible Dependent. For all Inside Wireman and CW/CE Employees, Employer contributions must be made on your Eligible Dependents' behalf in order for your Eligible Dependents to be covered. For MRA Employees to cover Eligible Dependents, you must elect family coverage and pay the required monthly self-payment amount. The self-payment amount is due to the Fund Office by the 15th of each month. Whenever you acquire a new Eligible Dependent, you should contact the Fund Office to update your personal information on file. In addition, you should notify the Fund Office of any change in your address.

Your Eligible Dependents are eligible for the same coverage you are, with the exception of the Weekly Disability, Death, and AD&D Benefits. Your Eligible Dependents are your legally married spouse and children up to the end of the month in which they turn age 26. You must submit written proof of your child's dependency status to the Fund Office, if requested.

Children include your natural children, stepchildren, foster children and legally adopted children (including children placed with you for adoption). You must provide satisfactory proof of dependency, if requested.

You may also extend coverage for your unmarried child after age 26 if your child is incapable of self-sustaining employment due to mental impairment or a physical handicap that existed before age 26, provided your child remains dependent on you for support. Your child will be considered dependent on you if your child resides with you for more than one half of the calendar year and is dependent on you for more than one half of the child's support and maintenance. Such coverage will continue as long as your child remains eligible. You must provide satisfactory written proof of your child's incapacity and dependency to the Fund Office within 31 days of your dependent's 26th birthday, and periodically thereafter upon request.

If your disabled child's principal place of residence is not with you, eligibility depends on their ability to meet the other non-residence-related requirements above (support and relationship tests) and to meet the following conditions:

- The Child's parents are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or live apart at all times during the last six months of the calendar year;
- The Child's parents provide over one-half of the Child's support; and
- The Child is in the custody of one or both of his or her parents for more than one-half of the calendar year; and
- The Child is the qualifying child or qualifying relative, as defined in the Tax Code, of one of the parents; or
- Not the dependent of any other person during the calendar year.

When Eligibility Ends

When your coverage or your Eligible Dependent's coverage ends, you or they may be eligible to continue coverage by making monthly payments for COBRA Continuation Coverage (see page 12).

For You

Your eligibility for coverage under the Plan will end on the:

- First day of the month in which you do not meet the Plan's continuing eligibility requirements;
- First day of a Benefit Month for which you do not make the required self-payment contribution by the due date;
- Date you do not timely elect COBRA Continuation Coverage;
- Date of your death; or
- Date this Plan ends.

For Your Eligible Dependent

Your Eligible Dependent's eligibility for coverage will end on the earlier of the:

- First day of the month in which you do not meet the Plan's continuing eligibility requirements (Inside Wireman and CW/CE Employees); the date in which you do not meet the Plan's continuing eligibility requirements (MRA Employees);
- Date a dependent no longer meets the Plan's definition of an Eligible Dependent (Inside Wireman and CW/CE Employees); last day of the month a dependent no longer meets the Plan's definition of Eligible Dependent (MRA Employees);
- Last day of the month in which your Eligible Dependent Child reaches age 26;
- First day of a Benefit Month for which the required self-payment contribution is not made by the due date;
- Date coverage would terminate in accordance with other provisions of the Plan;
- Date your Eligible Dependent does not timely elect COBRA Continuation Coverage;
- Date specified in a Qualified Medical Child Support Order (QMCSO) for an Alternate Recipient receiving coverage under the QMCSO.
- Last day of the month that a legal separation order or decision of the court is entered;
- Last day of the month a divorce decree is entered by the court and finalized; or

- Date this Plan ends.

In the event of your death, and if you had family coverage prior to your death, your Surviving Spouse may continue coverage for himself/herself and any Eligible Dependents under either COBRA Continuation Coverage (see page 10) or the Surviving Spouse Program (see page 10).

Reinstating Your Eligibility

If your coverage ends, you may reinstate eligibility by again meeting the Plan's initial eligibility requirements (see page 1). If you are an MRA Employee, your you must wait 12 consecutive months to reinstate Dependent coverage if coverage is terminated for non-payment.

Changing Classification to/from the MRA Plan

The Market Recovery Agreement (MRA) Program is an alternate program in the same Fund as the Inside Wireman Program. The MRA Program provides benefits for employees working for Employers that contribute to the Fund at different hourly rates than the Inside Wireman Program. As an active participant in the Inside Wireman Program, you may change classification and begin working for an Employer that participates in the MRA Program.

However, you first must meet that program's eligibility rules to participate in the MRA Program. Once you meet the initial eligibility requirements for the MRA Program, you will be entitled to the MRA schedule of benefits. Until you become eligible, you may continue your coverage under the Inside Wireman Program by making the necessary self-payment contributions.

If you change classification, you must notify the Fund Office of your change as soon as possible. If you do not contact the Fund Office, you will remain in the Inside Wireman Program until the Fund Office is notified of your change in classification. Upon notification, the Fund Office will transfer your Dollar Bank balance from the Inside Wireman Program to the MRA Program and have the amount apply towards your eligibility for the MRA Program.

For Example

Chris, who is currently eligible for Inside Wireman coverage, has a credit of $1,200 in his Dollar Bank when he moves to work for an Employer participating in the MRA Program. Chris notifies the Fund Office of his change in classification, after which the $1,200 credit in his Inside Wireman Dollar Bank is transferred to his new Dollar Bank with the MRA Program and will count toward meeting the initial eligibility requirements for Chris to have coverage with his new Employer. Chris may make the monthly self-payment contributions of $1,065 in the meantime to continue Inside Wireman coverage until he becomes eligible for MRA coverage.

LIFE EVENTS

Different events can affect your benefits coverage. Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when some of these life events occur.

Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Electrical Workers Local 369 Benefit Fund at (502) 635-2611 or (800) 427-2495.

The Children's Health Insurance Program Reauthorization Act of 2009 created two new special enrollment events if you are eligible for the Plan but are not enrolled in the Plan. First, if you or your Dependents were covered under Medicaid or a state CHIP plan and lose that coverage, you or your Dependents are entitled to a special enrollment period in this Plan. Second, if you or your Dependents become eligible for the state's health plan assistance program you are entitled to a special enrollment period. You have 60 days to notify the Plan of the event, and 31 days to provide proof of eligibility and enroll.

Contact the Fund Office to request special enrollment.

Getting Married

When you get married, your spouse is automatically eligible for dependent coverage under the Plan. MRA Employees must elect family coverage and self-pay the monthly family coverage amount in addition to your self-pay amount. Once you provide the required information (and pay the required self-payment amount in a timely manner, if you are an MRA employee), coverage for your spouse begins on the date of your marriage. At this time, you also may want to consider updating your beneficiary information for your Death and AD&D Benefits.

If your spouse is covered under another group medical plan, you must report such other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with your spouse's other coverage; benefits for your spouse under this Plan will be paid after any benefits are payable from your spouse's plan.

If you get married, submit the following information to the Fund Office:

- A copy of your marriage certificate;
- Your spouse's date of birth; and
- A copy of your spouse's medical information if he or she is covered under another plan.

Adding a Child

Your biological child will be eligible for coverage on the date of birth. MRA Employees must elect family coverage and self-pay the monthly coverage amount for the child to be covered, in addition to your own self-pay. If you adopt a child or have a child placed with you for adoption or foster care, coverage will become effective on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of an Eligible Dependent. Stepchildren are eligible for coverage on the date of your marriage. No benefits will be paid until the required information is received (and you make the required monthly self-payments) if you are an MRA Employee.

If you add a new child to your family, submit the following information to the Fund Office:

- The birth date, effective date of adoption or placement for adoption, or a copy of your marriage certificate (for stepchildren);
- A copy of the birth certificate, adoption papers, or marriage certificate (for stepchildren); and
- A copy of your child's other medical insurance information if he or she is covered under another plan.

If You Become Legally Separated or Divorced

If you and your spouse become legally separated or divorced, your spouse will no longer be eligible for coverage as a dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse must notify the Fund Office within 60 days of the divorce or legal separation for your spouse to obtain COBRA Continuation Coverage. At this time, you may also want to review your beneficiary designation for your Death and AD&D Benefits.

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for a Dependent child(ren), as determined by a court order. You may obtain a copy of the Plan's procedures for handling QMCSOs, at no charge, by contacting the Fund Office.

If you become legally separated or divorced from your spouse, you must submit to the Fund Office a copy of your separation or divorce decree and, if applicable, a copy of your QMCSO.

Child Losing Eligibility

In general, your child is no longer eligible for coverage at the end of the month in which they reaches age 26.

Once your child is no longer eligible for coverage under the Plan, they may elect to continue coverage under COBRA for up to 36 months. You must notify the Fund Office within 60 days of when your child is no longer eligible for coverage or your child may lose his or her right to COBRA.

If your child is not capable of self-supporting employment upon attaining age 26 because of a physical handicap or mental impairment, you may continue coverage for that child for as long as your own coverage continues and the child depends on you for support. To qualify, your child's disability must begin before their coverage would otherwise end and you must provide written proof of your child's incapacity to the Fund Office within 31 days of the child attaining age 26. Additionally, you must provide proof periodically thereafter, upon request from the Fund Office.

Taking a Leave of Absence Under the FMLA

Under the Family and Medical Leave Act (FMLA), you may be able to take up to 12 weeks of unpaid leave during any 12-month period. You may take FMLA leave due to:

- The birth of a child or placement of a child with you for adoption;
- The care of a seriously ill spouse, parent, or child;
- Your serious illness; or
- Effective when final regulations have been adopted by the Department of Labor, you have an urgent need for leave because your spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

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

- Be your spouse, son, daughter, parent, or next of kin;
- Be undergoing medical treatment, recuperation, or therapy, for a serious illness or Injury incurred in the line of duty while in military service; and
- Be an outpatient, or on the temporary disability retired list of the armed services.

During your leave, you will maintain all of the coverage offered through the Fund. The Fund will continue eligibility for a family medical leave and maintain your prior eligibility status until the end of the leave, provided your Employer properly grants the leave under federal law, makes the required notification, and contributes to the Fund for the time of the leave.

Contact your Employer for more information regarding your rights under the Family and Medical Leave Act.

Taking a Military Leave

If you enter the uniformed services, you may elect to continue your health coverage (medical, prescription drug, vision and hearing), in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your health care coverage will continue under the Plan if you serve for up to 31 days.

If you serve for more than 31 days, you may continue your coverage at your own expense until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after coverage ended.

Uniformed service includes service in the United States Armed Forces, the Army National Guard, the Air National Guard, National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or emergency. Service means the performance of duty on a voluntary or involuntary basis under competent authority and includes active duty, active duty training, initial active duty for training, inactive duty training, full-time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

You must give advance notice of your military service and provide a copy of your uniformed service orders to the Fund Office, unless you are unable to do so because of military necessity, advance notice is impossible, or it is unreasonable under the circumstances.

Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described in the "COBRA Continuation Coverage" section beginning on page 10, except that only the Employee has the right to elect USERRA coverage for himself or herself and his/her Dependents, if applicable, and that coverage will extend to a maximum of 24 months.

Generally, if you return to work within five years after you enter service, you will be reinstated for Plan benefits as if you had not left for military service if:

- You notify the Fund Office that you were called to service;
- You pay any required premiums;
- You leave service under conditions that are not dishonorable; and
- You report for work or apply for reemployment within the period specified in the following chart after you complete your active duty.

Length of Military Service	Reemployment Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

If you are hospitalized or otherwise incapacitated by a service-related illness or Injury, your reemployment deadlines may be extended up to two years.

Your coverage will continue until the last day of the month that you enter service. After that, to continue coverage, you or your Eligible Dependent must make the required self-payment contribution for coverage. However, if you have an unused amount in your Dollar Bank, it may be used toward continuing coverage for you and/or your Eligible Dependents before you begin making self-payment contributions for coverage or you may freeze your Dollar Bank until you return from service.

Your USERRA coverage may be terminated if:

- You do not pay the required premium for continuation of coverage;
- You exhaust the 24-month coverage period;
- The Plan ceases to provide group health coverage;
- You lose your rights under USERRA (for instance, for a dishonorable discharge); or
- You fail to return to work or apply for reemployment within the time required under USERRA.

However, your coverage will end at midnight on the earliest of the day:

- Your coverage would otherwise end as described above;
- Your former Employer ceases to provide any health plan to any Employee;
- Your self-payment contribution is due and unpaid; or
- You again become covered under the Plan.

If you are an Inside Wireman or CW/CE Employee, your Eligible Dependents may continue coverage under the Plan during your term of service by using any unused amounts in your Dollar Bank. However, if you elect to freeze your Dollar Bank until your return from service, your Eligible Dependents may continue coverage by self-paying for COBRA Continuation Coverage.

You need to notify the Fund Office in writing when you enter the uniformed services. For more information about continuing coverage under USERRA, contact the Fund Office.

When You Do Not Continue Coverage Under USERRA

If you do not continue coverage under USERRA, your coverage will end on the last day of the month in which you enter active uniformed service. You and your Eligible Dependents, if applicable, will have the opportunity to elect COBRA Continuation Coverage.

Reinstating Your Coverage

Once you are discharged from uniformed service, you may be eligible to apply for reemployment with your former Employer in accordance with the terms of USERRA and elect reinstatement in any existing health coverage provided by your Employer.

Upon honorable discharge or release, your eligibility will be reinstated if you make yourself available for work in the jurisdiction of the Union by the reemployment deadlines specified on the prior page. If your Dollar Bank has been depleted, you will be required to make self-payment contributions to maintain your eligibility. It is your responsibility to inform the Fund Office (in writing) of your return from service by the reemployment deadline.

If You Become Disabled

If you become disabled due to an Injury, you may also be eligible for an AD&D Benefit (see page 23).

If you have applied for a disability benefit from the Social Security Administration but have not yet received benefits (and you are not registered on the Union's out-of-work list), you may be entitled to make self-payment contributions to continue your eligibility for benefits under the Plan after the maximum amount has been awarded to your dollar bank. The amount and frequency of the self-payment contributions are determined by the Trustees.

You will be required to submit written proof of application for disability benefits from the Social Security Administration. You may continue self-payment contributions for up to 12 months or until you receive Social Security disability benefits, whichever occurs first. At the end of the initial 12-month period, or at such time as the Trustees may deem necessary, you may be required to provide written proof of your continued attempts to obtain Social Security disability benefits. If you do not provide the required proof when requested, you may not be eligible to make self-payment contributions to continue your eligibility and your coverage will end on the last day of the period for which the most recent self-payment contribution was made.

If, at the end of the initial 12-month period, you have not received disability benefits from the Social Security Administration but you provide satisfactory written evidence of your continued efforts, the Trustees may extend self-payment contributions for up to a maximum of 18 additional months.

If you are out of work due to a non-work related disability, you should:

- Notify your Employer and the Fund Office;
- Provide the Fund Office with proof of your disability; and
- Apply for Weekly Disability Benefits.

Work-Related Disability

If you are out of work due to a work-related disability, you should:

- Notify your Employer and the Fund Office; and
- Contact your local workers' compensation office to apply for workers' compensation benefits.

Temporary Disability

If you are out of work due to a non-work related disability, you may receive Weekly Disability Benefits. Benefits continue until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first (see page 22).

If you are out of work due to a work-related disability, you may be eligible for workers' compensation. Contact your local or state workers' compensation office. The Fund does not provide coverage for any work-related disability.

If you are disabled and receiving Weekly Disability Benefits, workers' compensation, or occupational disease benefits, you will be credited with the cost of monthly benefits for each full or prorated partial week of disability toward meeting the Plan's continuing eligibility requirements, subject to a maximum of 13 weeks for Weekly Disability Benefits, a maximum of 6 weeks (traditional delivery) or 8 weeks (Cesarean section) for Weekly Maternity Benefits for Female Active Employees, or a maximum of 12 months for Workers' Compensation or Occupational Disease. This amount is subject to change as the contribution rate changes. No credit will be given without a qualified Medical Doctor's (M.D.) or Doctor of Osteopathy's (D.O.) statement of disability received by the Fund Office. If your disability continues, you can self-pay for coverage.

Total and Permanent Disability

If you become totally and permanently disabled (see page 8), you may be eligible to continue coverage for yourself and your Eligible Dependents under the Plan's Disabled Employee Program. You must make self-payment contributions for this coverage. Coverage may continue until you:

- Are no longer disabled;
- Reach retirement age, at which time you may be eligible for coverage under the Plan's Retired Employee Program; or
- Die.

Coverage under the Plan's Disabled Employee Program is coordinated with Medicare. For more information on the Plan's Disabled Employee Program, see page 8.

When You Are Not Working

You may make self-payment contributions to continue your coverage under the Plan if you would otherwise lose eligibility under the Plan due to unemployment or lack of hours. If you are unemployed for more than one Benefit Month, you may make self-payment contributions to continue your eligibility for coverage for up to 18 months. If you are an MRA Employee, you must also continue making the self-payments

for family coverage, if applicable, in addition to your own self-pay amount. The monthly cost of coverage when you are not working and have exhausted your Dollar Bank balance is currently $1,065 for Inside Wireman Employees, $790 for CW/CE Employees and $570 for MRA Employees), per month. Self-payment contributions are due to the Fund Office within 30 days of the first day of the Benefit Month.

Coverage through self-payment contributions will run concurrently with COBRA Continuation Coverage. Regardless of either option, you can continue your eligibility for coverage under the Plan only for up to a total of 18 months.

As a reminder, if you elect COBRA Continuation Coverage, you will no longer be eligible for the Death Benefit, Weekly Disability Benefit, or AD&D Benefit provided under the Plan. Your payments will be due within the same timeframe of when COBRA Continuation Coverage payments are due.

Eligibility While You Are Not Working Example

In July, Chris, who is a CW/CE Employee and is currently eligible for coverage, had no employer contributions made on his behalf and has no balance in his Dollar Bank. Chris must make a self-payment contribution of $790 to continue eligibility for September.

In the Event of Your Death

Your spouse and/or Eligible Dependents, if applicable, may continue health care coverage by electing coverage under the Surviving Spouse Program (see page 10) or by electing COBRA Continuation Coverage (see page 10).

In the event of your death, your spouse or beneficiary must:

- Notify the Fund Office;
- Provide the Fund Office with a copy of your death certificate;
- Apply for your Death Benefit (and AD&D Benefit, if applicable); and
- If your Eligible Dependents want to continue coverage under the Plan, enroll for Surviving Spouse benefits or COBRA, as applicable.

When You Retire

The Plan offers you the opportunity to continue coverage once you retire. Depending on your age and your Eligible Dependents' ages when you retire, you may have different options for your coverage under the Retired Employee Program (see page 9).

CONTINUING COVERAGE

Disabled Employee Program

The Disabled Employee Program is designed to provide you and your Eligible Dependents, if applicable, with medical, prescription drug, vision, hearing, death, and AD&D benefits in the event you become totally and permanently disabled. You must make self-payment contributions to continue your eligibility for coverage for yourself and your Eligible Dependents, if applicable.

Under the Plan, totally and permanently disabled means you are unable to work at your usual trade or occupation due to a bodily Injury or Sickness. Your disability must be certified by a Physician to be of a long-term nature.

Your Disabled Employee Program coverage may continue until the earlier of the time you:

- Are no longer disabled (as defined by the Plan);
- Reach retirement age and enroll in the Retired Employee Program;
- Die; or
- Self-payment contributions are not made on a timely basis.

If you are eligible, you and your Eligible Dependents, if applicable, will be covered under the Plan's Disabled Employee Program if you make the required self-contribution payments. If you are eligible for Medicare benefits because of your disability or age, your benefits will be coordinated with Medicare, with Medicare paying benefits first.

If you are covered under the Disabled Employee Program upon your attainment of age 65, you and your Eligible Dependents, if applicable, will automatically be transferred to the Retired Employee Program.

Eligibility

You must be considered totally and permanently disabled, as defined by the Plan, to be eligible to continue coverage under the Plan's Disabled Employee Program. The Trustees will rely on written certification by your Physician for determining your total and permanent disability. The Trustees have the right to require you to submit to a physical examination(s), including diagnostic tests, administered by a Physician of the Trustees' choice and paid for by the Plan. In addition, you may be required to submit other documentation, including financial documents such as tax returns, as deemed necessary by the Trustees. The Trustees will consider all submitted documentation and make a final determination as to whether or not you are disabled within the meaning of the Plan. A Notice of Disability Award from the Social Security Administration will be considered by the Trustees as conclusive evidence of total and permanent disability under the Plan.

You will continue to be eligible for coverage under the Plan as long as you remain disabled and make the required self-payment contributions for coverage. If you do not make your self-payment contributions on a timely basis, your coverage under the Plan will end.

Delayed Enrollment or Reenrollment of Spouse

If your spouse has medical coverage available through another group plan, you may elect not to enroll your spouse when you are initially eligible for the Disabled Employee Program. To enroll your spouse later, you must notify the Fund Office in writing. You must elect coverage within 60 days following the date the other medical coverage ended or within 60 days following your disability. Proof of continuous coverage by another group plan and the self-payment are required at the time of application. You may only delay enrolling your spouse once in your lifetime.

Retired Employee Program

Depending on your age and your Eligible Dependents' ages when you retire, you may have different options for your coverage under the Retired Employee Program.

If you are between the ages of 55 and 65 when you retire, or if you have Eligible Dependents' that are not yet eligible for Medicare, you may be eligible to continue your active medical, prescription drug, life, and AD&D coverage (except that no Weekly Disability Benefits are available). There is a higher self-payment contribution amount for this coverage (see "Self-Payment Contributions" on page 10).

Once you and your Eligible Dependents reach age 65, you will be covered under the Plan's Retired Employee Program.

If you elect coverage under the Retired Employee Program (see the *Retired Employee Program Summary of Benefits* insert) and you are eligible for Medicare, you must enroll for Medicare Parts A and B or you will not be covered under the Retired Employee Program.

All benefits under the Retired Employee Program will be coordinated with any other group insurance program, as well as any Medicare or Medicaid program for which you are eligible. Since benefits are coordinated with Medicare, if you are eligible for coverage under the Retired Employee Program, Medicare will pay benefits first, before this Plan.

Eligibility

To be eligible for coverage as a Retired Employee, you must:

- Be at least 55 years old; and
- Have retired from the electrical trade.

The amount you pay in self-payment contributions to remain eligible in the Retired Employee Program depends on your length of service in the five-year period immediately preceding your retirement date. If you were eligible as an active Employee for fewer than 30 Benefit Months in the five-year period, you are required to pay the full (100%) cost of coverage. If you had more than 30 Benefit Months of eligibility in the preceding five-year period, you pay for only a portion of the full cost of coverage.

To ensure that you do not experience a break in your coverage, you should apply for coverage as a Retiree before your active coverage as an Employee ends, unless you elect to postpone Retired Employee coverage as described below.

You will continue to be eligible for coverage under the Plan as long as you make the required self-payment contributions for coverage. If you do not make your self-payment contributions on a timely basis, your coverage under the Plan will end. To elect coverage as a Retired Employee, you must waive your right to COBRA coverage.

Postponing or Suspending Retiree Coverage

When you are initially eligible and apply for retiree coverage, or at any time after you have retired, you will have the opportunity to postpone or suspend retiree coverage for yourself and/or your dependents if you and/or your dependents have other medical coverage available through another group plan, such as through your spouse's employer.

This is a one-time only option. You and your dependents are given the opportunity only once to postpone or suspend coverage and remain eligible for later coverage.

To be eligible to postpone or suspend coverage until a future date, you must:

- Be covered under another health plan (and provide proof of this other coverage); and
- Complete and file a form electing to postpone or suspend coverage.

If you want to postpone retiree coverage when you are initially eligible, you must make this election within 60 days of becoming eligible for retiree coverage.

Please note that if you elect to postpone or suspend coverage for yourself, this will also postpone or suspend coverage for your dependents. This election applies to all coverage, including medical, prescription drug, death, and accidental death and dismemberment benefits.

The application for retiree coverage will include a section about postponing or suspending coverage. If you elect to postpone or suspend retiree coverage (for yourself and/or your dependents), you must return the application to the Fund Office by the deadline provided.

Beginning or Resuming Coverage

To begin or resume coverage for yourself and/or your dependent after a postponement or suspension, you must:

- File a written application with the Fund Office within **60 days** following the date the other coverage ends (if your other coverage has terminated);
- Provide proof of continuous coverage by another plan since the date coverage under this Plan was postponed or suspended (if proof of continuous health coverage is not provided, you and/or your dependent will not be eligible for coverage); and
- Make the required self-payment contributions for coverage at the rate in effect at the time coverage begins or resumes.

Coverage will begin or resume as of the first day of the month after your application for coverage is approved, provided the required self-payment contribution is made. The above rule also applies to spouses and surviving spouses. For example, if

you elected to postpone coverage for your spouse only, you may elect to begin or resume your spouse's retiree coverage when his or her other coverage ends.

In the Event of Death

In the event of your death during the period that coverage is postponed or suspended for you and/or your dependents, your Eligible Dependents can begin or resume surviving spouse coverage either immediately or when their other coverage ends. Surviving spouse coverage is available to your eligible surviving dependents according to the same Plan rules that apply to surviving dependents of retirees who had not postponed or suspended coverage, as well as the other provisions outlined in the previous section.

To begin or resume coverage, your surviving Eligible Dependents must apply for surviving spouse coverage within **60 days** following the later of the date the other coverage ends, as described in the previous section, or the date of your death. If your surviving Eligible Dependents do not apply for coverage by this deadline, they will have no future rights to coverage under the Plan.

Surviving Spouse Program

In the event of your death, your surviving spouse, and any Eligible Dependents, may be eligible to continue medical, prescription drug, vision, dental, and hearing coverage under the Plan if they had coverage under the Plan before your death. Depending on your spouse's age and whether or not your surviving spouse has any Eligible Dependents and continues to be unmarried, your spouse may have different options for coverage.

Your spouse and any Eligible Dependents will be eligible to continue coverage under the Plan's Surviving Spouse Program if, at the time of your death, your spouse:

- Is under age 65; or
- Has Eligible Dependents.

If, at the time of your death, your surviving spouse is age 65 or older and has no Eligible Dependents, your spouse will be covered under the Plan's Retired Employee Program, excluding Death Benefits (see page 9).

If your surviving spouse is age 65 or older and has Eligible Dependents, he or she may continue coverage under the Surviving Spouse Program instead of under the Retired Employee Program.

Your surviving spouse's coverage will continue until the earlier of the date your surviving spouse remarries or when self-payment contributions are no longer made on a timely basis. Your Eligible Dependents' coverage will continue until the earliest of the date:

- Self-payment contributions are no longer made on a timely basis;
- He or she no longer meets the Plan's definition of an Eligible Dependent; or
- Your surviving spouse is no longer eligible for coverage due to remarriage.

Self-Payment Contributions

The self-payment contribution rates for the Disabled Employee, Retired Employee, and Surviving Spouse Programs are set by the Trustees, and are subject to change from time to time and depend on the coverage you elect. Since the Plan coordinates your coverage with Medicare (with Medicare paying benefits first, when applicable), the cost of providing Retired Employee Program coverage is less.

Self-payment contributions for coverage under the Retired Employee, Disabled Employee and Surviving Spouse Programs must be made monthly to the Fund Office. The Plan provides you with a choice as to how you would like to make self-payment contributions for your coverage. Self-payment rates are determined based on a per-covered-adult basis. There is no per person charge for Eligible Dependent children.

- **Make Self-Payment Contributions:** Self-payment contributions can be made by check or money order and must be received by the Fund Office on the first day of each month (but no later than the fifth day of each month) for which coverage is desired. The Fund Office **does not** accept cash.
- **Automatic Payments:** You can direct that your monthly self-payment contribution be automatically withdrawn from your checking or savings account. The withdrawal will be made on the 20th day of each month so that you will continue to be eligible for coverage the following month. You must complete an agreement, available from the Fund Office, authorizing the Fund to have debits made directly from your designated account.

COBRA Continuation Coverage

In certain situations where your coverage would otherwise end under the Plan, the Plan provides an opportunity for a temporary extension of health care coverage. The law that requires this coverage is the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. Health care coverage under COBRA is called COBRA Continuation Coverage. You do not have to show that you are insurable for COBRA Continuation Coverage. It is offered to you at rates (set by the Trustees) in specific instances (called qualifying events) where coverage under the Plan would otherwise end.

Qualifying Events

If you or your Eligible Dependents lose coverage because of a qualifying event, you or your Eligible Dependents are entitled to elect COBRA Continuation Coverage. Qualifying events include your:

- Reduction in hours or termination of employment (including layoff, strike, disability, medical leave of absence or retirement);
- Death;

- Legal separation or divorce;
- Entitlement to Medicare (eligible for and enrolled in Medicare); or
- Eligible Dependent child ceasing to qualify as a dependent child under the Plan.

Notifying the Fund Office

You or your dependent must notify the Fund Office of any qualifying events within 60 days of the later of its occurrence or the date coverage would be lost as a result of its occurrence. If you do not notify the Fund Office in a timely manner, you will lose your right to elect COBRA Continuation Coverage.

By law, your Employer is required to notify the Fund Office of your death, termination of employment or reduction in hours or entitlement to Medicare within 45 days of its occurrence. However, because Employers contributing to multiemployer funds may not be aware of these events, we urge you or a family member to notify the Fund Office of any and all qualifying events as soon as the qualifying event occurs.

When the Fund Office is notified that one of these events has occurred, you and your Eligible Dependents will be notified within 14 days of your right to elect COBRA Continuation Coverage.

Once you receive a COBRA notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. Your Eligible Dependents have the option to elect coverage independently from you if you choose not to elect COBRA Continuation Coverage.

If COBRA Continuation Coverage is elected, the Plan will provide coverage that is identical to the health coverage (excluding Weekly Disability, Death Benefits, and AD&D Benefits) provided to similar Employees and their Eligible Dependents.

If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA Continuation Coverage is in effect, you may add this child to your coverage. You must notify the Fund Office, in writing, of the birth or placement for adoption to add the child to your coverage.

Periods of Coverage

The maximum period of COBRA Continuation Coverage is 36 months from the qualifying event.

- **Coverage continues for a maximum of 18 months** if your coverage ends due to your termination of employment or your reduction in hours.
- **Coverage continues for a maximum of 29 months** if you or an Eligible Dependent qualifies for a Social Security Disability Award at the time you lose eligibility, or within 60 days after that, provided you notify the Fund within 60 days of the award and before the normal COBRA expiration date. Other members of your family who have elected COBRA Continuation Coverage can keep it for the extended 29-month period.
- **Coverage continues for a maximum of 36 months** if your spouse or other Eligible Dependent's coverage ends because of your:
  - Death;
  - Legal separation or divorce;
  - Entitlement to Medicare;
  - Dependent child no longer qualifying for dependent coverage under the Plan.

Loss of Continued Coverage

Once your COBRA Continuation Coverage ends, it cannot be reinstated. The period of COBRA Continuation Coverage for you or your Eligible Dependents may end if:

- You or your Eligible Dependents do not make the required self-payment contributions on a timely basis;
- You or your Eligible Dependents first become covered under any other group health care plan after electing COBRA Continuation Coverage;
- The Fund ceases to provide any group health benefits;
- You or your dependent reaches the end of the 18-month, 29-month, or 36-month continued coverage period and you are not eligible for additional continuation coverage under the rules described above;
- You become entitled to (eligible for and enrolled in) Medicare; or
- Your dependents become entitled to (eligible for and enrolled in) Medicare.

When your COBRA Continuation Coverage ends, you will be provided with certification of your length of coverage under the Plan. This may help reduce or eliminate any preexisting condition limitation under a new group medical plan.

Paying for COBRA Continuation Coverage

The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage is determined by the Trustees on an annual (12-month) basis. The amount a qualified beneficiary is required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving continuation coverage.

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your coverage and/or your Eligible Dependents' coverage under the Plan ended. The Fund Office will notify you of the due date for the first payment; subsequent payments are due the first of the month. If a payment is late, coverage will be terminated.

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Fund Administrator to confirm the correct amount of your first payment.

Monthly Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to make monthly payments for each subsequent coverage period. Payment is due on the first day of each month for that month's coverage. If you make a monthly payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace Periods for Monthly Payments

Although monthly payments are due on the first day of the month to which the coverage period applies, you will be given a grace period of 30 days after the first day of the payment due date to make each payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you make a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the coverage, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the coverage period) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent child loses coverage under another group health plan, you may enroll the spouse or dependent child for coverage for the balance of the period of COBRA Continuation Coverage. The spouse and/or dependent child must have been eligible but not enrolled for coverage under the terms of this Plan and declined coverage when enrollment was previously offered under this Plan. In addition, the spouse and/or dependent child must have been covered under another group health plan or had other health insurance coverage.

You must enroll the spouse and/or dependent child within 31 days after the termination of the other coverage.

The loss of coverage under the other plan must be due to one of the following:

- Exhaustion of COBRA Continuation under another plan;
- Loss of eligibility; or
- Employer contributions towards the other plan decline or are eliminated.

Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

Confirmation of Coverage to Health Providers

Under certain circumstances, the Fund may need to inform your health care Providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances:

- If a health care Provider requests confirmation of coverage during the COBRA election period and you, your spouse, or your dependent children have not yet elected COBRA Continuation Coverage, then the Fund Office will give a complete response to the health care Provider about your and your dependents' COBRA continuation rights during the election period.

  The Fund cancels your and your dependents' coverage as of the date coverage ends under the Plan. However, the Fund retroactively reinstates your coverage once COBRA Continuation Coverage is elected. If you have not yet elected COBRA, the Fund Office will inform the health care Provider that you do not currently have coverage, but that you and your dependents' will have coverage retroactively to the date coverage was lost if you elect COBRA Continuation Coverage.

- If after you have elected COBRA Continuation Coverage, a health care Provider requests confirmation of coverage for a period for which the Fund Office has not yet received payment, then the Fund Office will give a complete response to the health care Provider about your and your dependents' COBRA continuation rights during that period.

  The Fund cancels your and your dependents' coverage as of the first day of a period of coverage if it has not received your or your dependents' COBRA payment. However, the Fund retroactively reinstates your coverage once the COBRA payment is timely made. If you and/or your dependents have not paid the applicable COBRA payment, the Fund Office will inform the health care Provider that you do not currently have coverage, but that you and your dependents will have coverage retroactively to the first day of coverage if timely payment is made.

Health Insurance Marketplace

You may have other options available to you when you lose group health coverage. For example, you may be Eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the

Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are Eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

NOTE: If you opt out of Fund coverage and purchase your own coverage through a state or federal Health Insurance Marketplace, the Affordable Care Act prohibits you from participating in this Plan's HRA account.

MEDICAL BENEFITS

Your medical benefits cover a wide range of services and supplies, including Physician charges, diagnostic testing, prescription drugs, Hospital charges, and surgery. These benefits can pay a large part of your health care expenses and are designed to pay benefits for medical expenses related to non-occupational Sickness or Injury.

The Fund has contracted with a Preferred Provider Organization (PPO) to manage health care expenses for you and the Fund. Providers participating in the PPO have agreed to charge negotiated fees. When you use a PPO provider, you and the Fund both save money.

How the Medical Plan Works

The medical plan is a Preferred Provider Organization (PPO) plan. Providers who participate in the PPO network have agreed to negotiated fees for covered services.

You and the Fund save money when you use PPO providers. You can choose to use non-PPO providers, but you and the Fund will pay more for those services. See the *Important Contact Information* included with this booklet for information on how to find PPO providers.

Here's how your coverage works:

- **You have eligible expenses.** You, or a health care Provider, file a claim for reimbursement of covered expenses. PPO providers will generally file claims for you.
- **Before benefits are payable under the Plan,** you must satisfy an annual deductible. The amount of the deductible is listed on the *Summary of Benefits* insert for the Program under which you are covered.
- **Once you meet the annual deductible, you and the Plan share expenses.** There are levels of benefits provided under the Plan—PPO and non-PPO.
- **If you are an Inside Wireman Employee, you can pay for your eligible expenses using your Health Reimbursement Arrangement (HRA).** Your employer contributes to your HRA to help you pay for eligible medical expenses (see page 20).
- **Once your out-of-pocket expenses reach the annual maximum,** the Plan pays 100% of eligible benefits. Please note that copayments do not apply to the out-of-pocket maximum.

Annual Deductible

The annual deductible is the dollar amount you pay each year before the Plan pays benefits. The annual deductible applies to each covered person each calendar year. For a family, once the family has combined expenses equal to the family maximum, no further deductibles are required for that year.

You do not need to satisfy the annual deductible before benefits are payable for expenses relating to a second surgical opinion for TMJ. However, please note that no copayments or non-covered charges are applied toward meeting your annual deductible under the Plan's medical benefits. In addition, the penalty for failing to preauthorize an inpatient hospital admission does not count toward the deductible.

Cost Sharing—Copayments and Coinsurance

Copayments and coinsurance are the charges you are responsible for paying for certain covered health services. Copayments are usually expressed as flat dollar amounts. Coinsurance, generally expressed as a percentage, is the amount you pay for covered services after you meet the Plan's annual deductible, if applicable. You can find copayment and coinsurance amounts in the *Summary of Benefits* included with this booklet.

Annual Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you and your Eligible Dependents, if applicable, pay out of your pocket in a calendar year for medical Covered Charges. Once you reach the individual out-of-pocket maximum in a calendar year—or when your family's combined expenses reach the family out-of-pocket maximum in a calendar year, if applicable—the Plan pays 100% of medical Covered Charges for the rest of the calendar year.

The out-of-pocket maximum applies to the coinsurance percentage you pay when less than 100% is payable under the Plan. The following charges do not apply toward your out-of-pocket maximum:

- All copayments (including prescription drug copayments);
- Non-covered services;
- Amounts that exceed the Allowable Charge for a covered service, unless that service is subject to the No Surprises Act;
- Charges for covered services incurred due to failing to call and preauthorize treatment; and
- Amounts that exceed the maximum benefit specified, including, but not limited to:
  - Physical examinations;
  - School physicals;
  - Immunizations;
  - Weight loss/reduction;
  - Chiropractic treatment; and
  - Prescription drugs.

Benefit Maximums

The Plan pays up to the annual benefit maximum amounts (listed on the *Summary of Benefits* insert for the Program under which you are covered) per person each year.

Protections from Surprise Medical Bills

Under a federal law called the No Surprises Act, you have protection against surprise medical bills from non-network providers and facilities. This law mainly applies to Non-Network Emergency Services, services provided by non-network providers at Network facilities, and Non-Network Air Ambulance Services.

Non-Network Emergency Services

Covered Emergency Services are treated as In-Network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum, even if the services were received from a non-network Emergency facility. This means you will be responsible for the network cost-share amount. The Plan will count any cost-sharing payments toward the in-network deductible and/or the in-network out-of-pocket maximums in the same manner it would count cost-sharing payments made for in-network Emergency Services.

Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive Emergency Services from a non-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

Non-Network Providers at Network Facilities

Unless you consent to receiving services from the non-network provider (as described in this section), covered services performed by non-network providers at network hospitals or ambulatory surgical centers are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount, and the Plan will count any cost-sharing payments incurred for these services toward the in-network deductible and/or the in-network out-of-pocket maximums under the Plan in the same manner it would count cost-sharing payments made for in-network services.

Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive services from a non-network provider at a network facility, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

Non-Network Air Ambulance Providers

Covered Air Ambulance Services are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount and the Plan will count any cost-sharing payments incurred for covered Air Ambulance Services toward the in-network deductible and/or the in-network out-of-pocket maximums in the same manner it would count cost-sharing payments made for in-network services.

Your cost-sharing will be based on the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

If you receive Air Ambulance Services from a non-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, including payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

Waiving Surprise Medical Bill Protections

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. You may be able to waive these protections for (1) services from a Non-Network Provider at a Network Facility or (2) services from a Non-Network emergency facility or provider after you are stabilized. This can occur if you are notified by the Non-Network Provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and waive the protections.

If you give informed consent to be treated by the Non-Network provider, then the Plan will treat these services as Non-Network. This means you will be subject to Non-Network cost-sharing, the provider can bill you for the balance directly, and the provider can balance bill you for the difference between what the provider charges and the amount paid by the Plan and the cost-sharing amounts paid by you.

You may not waive No Surprises Act protections for ancillary services provided by a Non-Network Provider in a Network facility. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services, including radiology and laboratory services.

Plan Payment to Provider

The Plan will pay the provider or facility the Out-of-Network Rate minus any cost-sharing amounts (copayments, coinsurance, and/or amounts paid towards deductible) you paid.

Continuing Care

If you are receiving care from a network provider that becomes non-network, you may have certain rights to continue your course of treatment if you are a "continuing care patient."

A continuing care patient is a patient that

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under Social Security Act) and is receiving treatment for such illness from such provider or facility.

A serious and complex condition means a condition that

- in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that
- is life-threatening, degenerative, potentially disabling, or congenital; and
- requires specialized medical care over a prolonged period of time.

If the Plan terminates its contract with your Network provider or facility or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, you will be notified of the change and informed of your right to elect to receive transitional care from the provider. You may choose to continue your course of treatment under the same terms and conditions as would have applied for an in-network provider for up to 90 days after the notice is provided or until you no longer qualify as a continuing care patient (whichever is earlier). These providers cannot balance bill you during this time.

Termination of a contract includes the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Provider Directory

If you rely on information in the Plan's provider directory that inaccurately states that a non-network provider is in-network, you will only be subject to in-network cost sharing amounts. These cost-sharing amounts will be applied toward the in-network deductible and/or in-network out-of-pocket maximum in the same manner in-network cost-share would be applied.

Covered Medical Benefit Expenses

The following expenses are covered if they are Medically Necessary for the treatment of a non-occupational Injury or Sickness, up to the maximums shown on the *Summary of Benefits* insert for the Program under which you are covered.

The Plan also covers emergency medical care while you are traveling outside the United States. You must pay for the service and file a claim for reimbursement.

Hospital Benefits

The Plan covers charges made by a lawfully operated Hospital up to the Hospital's regular or average rate for semi-private accommodations. Hospital benefits are not payable for expenses an Eligible Dependent child incurs due to pregnancy, childbirth, or miscarriage. However, the Plan will cover an Eligible Dependent child's expenses for pregnancy tests required by a hospital or physician in order to perform other non-pregnancy related procedures.

Unless medically justified, Inpatient charges for weekend admissions (Friday, Saturday or Sunday) for non-emergency procedures are not covered. However, Sunday admissions are covered if surgery is scheduled for the following day.

You must call the Plan's Utilization Review (UR) provider to preauthorize any inpatient, non-emergency hospitalization, including maternity, at least five days before it occurs. In the event of an emergency hospital admission, you or a family member must call the Plan's UR provider within 48 hours after the hospital admission. If you do not call for preauthorization of a hospital admission, you will be responsible for certain covered expenses before the Plan begins to pay benefits.

Federal law requires that the Plan pay Hospital expenses for any Hospital length of stay in connection with childbirth for a mother and/or the newborn child for at least 48 hours (following a vaginal delivery) or at least 96 hours (following a cesarean section). However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours, if applicable) following delivery.

Surgical Benefits Related to a Mastectomy

The Plan pays charges for surgery by a Physician, including medical and surgical benefits in connection with a mastectomy. In addition, in compliance with federal law, the Plan provides benefits for certain reconstructive surgery the same as other medical and surgical benefits. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Physician Benefits

The Plan pays charges for Physician visits, including Physician office visits, subject to any required copayments.

Organ Transplant Benefits

The Plan pays benefits up to the amounts listed on the *Summary of Benefits* insert for the Program under which you are covered. Benefits are paid for both the organ donor and the organ recipient, provided both are eligible under this Plan. No benefits are payable for any expenses incurred for Experimental or Investigative procedures.

The following organ procurement expenses will be paid when the transplant is performed in an in-network facility:

- Hospital expenses incurred by a donor(s) as related to the transplant;
- Testing to identify suitable donor(s)
- The expense of life support of a donor pending the removal of a usable organ; and
- Transportation of organ(s) or a donor on a life support system.

You must call the Plan's UR provider for preauthorization before receiving any transplant services. If you do not call for preauthorization, benefits paid by the Plan will be reduced by 50%. Any additional amounts you pay when preauthorization is not obtained do not apply toward meeting your annual deductible or out-of-pocket maximum.

Weight Loss/Reduction Benefits

The Plan pays benefits up to the lifetime maximum (listed on the *Summary of Benefits* insert for the Program under which you are covered) for counseling, behavior modification, and diagnostic services in connection with weight loss or reduction. However, benefits are only paid if the program is supervised by a Physician and the individual is:

- At least 50 pounds over the desirable weight (taking into account age, height, sex and body structure);
- Not at least 50 pounds over the desirable weight but there is a medical condition (e.g., hypertension, diabetes, heart trouble, hypothyroidism) certified by a Physician that requires a loss of weight.

Benefits are not paid for products designed to assist in weight loss where no Physician supervision is required, regardless of whether purchased with or without a prescription.

Chiropractic Visits

The Plan pays for up to 24 visits per person per calendar year. Additional visits require pre-approval. Clinical records and diagnostic tests must be submitted for medical review before approval is considered.

Wellness Benefits

The Plan pays for the following wellness benefits (subject to any maximums listed on the *Summary of Benefits* insert for the Program under which you are covered):

- Physical examinations;
- School physical examinations; and
- Immunizations.

Durable Medical Equipment

The Plan covers durable medical equipment. Durable medical equipment means equipment, devices or supplies that:

- Are certified, in writing, by the prescribing Physician as necessary in the treatment or rehabilitation of a handicapped person;
- Are clearly related to and necessary for the treatment, rehabilitation or training of persons with a specified handicap;
- Improve the function of a malformed body part or retard further deterioration of the handicapped person's condition;
- Would not be necessary in the absence of a physical or mental disability;
- Are primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for transportation, comfort or convenience;
- Are not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe); and
- Are appropriate for and intended for use in the home.

Durable medical equipment includes, but is not limited to:

- Artificial limbs or eyes to replace natural limbs or eyes;
- Surgical dressings and bandages;
- Splints;
- Trusses;
- Casts;
- Braces;
- Crutches; and
- Rental, up to purchase price, of Hospital type beds, wheelchairs, ventilators or other durable medical equipment requiring a Physician's order.

The Plan covers charges for deluxe items only up to the cost of standard items. In addition, expenses for special fittings, adaptations, or maintenance agreements for durable medical equipment are not covered.

Home Health Care Benefits

The Plan covers charges for home health care made by a Home Health Care Agency, provided that the Home Health Care Plan:

- Is prescribed by a Physician;
- Is reviewed and approved by the Physician every two weeks; and
- Contains a statement expressing the belief of the Physician and Home Health Care Agency that the:
  - Number of days of home health care does not exceed the number of days of confinement in a Hospital or nursing home that would have been required;
  - Home health care will cost less per day than the daily rate for confinement in a Hospital or nursing home; and
  - Confinement in a Hospital or nursing home would otherwise be required.

A copy of the Home Health Care Plan must be provided to the agency.

Home health care includes:

- Skilled nursing care and home health aide services; and
- Any other services and supplies provided instead of the services, which would have been covered under the Plan, if the Employee were confined in a Hospital or nursing home.

Dental Benefits

Your medical coverage provides dental benefits for certain services, including:

- Charges for the surgical extraction of impacted wisdom teeth and related anesthesia administered for the procedure.

Routine and preventive dental care is covered under the Limited Dental Benefit Program (see page 20).

Temporomandibular Joint (TMJ) Dysfunction Benefits

The Plan covers TMJ expenses if the covered individual is advised by a Physician or surgeon to have a surgical procedure performed for the treatment of temporomandibular joint (TMJ) dysfunction, including associated myofacial repair, mandibular or maxillar osteototomy or any related surgery. However, the Fund requires that the individual obtain a second surgical opinion. The Fund will pay 100% of the expenses incurred for such second surgical opinion relating to the Medical Necessity for surgery (including x-rays and laboratory services) and no Plan deductibles will apply. The Physician or surgeon rendering the second surgical opinion may be chosen by the covered individual, provided the Physician or surgeon satisfies the conditions listed in the following "Confirming TMJ Surgical Treatment" section.

No benefits are payable for any TMJ surgical procedures without first obtaining a second opinion, as described above.

Mandibular Advancement Device/Oral Appliance

Mandibular Advancement Devices and/or Oral Appliances are covered when Medically Necessary for individuals diagnosed with obstructive sleep apnea. No coverage is provided for lost or stolen appliances. Benefits are payable from a in-network dentist who is certified by the American Academy of Dental Sleep Medicine (AADSM) to create such a device.

Genetic Testing

Benefits are payable for genetic testing only when the Fund's UR firm has determined that this service is Medically Necessary.

Confirming TMJ Surgical Treatment

The Physician or surgeon confirming a second surgical opinion must:

- Be a specialist certified by the American Association of Oral and Maxillo-Facial Surgeons;
- Be independent of the Physician or surgeon who first advised the surgery; and
- Not be the Physician or surgeon who performs the surgery.

Member Assistance Program

The Member Assistance Program (MAP) is a confidential and professional consultation and referral program designed to help you and your Eligible Dependents deal with difficult situations that can cause stress and result in problems with your mental health and well-being. The program is designed to make it as easy as possible for you to get help for personal and work-related problems, such as mental or nervous disorders, alcoholism, chemical dependency or substance abuse. The program is voluntary.

The MAP network consists of organizations and professionals that have demonstrated a commitment to maintaining the highest quality of care. From hospitalization and residential rehabilitation centers to Outpatient treatment, the alternatives for care can be matched with your treatment needs or the treatment needs of your Eligible Dependents.

Mental Health and Substance Abuse Treatment Benefits

The Plan covers treatment of mental and nervous disorders, alcoholism, chemical dependency and substance abuse. In addition, you should follow the treatment plan to ensure you get the care you deserve. Benefits for mental health and substance abuse treatment are covered as provided on the *Summary of Benefits* insert for the Program under which you are covered.

LiveHealth Online®

You have a convenient, high-tech way for you and your covered dependents to access care with LiveHealth Online. The online service gives you quick and easy access to a doctor wherever you are, 24 hours a day, seven days a week, 365 days a year. LiveHealth Online is provided in partnership with Anthem BlueCross BlueShield.

If you or a family member is under the weather, getting a private, secure and convenient online medical visit through LiveHealth Online is a great option when you are away from home or your doctor is unavailable. LiveHealth Online doctors can answer medical questions, make a diagnosis and even prescribe medication for you, if needed (except in certain states). They can help with minor injuries and common medical ailments like colds, flu symptoms, fevers, allergies, infections, headaches, sore throats, minor rashes and ear aches.

You can save time and get the care you need without having to schedule a doctor's appointment or be exposed to other sick people while sitting in a doctor's waiting room. And it's less

expensive than going to an emergency room or urgent care facility.

There is a copayment each time you visit a doctor through LiveHealth Online (if your doctor is an In-Network Provider). See the *Schedule of Benefits* insert for the copayment amount. The deductible will not apply to LiveHealth Online visits. You can pay by credit card. Each online session generally lasts about 10 minutes.

You can connect directly with LiveHealth Online board-certified doctors face-to-face using a computer with a webcam or through your mobile device. You can access LiveHealth Online from your Android or iOS mobile device by downloading the free app. On your computer, you can go to **livehealthonline.com**. You must first enroll using the on-screen instructions in order for your session to be covered by the Fund.

Medical Benefits Not Covered Under the Plan

A list of medical expenses not covered under the Plan is included in the "General Exclusions and Limitations" section (see pages 24 and 25).

PRESCRIPTION DRUG BENEFITS

Prescription drug coverage can play an important role in your and your Eligible Dependent's overall health. Recognizing the importance of this coverage, the Fund has contracted with a prescription drug network Provider, which provides a retail pharmacy program and a mail order program.

When you have your prescriptions filled at a participating pharmacy or through the mail order program, you save money for yourself and the Plan.

When you need a medication for a short time—an antibiotic or cold remedy for example—it is best to choose the retail pharmacy program. If you are taking a medication on a long-term basis, it is usually best to have it filled through the mail order program.

How the Plan Works

When you need to have a prescription filled, go to any participating retail pharmacy and show your ID card or send your prescription to the mail order program. Before your benefits are payable under the Plan, you must satisfy an annual deductible. This annual deductible amount includes expenses paid for prescription drugs dispensed through the retail pharmacy program and/or through the mail order program. Once you satisfy the annual deductible amount, you and the Plan will share expenses, up to an annual maximum amount.

The applicable prescription drug annual deductible, copayments and annual maximum amounts are specified on the *Summary of Benefits* insert for the Program under which you are covered. These amounts do not count toward the deductibles or maximum out-of-pocket limits that apply to your medical benefits.

Specialty Pharmacy Program

Specialty drugs are prescriptions that require special ordering or handling and are distributed by a Specialty Pharmacy. The Plan's prescription drug network provider offers a specialty pharmacy program that helps you manage your prescription care if you or your Eligible Dependent(s) are undergoing treatment for certain conditions, such as hepatitis C, cystic fibrosis, multiple sclerosis, or rheumatoid arthritis.

When you need to have a prescription filled for a specialty medication (including any specialty medications you are currently taking), you will need to contact the Plan's prescription drug network provider.

For your initial prescription for a specialty medication, you may have your prescription filled at a network retail pharmacy for up to a 30-day supply. After that, most prescriptions for specialty medications must be filled through the provider's specialty mail order program.

Retail Pharmacy Program

Retail pharmacy benefits are provided through a retail pharmacy network. The network includes participating pharmacies throughout the United States, including many national and regional chains and independent pharmacies. By being part of this network, participating retail pharmacies are generally able to offer prescriptions at a lower cost than non-participating pharmacies. To take advantage of this cost savings, you should use a participating retail pharmacy whenever you need to fill a prescription. See the *Important Contact Information* insert for details on locating a participating retail pharmacy.

Mail Order Program

Use the mail order prescription drug program when you have prescriptions filled for maintenance drugs (medications that you take on an ongoing basis).

When you need to order medication through the mail order prescription drug program, you should:

- Ask your Physician to prescribe a 90-day supply with refills, if appropriate; and
- Mail the original prescription along with the appropriate form to the mail order drug program. You can obtain a form from the Fund Office.

Allow about 14 business days from the time you mail in your order to receive your prescription(s). If you need to begin taking the medication right away, you may want to ask your Physician for two prescriptions:

- A short-term supply that you can have filled right away at a participating retail pharmacy; and
- A 90-day, refillable supply that you can have filled through the mail order prescription drug program.

Generic Equivalents and Brand Name Medications

Many prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. On average, generic medications can save about half the cost of the brand name medications, but for some medications this savings can be as great as 90%. This can be a significant source of savings for you and the Fund. In general, the savings achieved by using generic medications will help control the cost of health care while providing quality medications.

You should discuss with your Physician if a generic equivalent is available for any prescriptions you need filled. Your Physician or pharmacist can assist you in substituting generic medications when appropriate.

To encourage you to use generic medications whenever possible, your copayment amount is less when you use generic medications. In addition, if a generic drug is available and you request a brand name drug, you will be responsible for the difference in the cost of the generic and brand name medication in addition to your brand name prescription drug copayment. This does not apply if your Physician specifies Dispense as Written (DAW) on your prescription.

Covered Prescription Drug Expenses

The Plan covers medications that require a written prescription from a Physician, subject to any Plan limits. Most medications obtained from a retail pharmacy or through the Plan's mail order program are covered. To save the most money for yourself and the Fund, use participating retail pharmacies when filling a prescription.

Covered Prescription Drug Expenses Include:

1. Flu shots at no cost to you or your Eligible Dependents at pharmacies in the SavRx network.
2. Legend Drugs, which are drugs, medicines or medications that, under federal or state law, may be dispensed only by prescription from a qualified practitioner, unless they are excluded from Prescription Drug coverage (see below).
3. Insulin.
4. Injectibles.
5. Growth Hormones.
6. Self-injectibles.
7. Vitamins (only with a Prescription).
8. Prenatal vitamins (for Employee and Dependent spouse only, with a Prescription).
9. Oral Contraceptives (for Employee and Dependent spouse only).
10. NuvaRing (for Employee and Dependent spouse only).
11. Ortho Evra (for Employee and Dependent spouse only).
12. Depo Provera (for Employee and Dependent spouse only).
13. Seasonale (for Employee and Dependent spouse only), with 90-day copayment.
14. Mental health medications.
15. Attention deficit disorder medications.
16. Weight loss medications.
17. Impotency medications.
18. Non-Sedating Anti-Histamines.
19. Smoking cessation medications (only with a Prescription).
20. Transplant medications.
21. Retin A up to age 19, or with prior authorization, at age 19 and over.

Prescription Drug Expenses Not Covered Under the Plan

In addition to any general exclusions and limitations listed on pages 24 and 25, the expenses listed below are not covered under the Plan's prescription drug benefits.

1. Experimental or Investigative drugs or medications.
2. Drugs or medications not requiring a written prescription.
3. Insulin syringes, diabetic supplies or diabetic machines.
4. Syringes.
5. Contraceptive implants for all Employees and Dependents (NuvaRing is not considered an implant).
6. Any form of contraceptives for Dependent children, except when Medically Necessary for purposes other than prevention of pregnancy, and a letter of Medical Necessity is presented.
7. Diaphragms.
8. Devices or appliances.
9. Fertility/infertility medications.
10. Cosmetic drugs.
11. Over-the-counter medications, vitamins or smoking cessation medications, unless obtained with a Prescription.

DENTAL BENEFITS

The Plan offers dental coverage via the Limited Dental Benefit Program to all Active Employees and their Eligible Dependents covered under the Inside Wireman, Market Recovery Agreement (MRA) Program or the Construction Wireman/ Construction Electrician (CW/CE) Employees Program. This is an optional benefit. If you do not want to participate in the Limited Dental Benefit Program, contact the Fund Office for an opt-out form.

You may visit any licensed dentist. There is no network. The Limited Dental Benefit Program covers routine diagnostic and preventive exams, cleanings, and x-rays up to a Calendar Year Maximum. See the *Summary of Benefits* insert for details.

Please note that the surgical extraction of impacted wisdom teeth and related anesthesia administered for the procedure are covered through the Medical Benefits (See page 17).

You have two choices for how to use your benefit:

1. Pay your dentist directly and then submit a copy of your bill and a claim form to the Fund Office for reimbursement.

Have your dentist send their bill to the Fund Office. We will pay the eligible covered amount to your dentist and then bill you for any amounts in excess of your annual calendar year maximum or for non-covered services.

VISION CARE BENEFITS

Maintaining good vision is an important part of staying healthy. The Fund provides vision care benefits for you and your Eligible Dependents.

Covered Vision Expenses

The Plan covers vision care benefits for eye exams, lenses, frames and contact lenses, up to the maximums listed on the *Summary of Benefits* insert for the Program under which you are covered.

When you visit any participating vision care provider, such as a licensed ophthalmologist, the Plan pays 100% of the covered expense up to a Calendar Year Maximum for adults age 18 and over. There is no Calendar Year Maximum for a covered participant under age 18. You pay out-of-pocket at the time of service and then submit a claim for reimbursement to the Fund.

Note: These vision benefits are offered by the Fund and are different from Delta Dental's vision benefits.

HEARING CARE BENEFITS

The Fund provides hearing care benefits for you and your Eligible Dependents. Hearing care benefits are not available under the Retired Employee Program.

Covered Hearing Expenses

The Plan covers hearing care benefits for hearing aids and related services and supplies, up to the maximums listed on the *Summary of Benefits* insert for the Program under which you are covered.

Benefits are only payable if the:

- Examination indicates that there is a need for a hearing aid; and
- Examination and hearing aid(s) are furnished by a licensed audiologist or hearing specialist.

HEALTH REIMBURSEMENT ARRANGEMENT

Inside Wireman and MRA Employees have access to a Health Reimbursement Arrangement (HRA) to help you pay for health care expenses. Employers contribute to the HRA on your behalf to let you pay for eligible expenses tax-free.

Eligibility and Other Plan Coverage

If you work in Covered Employment, or if you are a Non-Bargaining Unit Employee who participates in the Plan in accordance with a written participation agreement between your Employer and the Fund, you are permitted to participate in the HRA.

If you are eligible, but elect not to participate in the Plan's Active or Retiree health benefit programs, you must be enrolled in another group health plan that covers at least 60% of eligible expenses in order to be eligible to participate in this Plan's HRA. A plan that covers at least 60% of eligible expenses is considered to have met the minimum value standard set by the Affordable Care Act.

If you opt out of Plan coverage and are covered by another group health plan, you must provide proof of the other coverage to the Plan. If you do not provide sufficient proof, or if your other group coverage does not meet the minimum value standard, there will be limits on the types of expenses that can be reimbursed to you by your HRA. You will only be able to use your HRA account to reimburse your expenses for copayments, coinsurance, deductibles, expenses that are not essential health benefits and premiums for the purchase of the other group health plan.

You also cannot use your HRA account to be reimbursed for

premiums for coverage you may purchase through a state or federal Health Insurance Marketplace, nor can you use your HRA account to pay for Individual Medicare Supplement, Medicare Prescription Drug Plan or Medicare Advantage policies.

HRA Contributions

You do not enroll in nor do you elect your HRA. Employer contributions fund your HRA with 50 cents for every hour you work. Your HRA balance will grow over time. You can use the money in your HRA to pay for a variety of health care expenses that the Benefit Fund does not cover – Plan and Medicare premiums, co-pays, dental expenses, and many medical products and services (provided you have not opted out of HRA coverage and waived or forfeited your HRA balance). The distributions from your HRA are tax-free.

The money that remains in your account at the end of the year rolls over to the next year.

Option to Waive Your Participation in the HRA Plan

If you participate in the HRA, you are now allowed, at least once a year, to permanently opt out of the HRA coverage and waive future reimbursements from the HRA. If you elect to opt out of the HRA Plan, you will forfeit any remaining money in your account on the date that your opt-out is effective.

The Affordable Care Act requires that you be allowed to choose to opt out to provide you with the choice of spending down your HRA balance or applying for a premium assistance tax credit in a Health Insurance Marketplace. If you have an account balance, you would not be eligible for the tax credit.

When HRA Eligibility Ends

You will continue to be eligible for reimbursement of Medical Care Expenses until the earlier of:

- the date that funds in the your HRA account are exhausted,
- the date the HRA is terminated, or
- the date you opt out of HRA coverage and waive or forfeit the balance in your HRA.

If You Enroll in COBRA

If you stop working and continue your coverage through COBRA, or if you retire, you can continue submitting claims for reimbursement from your HRA until the account is empty (provided you have not opted out of HRA coverage and waived or forfeited your HRA balance).

If You Take a Leave of Absence

If you go on a qualifying leave of absence under FMLA or USERRA, you will remain a participant in the HRA and your Employer will continue contributions as if you were still an active Employee.

If You Die

If there is money in your HRA account when you die, your Eligible Dependents can continue to submit claims for reimbursement to the Fund Office until your HRA account is depleted. Participants can submit claims for reimbursement for up to 12 months after incurring an eligible expense, up to the remaining balance of the account.

Forfeiting Your Account

Your HRA account will be forfeited either:

- on the first day of the month following 60 consecutive months of no payments to the Plan on your behalf or on behalf of your Eligible Dependents, provided that, on that date, your HRA account balance is $500 or less, or
- when you opt out of HRA coverage and waive or forfeit your HRA account balance.

Using Your HRA

Using your HRA to pay for eligible medical services is simple.

1. At the time of service, you pay the provider out of your own pocket.
2. Collect your proof of payment, which can be the itemized receipt (not a cash register receipt) from a qualified purchase or the service provider; or the explanation of benefits (EOB) from your carrier.
3. Access a claim form by:
   - Picking up the form from the IBEW 369 Local Union or the Fund Office;
   - Calling the Fund Office and requesting a form be mailed to you; or
   - Downloading the form from **www.369benefitfunds.com**.
4. Claims can be submitted up to twelve months after the date of your eligible medical service. Submitted claims must add up to at least $20.
5. Complete the claim form, include your proof of payment and send to the Fund Office by:
   - Mailing the completed claim form and a copy of your proof of payment to:
     Electrical Workers Local 369 Benefit Fund
     906 Minoma Ave.
     Louisville, KY 40217;
   - Faxing the claim form and proof of payment to 1-502-637-3444;
   - Emailing the form and proof of payment to **HRAclaims@369benefits.com**.
6. If your claim is approved, you will be reimbursed by the Plan within 30 to 45 days of approval, depending on circumstances. You will be notified if your reimbursement will take more than 30 days.

What's Covered

You can use your HRA to pay for eligible medical expenses. These include hospital and doctor bills, prescription drugs and health insurance premiums. See "Covered Medical Benefit Expenses" beginning on page 15 for a list of eligible medical expenses under the Plan.

What's Not Covered

Not all medical expenses are covered under an HRA. For a full list of what is and isn't covered, visit **www.irs.gov**.

Examples of services or products not covered include:

- Advance payment for services
- Athletic club membership
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Bottled water
- Clothing
- Commuting expenses of a disabled person
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an Injury or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease
- Cosmetics, hygiene products, and similar items
- Dental bleaching
- Diaper service
- Domestic help
- Electrolysis
- Funeral, cremation, or burial expenses
- Hair transplant
- Health programs offered by resort hotels, health clubs, and gyms
- Illegal operations and treatments
- Illegally procured drugs
- Long-term care medical care services
- Marijuana, even if prescribed for medicinal purposes
- Massage therapy (unless prescribed)
- Maternity clothes
- Missed appointment fees
- Pastoral counseling
- Premiums for life insurance, income protection, disability, loss of limbs, sight, or similar benefits
- Scientology counseling
- Social activities, such as dance lessons (even though recommended by a Physician for general health improvement)
- Special foods or beverages
- Specially designed car for the handicapped, other than an autoette, or special equipment
- Swimming pool
- Travel for general health improvement
- Tuition and travel expenses for a problem child to a particular school
- Ultrasound – 4D/Elective
- Vitamins – daily multivitamins taken for general well-being
- Weight loss programs for general health
- Any item that does not constitute "medical care" as defined by the IRS
- Premiums paid through salary reduction contributions
- Premiums for individual marketplace coverage or insurance plans purchased from a state or federal Health Insurance Marketplace. Individual Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies are also not reimbursable.

DEATH AND DISABILITY BENEFITS

Weekly Disability Benefits (Active Employees Only)

The Plan includes disability coverage that protects you and your family by providing income in the event that you become disabled and cannot work due to a non-occupational disability. Weekly Disability Benefits are not payable for an occupational disability (an Injury or Sickness that arises out of or in the course of any employment for wage or profit).

You may be eligible for Weekly Disability Benefits up to the amount stated on the *Active Employee Program and Disabled Employee Program Summary of Benefits* insert and limited to the maximum number of weeks stated. If you are eligible, benefits will begin on the:

- Eighth day of your absence due to Sickness; or
- First day of your absence due to Injury.

Once you begin receiving Weekly Disability Benefits or workers' compensation (or other occupational disease law) payments due to a disability, you and your Eligible Dependents, if applicable, will remain eligible under the Plan for a maximum of 13 weeks for Weekly Disability Benefits, a maximum of 6 weeks (traditional delivery) or 8 weeks (Cesarean section) for Weekly Maternity Benefits

for Female Active Employees, or a maximum of 12 months for Workers' Compensation or Occupational Disease. No self-payment contributions will be required during this initial period. However, if your disability continues beyond this initial maximum period, you will be required to make self-payment contributions to continue coverage. All Employee classifications must provide certification from a Physician of your continued disability every two weeks.

Related periods of disability will be considered one period of disability unless between the periods of disability you return to full-time work for a minimum of two consecutive weeks. If you sustain unrelated Injuries or Sicknesses, you may be granted additional periods of Weekly Disability Benefit payments (not to exceed 13 weeks).

Weekly Maternity Benefits (Active Employees Only)

If you give birth to a child, the Fund will pay you a Weekly Maternity Benefit as described in the *Schedule of Benefits*. A multiple birth (e.g., twins or triplets) is considered one birth for purposes of this benefit. You are not eligible for a Weekly Disability Benefit during the time period in which you are receiving the Weekly Maternity Benefit. The Weekly Disability Benefit and the Weekly Maternity Benefit run consecutively, meaning that your receipt of the Weekly Maternity Benefit does not reduce your eligibility for the Weekly Disability Benefit.

Death Benefits (Active, Disabled, and Retired Employees Only)

In the event of your death while you are covered under the Plan as an Active, Disabled, or Retired Employee, the Plan pays your designated beneficiary a Death Benefit. The amount of this benefit is listed on the *Summary of Benefits* insert for the Program under which you are covered.

The death benefit is paid to your beneficiary once the Fund Office receives a copy of your death certificate. However, your beneficiary may request to receive up to one-half of the benefit amount before receiving a death certificate. Payment of this partial amount will only be made upon notice of your death from a funeral director to the Fund Office. The balance of the benefit will then be paid to your beneficiary once a death certificate is submitted to the Fund Office.

Terminal Illness Benefit

Benefits under the Plan include a Terminal Illness Benefit. In the event that you are terminally ill, you may elect to receive this lump sum benefit, equal to 50% of your Death Benefit amount.

You are considered terminally ill and eligible for this benefit if you have a life expectancy of less than six months, as certified in writing by a Physician and submitted to the Fund Office.

If you elect to receive this benefit, the amount of the Death Benefit payable at the time of your death will be reduced by the amount of the Terminal Illness Benefit you received.

The Terminal Illness Benefit is a voluntary benefit that you must elect to receive. You are not eligible for this benefit if you are required by:

- Law to use the proceeds from the Terminal Illness Benefit to meet claims of creditors (bankruptcy or otherwise); or
- A governmental agency to use this benefit to apply for, get, or keep a governmental benefit.

Accidental Death and Dismemberment (AD&D) Benefits (Active, Disabled, and Retired Employees Only)

The Accidental Death and Dismemberment Benefit (AD&D) Benefit is paid if you sustain a loss as the result of an Injury. The loss must occur within 13 weeks of the Injury. If more than one loss occurs as the result of the same Injury, only one benefit, the greatest amount, will be paid. This benefit is in addition to any other benefits payable under this Plan.

For loss of life, the benefit will be paid to your beneficiary; for any other loss, the benefit is payable to you. Loss of hands or feet means severance at or above the wrist joint or the ankle joint. Loss of sight means the total and permanent loss of sight.

The amount of the benefit is shown on the Summary of Benefits insert for the Program under which you are covered.

When Benefits Are Not Paid

Benefits are not paid for losses caused by:

- Self-inflicted injuries or suicide or an attempt at suicide;
- Physical or mental Sickness or infirmity, ptomaines or any kind of poisoning or bacterial infection;
- Flying for training; and
- An Injury or illness due to an act of war (declared or undeclared).

Designating a Beneficiary

Your beneficiary is the person, persons or legal entity (such as your estate) that you designate to receive any Plan benefits you are eligible for in the event of your death. If you name more than one individual as your beneficiary without specifying their respective shares, benefits will be paid in equal shares.

To designate a beneficiary, you need to complete a beneficiary designation form and submit it to the Fund Office. You may change your beneficiary at any time by filing a new beneficiary designation form with the Fund Office. Any change in your designation is not effective until it is received by the Fund Office.

If you do not designate a beneficiary (or if your designated beneficiary dies before you), any benefits to which you are eligible upon your death will be paid to your Surviving Spouse.

If you do not have a Surviving Spouse, benefits will be paid, in equal shares, to your:

- Children, including grandchildren who are children of your deceased children; or if none, then
- Parents; or if none, then
- Brothers and sisters, including nieces and nephews who are children of deceased brothers and sisters; or if none, then
- Estate.

GENERAL EXCLUSIONS AND LIMITATIONS

In addition to any exclusion or limitation listed in the previous sections of this booklet, no benefit will be paid under any section of the Plan for the following exclusions and limitations.

1. Services or supplies connected with an Inpatient admission lasting more than one day and falling on a Friday, Saturday and/or Sunday, unless the admission is for an Emergency Accident or Sickness or surgery is scheduled on the day following the admission.
2. Loss caused by bodily Injury that arises either out of or occurs in the course of any occupation, employment or Sickness that entitles the eligible person to benefits under a workers' compensation or occupational disease law.
3. Loss caused by war or any act of war (declared or undeclared) or military or naval service of any country.
4. Care provided by a veterans' administration facility if the Sickness or Injury is military service related or for which the individual is not required to pay.
5. Self-inflicted injuries or attempts at suicide or an attempt at suicide (this exclusion only applies to the Plan's Accidental Death and Dismemberment Benefit).
6. Injury suffered as a result of the willful participation in, or as a result of, the commission of a felony, if charged and convicted, except that the Plan will cover medical expenses that are the result of domestic violence.
7. Services rendered by Christian Science practitioners or nurses.
8. Personal items while in the Hospital.
9. Fertility treatments, artificial insemination, in vitro fertilization, gamete intra fallopian transfer (GIFT), sexual transformation or treatments related to sexual dysfunction, except that the diagnosis of the existence of the condition is covered.
10. Services or supplies that are not provided in accordance with generally accepted professional medical standards.
11. Charges for any Experimental or Investigative treatment facility, equipment, drug, device, service, or supply.
12. Services or supplies for cosmetic purposes, including cosmetic surgery designed primarily to improve or enhance the appearance of normal or abnormal structures without having a significant impact of the function of that structure. Covered reconstructive surgery is Medically Necessary surgery designed to improve the function of abnormal structures, including those caused by illness, accident, covered surgery or congenital malformation where there are objective functional defects. The presence of a psychological or emotional condition by itself does not make a surgical procedure reconstructive.
13. Services or supplies furnished by any person or institution acting beyond the scope of his or her license.
14. Care or supplies to the extent that the charge is a Medicare liability.
15. Travel, whether or not recommended by a Physician, except as provided for organ transplants.
16. Charges for failure to keep a scheduled appointment, completion of a claim form or for photocopies.
17. Recreational or diversional therapy.
18. Materials used in occupational therapy.
19. Personal hygiene and convenience items, such as hot tubs, air conditioners, humidifiers, whirlpools, swimming pools, physical exercise equipment, or health club memberships, even if such items are prescribed by a Physician.
20. Expenses incurred by an Eligible Dependent child for pregnancy, childbirth, or miscarriage, except for pregnancy tests required by a Hospital or Physician in order to perform other non-pregnancy related procedures.
21. Products designed to assist in the loss of weight that require no supervision or any other appetite suppressant or control products, whether purchased with or without a prescription.
22. Services provided before the individual became eligible for benefits.
23. Respiratory/inhalation therapy (the introduction of dry or moist gases into the lungs for treatment purposes) when performed in an Outpatient setting, unless such therapy is performed in conjunction with an Emergency Accident.
24. Take home drugs or medications.
25. Drugs, medications or supplies that may be obtained without a Physician's written prescription, except for insulin or diabetic or colostomy supplies.
26. Speech therapy for the correction of a speech impairment unless resulting from a birth defect, disease, surgery, Injury or previous therapeutic process.
27. Sterilization reversal.
28. Services provided by a person who resides in the household of the person being treated or who is a member of such person's immediate family.

29. Private duty nursing services, except under the provisions of the home health care benefit.
30. Abortions or termination of pregnancy, except in cases where the life of the Employee or Eligible Dependent spouse is threatened; however, complications of abortions will be covered by the Plan.
31. Pre-employment physical examinations or testing for addictive substances.
32. Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning.
33. Services or supplies that are not Medically Necessary.
34. Routine foot care.

CLAIMS AND APPEALS

Filing Claims

Most Providers will file claims for you. If your Provider does not file your claim for you, follow the steps described in this section. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed by the Trustees.

When you need to file a claim, contact the Fund Office. The staff there will provide you with all the necessary forms for filing your claim. The Plan requires proof of loss—usually in the form of written certification of the occurrence, character, and extent of loss incurred. The Fund Office will provide you with information as to what you need to submit. If the Fund Office does not provide the claim form and request for proof of loss within 15 days of your request (or sooner as specified in the remainder of this section), you will be considered to have met the Plan's proof of loss requirement for that claim.

You may designate an authorized representative to act on your behalf for filing claims and appeals. The Plan requires you to provide a written statement of your authorized representative's name and contact information. If you are unable to provide a written statement, your power of attorney or legal guardian must do so on your behalf. Once received, the Fund Office will work directly with your authorized representative.

To assist the Fund Office in processing claims as quickly as possible, please follow the steps listed below.

Step 1: Obtain the appropriate claim form from the Fund Office.

Step 2: Complete the form by filling in all information requested. Be sure to include your social security number and sign your form. If the claim is for an Eligible Dependent, provide the name of the Eligible Dependent.

Step 3: When necessary, have your Provider complete the appropriate portion of the claim form, including the diagnosis.

Step 4: Attach all bills or receipts relating to the service provided. Make sure each bill clearly identifies the diagnosis, the service or supply, the fee, the patient's name and the date of service.

Step 5: Forward the completed form and all related bills to:

Electrical Workers Local 369 Benefit Fund
906 Minoma Avenue
Louisville, KY 40217

All claims should be submitted as soon as possible. If a claim is submitted more than one year after the expense is incurred, the claim may be denied.

Health Care Claims

Many health care Providers will submit claims for you. Health care claims include medical, prescription drug, vision and hearing benefits. Be sure to show your ID card so your Provider knows where to submit your claim. If your Provider does not submit your claim for you, it is then your responsibility to do so.

If you or an Eligible Dependent has coverage under two or more health care plans, be sure to include the name of the other health care plan(s) on your claim form. In addition, if you are also covered by Medicare and/or another plan, attach a copy of the itemized bill relating to the health care service provided and a copy of any explanation of benefits. Both the bill and explanation of benefits must be submitted.

If the claim is the result of an Injury, be sure to complete the Injury portion of the claim form. If your claim is filed by a Provider, please complete the statement of claim information sent from the Fund Office.

There are four basic types of health care claims:

- **Urgent Care.** An urgent care claim is a type of pre-service claim for medical care or treatment that:
  - Would seriously jeopardize your life, health, or ability to regain maximum function if normal pre-service standards were applied; or
  - Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.
- **Pre-Service.** A pre-service claim is any claim for which the Plan requires that you obtain preauthorization. You must receive pre-approval for any inpatient, nonemergency admissions, transplant services.
- **Post-service.** A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim.
- **Concurrent Claims.** A concurrent claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. A concurrent claim can also pertain to a request for an extension of previously approved urgent care treatment or services.

Weekly Disability Benefit Claims

Be sure to notify your Employer and the Fund Office if you are sick or injured and are unable to work. The Fund Office will send you a claim form. Have your Physician complete the form. Then send the completed form to the Fund Office as soon as possible. Benefits are not payable until you apply for them and submit the required information.

If approved, weekly benefits are paid every two weeks. Your attending Physician will need to certify your continued disability every two weeks.

Death and AD&D Benefit Claims

In the event of your death, your beneficiary should call the Fund Office for help in filing a claim. If you have an Injury covered under the Plan's AD&D benefits, you should file the claim and, upon approval, any benefits will be paid to you.

Claim Decisions and Benefit Payment

When you submit a claim for benefits to the Fund Office, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. In some situations, the Fund has the right to request a physical exam by a Physician of its choice or an autopsy in the event of death (at the Fund's expense).

Health Care Claims

Generally, all health care benefits will be paid within 15 days after acceptable proof is received. The Plan will notify you of its initial decision within certain timeframes. If a post-service claim is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Plan will give you written notice of its decision about your claim.

The deadlines differ for the different types of claims as shown in the following information:

- **Urgent Care Claims.** An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will then have up to five days to supply the information. You will receive notice no later than 48 hours after your information is received or the end of the five-day period, whichever is earlier.

  If you improperly file an urgent care claim, you will be notified as soon as possible, but no later than 24 hours after receiving the claim. The notice will describe the proper procedures for filing an urgent care claim. You must re-file the claim to begin the urgent care claim determination process.

- **Pre-Service Claims.** An initial determination will be made within 15 days from receipt of your claim. If additional time is necessary, the Plan may take up to 15 additional days, due to matters beyond the control of the Plan; you will be informed of the extension within this 15-day deadline. In addition, if additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

  If you improperly file a pre-service claim, you will be notified as soon as possible, but no later than five days after receiving the claim. The notice will describe the proper procedures for filing a pre-service claim. You must re-file the claim to begin the pre-service claim determination process.

- **Post-Service Claims.** An initial determination will be made within 30 days from receipt of your claim. If additional time is necessary, the Plan may take up to 15 additional days, due to matters beyond the control of the Plan; you will be informed of the extension within this 15-day deadline. In addition, if additional information is needed to process your claim, you will be notified within 30 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

- **Concurrent Claims.** Concurrent claims, which involve terminating or reducing a benefit, will be made as soon as possible and early enough to allow you to have an appeal decided before the benefit is reduced or terminated. Concurrent claims constitute a request for an appeal of an adverse benefit determination. Concurrent claims must be made in writing, except that concurrent claims that are also urgent claims may be made orally and followed up with a written claim.

  For claims that involved the extension of an approved urgent care treatment, the Fund will respond within 24 hours of receipt, provided the claim is received at least 24 hours before the expiration of an approved treatment. Concurrent claims and determinations involving urgent care may both be provided orally and confirmed in writing. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service claim timeframes.

Generally, when PPO Providers submit the claims, payment is made directly to the Provider. PPO Providers handle all the paperwork for you. However, if you submit the claim, payments are generally made directly to you, unless you assign benefits to the Provider. In the event of your death, death benefits are paid to your beneficiary; any outstanding medical benefits are paid to the Provider or your estate.

Weekly Disability Benefit Claims

Generally, you will receive written notice of a decision on your initial claim within 45 days of receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within 45 days. A decision will be made within

30 days of when you are notified of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund Office notifies you before the first 30-day extension period expires. The notification will detail the circumstances requiring the extension and the date the Fund expects to make a decision.

In some instances, the Plan may require additional information to process and make a determination on your claim. If such information is required, the Plan will notify you within 45 days of receiving your request. You then have up to 45 days in which to submit the additional information. If you do not provide the information within this time, your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision will be suspended for 45 days from the date of the extension notice or until you respond to the request, whichever occurs first. Once you respond to the request for information, you will be notified of the Fund's decision within 30 days. If approved, weekly benefits are paid every two weeks.

Death and AD&D Benefit Claims

Generally, you will receive written notice of a decision on your claim within 90 days after the Plan receives your claim. If circumstances require an extension of time for processing your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

If a Claim is Denied

If your claim is denied (in whole or in part), the Plan will:

- Provide you with certain information about your claim; and
- Notify you of its denial of your claim within certain timeframes.

Information Requirements

When the Plan notifies you of its initial denial on your claim, it will provide:

- The specific reason or reasons for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;
- A statement that if you disagree with the denial, you or your authorized representative may appeal by requesting the Fund to review its decision. You will have 180 calendar days following receipt of an initial denial on a health or Disability claim (or 60 days for a Death or AD&D claim) to request this review. The Fund will not accept appeals filed after the applicable claim period.

In addition, for ***health care*** and ***Weekly Disability Benefit*** claims the notice will include:

- A copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

If your appeal is due to the denial of an urgent care claim, the notice will also include a description of the expedited review process.

In addition, for Weekly Disability Benefit claims, the notice will include:

- An explanation for agreeing or disagreeing with following:
  - The views you presented to the Plan of the health care professionals treating and evaluating you;
  - The views of the health care professionals whose advice was obtained on behalf of the Plan in connection with the denial of your disability claim, whether or not the advice was relied upon in the decision on appeal; and
  - The disability determination you presented to the Plan made by the Social Security Administration regarding your disability.
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- Notice of the decision on appeal will be provided in a culturally and linguistically appropriate manner in accordance with Department of Labor Regulation Section 2560.503-1(o).

Appealing a Denied Claim

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

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

In general, you should send your written request for an appeal to the Board of Trustees at the Fund Office as soon as possible.

For urgent care claims, your appeal may be made orally. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

- 180 days from the date of a decision for health care or Weekly Disability Benefit claims; or
- 60 days from the date of a decision for Death or AD&D Benefit claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative. A health care professional that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- Submit additional materials, including comments, statements or documents; and
- Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:
  - Was relied upon by the Plan in making the decision;
  - Was submitted, considered or generated (regardless of whether it was relied upon); or
  - Demonstrates compliance with the claims processing requirements.

In addition, if your claim is for ***health care*** or ***Weekly Disability Benefits*** and is denied based on:

- An internal rule, guideline, protocol or other similar criteria, you have the right to request a free copy of such information; and
- A Medical Necessity, Experimental treatment or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

In addition, if your claim is for Weekly Disability Benefits:

- Prior to the date that the Plan can issue a decision on your disability claim on appeal based on new or additional evidence or rationale, the Fund will provide you with the new or additional evidence or rationale, free of charge. The Fund will provide the new information as soon as possible and in an amount of time that gives you a reasonable opportunity to respond.

You may request an opportunity to appear before the Board of Trustees in person or by representative. If you do not request to appear before the Trustees, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing, by certified mail (return receipt requested) of the date, time, and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

Your Rights When Making a Appeal

When you are appealing the denial of a claim, you must be provided with the following:

- Reasonable access to copies of all relevant documents, records and other information to upon request and without charge;
- The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- A full and fair review that takes into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial benefit determination;
- A review that does not defer to the initial denial and is conducted by a named fiduciary of the Fund who is neither the individual who made the adverse benefit determination or the subordinate of that individual;
- In deciding an appeal that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or not appropriate, the fiduciary described above will:
  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment;
  - Be neither an individual who was consulted in connection with the denial nor the subordinate of that individual; and
  - Identify upon request the medical or vocational experts whose advice was obtained on behalf of the Fund in connection with the denial without regard to whether the advice was relied upon in making the benefit determination.

Hearing Procedures

You or your authorized representative may appear before the Board of Trustees to examine witnesses and produce documents and other evidence relating to your claim. In conducting the hearing, the Board will not be bound by the usual common law or statutory rules of evidence. Copies of all documents and records will be introduced at the meeting and will be attached to the record of the hearing. All information upon which the Board bases its decision will be disclosed to you or your representative. In the event that additional evidence is introduced by the Board that is not made available to you prior to the hearing, you will be granted a continuance not to exceed 30 days, provided that you agree in writing to

such an extension. Evidence discovered upon examination of your own witnesses will not be considered new evidence. You will be given the opportunity to present any evidence on your behalf. If you offer new evidence, the hearing may be adjourned (with your written consent) for a period of no more than 30 days so that the Board may investigate and determine whether additional evidence or the accuracy of your new evidence will be considered.

The Plan provides guidelines for who may act as your authorized representative and how you designate them as such. Contact the Fund Office for more details.

Appeal Decisions

If you file your appeal on time and follow any applicable required procedures, a new, full, and independent review of your claim will be made and the decision will not be deferred to the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

If the appeal is decided at a meeting of the Board of Trustees, the Plan will notify you, in writing, of the decision on any appeal within five days. However, oral notice of a determination on your urgent care claims may be provided to you sooner; otherwise, the time frame for decisions will be as provided in the next section.

Appeal Decision Timeframes

The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

- **Health Care Claims:**
  - *Urgent Care Claims.* A determination will be made within 72 hours from receipt of your appeal.
  - *Pre-Service Claims.* A determination will be made within 30 days from receipt of your appeal.
  - *Post-Service Claims.* A determination will be made no later than the date of the Board of Trustees meeting immediately following receipt of your appeal, unless the appeal is received within 30 calendar days before the date of that meeting. In such case, a determination will be made no later than the second meeting following receipt of your appeal. If special circumstances require a further extension of time for processing, the determination will be made no later than the third meeting following receipt of your appeal. If an extension is necessary, the Fund will provide you with a notice of extension describing the special circumstances and the date the determination will be made. The Fund Administrator will notify you no later than five days after the determination is made.
  - *Concurrent Claims.* A concurrent claim involving the termination or reduction of a benefit is considered an appeal. Concurrent claims involving an extension of non-urgent care claims will follow the procedures discussed above under "Pre-Service Claims."
- **Weekly Disability Benefits, Death and AD&D Benefits.** A determination will be made no later than the date of the Board of Trustees meeting immediately following receipt of your appeal, unless the appeal is received within 30 calendar days before the date of that meeting. In such case, a determination will be made no later than the second meeting following receipt of your appeal. If special circumstances require a further extension of time for processing, the determination will be made no later than the third meeting following receipt of your appeal. If an extension is necessary, the Fund will provide you with a notice of extension describing the special circumstances and the date the determination will be made. The Fund Administrator will notify you no later than five days after the determination is made.

Medical Judgments

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional who:

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

You have the right, upon request, to be advised of the identity of any medical experts consulted in making a determination of your appeal.

Under the Employee Retirement Income Security Act of 1974 (ERISA), you must follow these claims and appeals procedures completely before you can take legal action to obtain benefits if your claim has been denied.

Information Requirements

When the Plan notifies you of its determination on your appeal, it will provide:

- The specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based;
- A statement notifying you that you have the right to request a free copy of all documents, records and relevant information;
- A statement that you may bring a civil action suit under ERISA;

In addition, for ***health care*** and ***Weekly Disability Benefit*** claims the notice will include:

- A copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your

claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

In addition, for Weekly Disability Benefit claims, the notice will include:

- An explanation for agreeing or disagreeing with or not following:
  - The views you presented to the Plan of the health care professionals treating and evaluating you;
  - The views of the health care professionals whose advice was obtained on behalf of the Plan in connection with the denial of your disability claim, whether or not the advice was relied upon in the decision on appeal; and
  - The disability determination you presented to the Plan made by the Social Security Administration regarding your disability.
- Any applicable contractual limitations period that applies, including the calendar date on which the contractual limitations period expires for the claim.
- Notice of the decision on appeal will be provided in a culturally and linguistically appropriate manner in accordance with Department of Labor Regulation Section 2560.503-1(o).

External Review

You may request an external appeal review after an initial Claim Denial and subsequent internal review appeal denial to dispute determinations that involve whether the Plan complied with the surprise billing and cost-sharing protections under the No Surprises Act. The process for an external review is as follows:

Request for External Review

An external appeal must be allowed if you request an external appeal within four months after receipt of notice of Claim Denial or appeal denial. An immediate external review must also be allowed if the Plan has failed to adhere to the appeals regulations unless the violation was: 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond the Plan's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance. If the Plan asserts an exception, you are entitled, upon written request, to an explanation of the Plan's basis for asserting the exception. If the external reviewer rejects your request for immediate review on the basis that the Plan has met the five-element exception, you are permitted to resubmit and pursue and internal appeal.

Preliminary Review

The preliminary review of the external appeal must be completed within five business days after receipt of request to determine whether:

- You were covered under the Plan at the time the health care item or service was provided;
- The initial Claim Denial or internal review Claim Denial did not relate to your failure to meet eligibility requirements for eligibility under the Plan;
- You have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under the regulations; and
- You have provided all the information and forms required to process an External Review.

Within one business day after completion of preliminary review, the Plan must issue you notification in writing. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (call toll-free (866) 444-EBSA (3272)). If the request is not complete, such notification must describe the information and materials needed to make the request complete and the Plan must allow you to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of notification, whichever is later. Note that for an urgent care issue, the preliminary review must be done immediately and you must be notified of the decision immediately.

Referral to Independent Review Organization (IRO)

The Plan must utilize an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan must take action against bias and ensure independence.

Accordingly, the Plan must contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The IRO process may not impose any costs, including filing fees, on you as the claimant requesting the external review.

Within five business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. The IRO must provide written notice of its decision within 45 days of assignment. For urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.

Implementation of Reversal

Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

Privacy Policy

The Plan is required to protect the confidentiality andsecurity of your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), and the rules issued by the U.S. Department of Health and Human Services.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy and security policies and procedures and outlines your rights under the privacy and security rules and regulations.

Your rights under HIPAA include the right to:

- Receive confidential communications of your protected health information, as applicable;
- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Plan's Privacy Official at the Fund Office.

Breach Notification Rights for Unsecured Protected Health Information under HIPAA

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

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

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

Sole Authority on Plan Benefits

Under the documents creating the Benefit Fund (and the terms of the Plan), the Trustees have sole and broad discretionary authority to make final determinations regarding eligibility for benefits, the types and forms of benefits, any applications for benefits, the interpretation of the Plan and any administrative rules adopted by the Trustees. 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 and broad discretion, decide the participant or beneficiary is entitled to benefits under the terms of the Plan.

The decision of the Trustees is final and binding and will receive judicial deference to the extent that it does not constitute an abuse of discretion. If a decision of the Trustees is challenged in court, the decision will be upheld unless the court finds that it is arbitrary and capricious. Individual Trustees, Employers, or Union representatives do not have the authority to interpret the Plan on behalf of the Board of Trustees or to act as agents of the Board with respect to interpretation of the Plan. You may only rely on information regarding the Plan that is communicated to you in writing and signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees, signed by the Board's designated representative.

You must follow the Plan's claims and appeals procedures before you bring any legal action under the Employee Retirement Income Security Act of 1974 (ERISA) to obtain Plan benefits. You or any other claimant may not begin any such legal action, including proceedings before administrative agencies, until you have followed and fully exhausted the Plan's claims and review procedures described in this booklet. You may have, at your own expense, legal representation at any stage of the review process. If a provision of the Trust Agreement or the Plan, or any amendment to the Trust Agreement or the Plan, is determined to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions of the Trust Agreement or Plan.

General Coordination and Nonduplication of Benefits

The Benefit Plan is designed to help you pay for your health care expenses, including medical, prescription drug, vision and hearing care. It is not intended that you receive greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will be coordinated with any coverage you or an Eligible Dependent has under other health care plans. Other plans include benefits or services provided by:

- Group, blanket or franchise insurance coverage;
- Service plan contract, group practice, individual practice and other prepayment coverage;
- Any labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans; and

- Any coverage under governmental programs, including any coverage required or provided by any statute; however, the Plan pays primary to Medicaid.

This Fund will always pay either its regular benefits in full, or a reduced amount that, when added to the benefits payable on your behalf by other plans, will equal the total regular benefits in full. However, no more than the maximum benefits payable under this Plan will be paid.

Order of Payment

If you or your Eligible Dependent is covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits payable does not exceed 100% of covered expenses incurred. You must report your other coverage when you file a claim.

The following rules determine which plan is the primary plan:

- A plan that does not have a coordination of benefits rule is always primary;
- A plan that covers an individual as an employee is primary; and
- A plan that covers an individual as an active employee or dependent of an active employee is primary (over a plan that covers an individual as a laid-off or retired employee or dependent of such employee).

In addition, if an eligible person receives benefits or services pursuant to group or individual automobile policy, then this Plan will be secondary.

If an Eligible Dependent child is covered under more than one plan and the parents are *not* divorced or separated, the plan that covers the parent whose date of birth occurs earlier in the calendar year (excluding the year of birth) is primary. If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary.

If an Eligible Dependent child is covered under more than one plan and the parents *are* divorced or separated, the following rules determine which plan is primary:

- If there is a court decree that establishes the financial responsibility for the health care expenses of the child, benefits will be determined in accordance with the terms of the court decree, provided that the child meets the definition of an Eligible Dependent; or
- If there is no court decree and the parent with custody has:
  - Not remarried, the plan of the parent with custody will be the primary plan and the plan of the parent without custody will be the secondary plan, provided that the child meets the definition of an Eligible Dependent; or
  - Remarried, the plan of the parent with custody will be the primary plan, the stepparent's plan will be the secondary plan, and the plan of the parent without custody will pay third provided that the child meets the definition of an Eligible Dependent.

For an Eligible Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as an Eligible Dependent under a spouse's plan, the plan that has covered the person for the longer period of time is primary. In the event the Eligible Dependent child's coverage under the spouse's plan began on the same date as the Eligible Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule noted above to the Eligible Dependent child's parent(s) and the Eligible Dependent's spouse.

In all instances if no other provision applies, the plan that has covered the individual for the longest period of time is primary, with the following exceptions:

- The benefits of a plan covering the person as a laid-off or retired employee or a dependent of such person will be determined after the benefits of any other plan covering the person as an employee; and
- If an eligible person receives benefits or services pursuant to a group or individual automobile policy without regard to fault or any other arrangement of insured or self-insured group coverage, this Plan will be secondary to such coverage.

Coordination of Benefits with Medicare

Medicare is a multi-part program:

- Hospital Insurance Benefits for the Aged and Disabled (commonly referred to as Part A of Medicare) covers Hospital benefits, although it also provides other benefits.
- Supplementary Medical Insurance Benefits for the Aged and Disabled (commonly referred to as Part B of Medicare) primarily covers Physician's services, although it, too, covers a number of other items and services.
- Medicare Advantage (Part C of Medicare) covers Medicare managed care offerings.
- Medicare Prescription Drug Coverage (Part D of Medicare) covers prescription drug benefits.

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

Benefits under this Plan are coordinated with Medicare for covered individuals who are enrolled in Parts A and/or B of the Medicare program due to age or qualifying disability. This Plan will remain primary if you are actively employed. Once you retire or are disabled and eligible for Medicare, benefits from this Plan are reduced by the amount of benefits that are eligible for payment under Medicare. Benefits from this Plan are reduced regardless of whether you actually enroll

in Medicare, so it is essential that you enroll for Part A and Part B coverage as soon as possible when your active coverage terminates. Charges for services and/or supplies approved by Medicare but that are not Covered Charges under this Plan will not be paid by this Plan. In no event will benefits paid by this Plan exceed the applicable amounts listed on the *Summary of Benefits* insert for the Program under which you are covered nor will the combined amounts payable under Medicare and this Plan exceed the Covered Charges incurred.

For purposes of this Plan, the Prescription Drug benefit terminates immediately for anyone who enrolls in Medicare Part D. However, if the individual subsequently drops Medicare Part D coverage, he or she will be able to re-enroll one time only in the Prescription Drug benefit. The monthly self-payment for any Medicare-eligible individual will not be reduced if the individual enrolls in Medicare Part D coverage. In the event the prescription drug coverage under this Plan becomes less favorable than the prescription drug benefits provided under Medicare Part D, you will receive notification from the Fund Office.

Assignment of Benefits

All benefits with the exception of the Death Benefit, AD&D and the Weekly Disability Benefit may be assigned but only to the provider of services or supplies.

Right to Receive and Release Necessary Information

To determine the applicability of and implement the terms of this Plan (or any provision of similar purpose of any other plan), the Fund may, in accordance with applicable law, without the consent or notice to any person, release to or obtain information from any other welfare fund or group plan, other organization or person any information with respect to any claimant that the Fund deems necessary. Any covered person claiming benefits under this Plan must furnish any and all information necessary to implement this provision.

Right of Payment

The Trustees have the right to pay benefits to any other organization or person, as needed, to carry out the provisions of the Plan.

The Trustees may pay for or provide services or equipment that they deem to be Medically Necessary, but not otherwise covered by the Plan, if in their sole discretion, they conclude that paying for or providing such services or equipment would be financially beneficial to the Plan. This action is not deemed to be an amendment to the Plan nor does it establish a precedent, nor will it obligate such actions in the case of any subsequent claim. The Trustees may, but are not required to, delegate to their administrative manager the authority to authorize such payments on a uniform application.

Right of Recovery

Whenever payments have been made by this Plan in error or on the basis of fraudulent information, the Plan has the right to recover such payments from any person, insurance company or other plan or organization to whom or on whose behalf the payments were made. Additionally, in the event of an Injury or Sickness for which someone other than you and the Fund is liable, the Fund has the right to recover the amount of any benefits paid.

Rescission of Coverage

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

However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- When the Plan terminates your coverage retroactive to the date you lose eligibility for coverage, if there is a delay in administrative record keeping between the date you lose eligibility and the date the Plan is notified of your loss of eligibility;
- When the Plan retroactively terminates your coverage because you fail to make timely self-payments for your coverage; or
- When any unintentional mistakes or errors result in you or your Dependents being covered by the Plan when you should not have been covered; in this instance, the Plan will cancel your coverage prospectively—for the future—once the mistake is identified.

Right of Subrogation

Whenever the Plan provides benefits as a result of claims arising from an Injury or Sickness for which a third party, including an insurer, may be liable, the Fund may make a claim or take legal action against the third party. An example of a situation where this might happen would be if you were injured in a car accident caused by someone else.

Whenever you or an Eligible Dependent have a claim or demand against any third party arising from and in connection with a loss suffered by you or your Eligible Dependent, benefits provided under this Plan will be paid according to Plan provisions. Before such payments are made, however, you or your Eligible Dependent must agree, in writing, that the Fund will assume legal rights to recover against any such third party that may be held responsible, to the extent of any payments made by the Fund, and that the Fund is entitled to first dollar reimbursement from any recovery by you or your Eligible Dependent.

This right of subrogation and reimbursement means that the Fund is entitled to recover, from any recovery by you or your Eligible Dependent, the full amount of its claims paid on account of the incident, before payment to anybody else. The Fund has a lien on any benefits you or your Eligible Dependents recover to the extent of all benefits paid on your or your Eligible Dependent's behalf. In the event the claim is

for a Death Benefit on behalf of a participant, this subrogation provision will have no effect.

The "make whole" rule is specifically and unequivocally rejected. The Fund's right of first dollar subrogation or reimbursement applies regardless of whether you or your Eligible Dependent is made whole or receives a partial recovery and regardless of the characterization or application of any recovery. The subrogation and reimbursement provisions of the Plan will apply even in the absence of the execution of a written agreement. Any person who is represented by counsel will give notice of the written agreement, and a copy thereof, to their counsel.

You should provide the Fund with the identity of all potential defendants, their addresses, insurers, adjusters and claim numbers, as well as accident reports and any other information the Fund requests. If you fail to notify the Fund, as required, then upon any recovery made, whether by suit, judgment, settlement, compromise or otherwise, by you or your Eligible Dependent, the Fund will be entitled to reimbursement to the extent of benefits paid, immediately upon demand. You or your attorney will be deemed to hold any recovery made against any third party in trust for the Fund.

The Fund has the right to offset any pending or future claims against any recovery by you or your Eligible Dependent to the extent the recovery exceeds the unreimbursed benefits paid by the Fund, even if no benefits have been paid by the Fund. The Fund will also have a lien to the extent of the benefits paid, which may be filed with any person claimed to be liable to you or your Eligible Dependent on account of the loss incurred.

Amendments to the Plan

The Trustees may amend or alter the Plan and have full authority at all times to make benefit determinations and to construe and interpret the provisions of the Plan. If the Plan is amended, you will be notified in writing.

IMPORTANT PLAN INFORMATION

Plan Name
Electrical Workers Local 369 Benefit Fund.

Plan Year
July 1 – June 30.

Employer Identification Number
The Employer Identification Number (EIN) is 61-0605310.

Plan Number
The Plan number is 501.

Plan Sponsor and Plan Administrator
The Board of Trustees is the Plan Sponsor and Plan Administrator. The Board is made up of representatives of both Union and Employer Trustees. The Board of Trustees, and any of its delegates, are responsible for managing and administering the Plan and interpreting its provisions. If you wish to contact the Board of Trustees, you may use the address and phone numbers below:

Electrical Workers Local 369 Benefit Fund
906 Minoma Avenue
Louisville, KY 40217
502-635-2611
800-427-2495

The Trustees and their addresses are listed on the *Important Contact Information* insert in the back of this booklet.

Plan Type
The Plan is maintained for the purpose of providing medical, prescription drug, vision, hearing,, disability, death, and AD&D benefits.

Collective Bargaining Agreements
The Plan is maintained under collective bargaining agreements between the Union and the Association, the Union and individual Employers or between the Board of Trustees and an Employer. The collective bargaining agreement will indicate the Employer's contribution rate. Please call the Fund Office to verify if an employer is participating in the Fund through a collective bargaining agreement.

Contributions to the Plan
The Plan is financed solely by contributions from Employers and, under certain circumstances, participant self-payment contributions.

All benefits, with the exception of medical benefits for Medicare-Age eligible Retired Employees and their spouses, are provided on a self-funded basis from a Trust Fund consisting of the assets of the Fund and the investment income earned.

Agent for Service of Legal Process
Any legal process relating to the Plan should be delivered to Fund Counsel:

Rex Dunn, Esq.
Dunn and Wallbaum, PLLC
105 Daventry Lane, Suite 200
Louisville, KY 40223

Legal process may also be served upon any of the individual Trustees at the Fund Office.

Claims Procedures
The procedures to follow for filing a claim for benefits are set forth starting on page 25. If all or part of your claim is denied, you may request a review of that decision. An explanation of the procedures for requesting a review of a claim that has been denied begins on page 27.

Plan Amendment and Termination

Although the Trustees expect to continue the Plan, they reserve the right, in their sole and broad discretion, to change or modify the Plan from time to time. The Trustees may also discontinue all or any part of the Plan at any time. In the event of Plan termination, claims incurred before the date of termination will be paid out of the Trust that holds the Plan assets. If the Plan is terminated, you will be notified in writing.

YOUR ERISA RIGHTS

As a participant in the Electrical Workers Local 369 Benefit Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to the following rights.

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Administrator's office and at other specified locations, such as work sites and Union hall, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. The Fund Office will provide you with the rules governing your COBRA Continuation Coverage rights.

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 plan. 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 a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have 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 above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. 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 you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

National Office

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

Regional Office

Employee Benefits Security Administration
Cincinnati Regional Office
885 Dixie Highway, Suite 210
Ft. Wright, KY 41011
859-578-4680

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

DEFINITIONS

Air Ambulance Service

Air Ambulance Service means medical transport by helicopter or airplane for patients.

Allowable Charge

Allowable Charge for a network Provider means the negotiated fee/rate set forth in the agreement with the participating network health Provider, facility, or organization and the Plan. The Allowable Charge for a non-network Provider means the amount as determined by the Board of Trustees that the Plan will pay for a particular service or supply. The Plan will pay Allowable Charges for out-of-network services or supplies only as determined by the Board of Trustees, and not as determined by any Provider, facility, or other person or organization other than the Board of Trustees. Allowable Charges means the charges that are typically made for services and supplies in the geographic area based on the complexity of treatment received. Amounts that exceed the Allowable Charge will not apply toward the calendar year deductible or out-of-pocket maximum.

Association

Association means the Louisville Chapter of the National Electrical Contractors Association, Inc.

Covered Charges

Covered Charges mean charges for the treatment of a non-occupational Injury or Sickness that have been ordered by a Provider.

Covered Employment

Covered Employment means work you perform for an Employer that is required to make contributions to the Fund.

Eligible Dependent

Your Eligible Dependents include:

- Your spouse: the lawful spouse as recognized by the law of the state in which you live, or in which the marriage was performed. In addition, your spouse must reside with you in your permanent place of residence.
- Your child:
  - Natural child;
  - Legally adopted child, including a child placed with you for adoption;
  - Foster child;
  - Stepchild who is the natural or adopted child of your spouse; or
  - Your child, whether single or married, who is younger than age 26 unless disabled, and who received uninterrupted coverage under the plan since eligible.
- Your child for whom you have legal guardianship, provided the child is younger than age 26. You must provide documentation of legal guardianship;
- Your unmarried child age 26 or older who is disabled due to a mental or physical disability. Initially, you must provide written proof of your child's disability within 31 days of the Fund's request for proof. Thereafter, you need to provide documentation of the continued disability annually. The disabled child must:
  - Meet the Plan's definition of child or be a child for whom you have legal guardianship;
  - Have become disabled due to mental or physical disability before age 26;
  - Be incapable of self-sustaining employment and continue to be incapable of such employment;
  - Be dependent on you for more than one-half of his or her financial support and maintenance; and
  - Maintain his or her principal place of residence with you for more than one-half of the calendar year.
- Your child covered under a Qualified Medical Child Support Order (QMCSO). In addition to the above Dependent children, the Plan covers children who are required to be covered under a Qualified Medical Child Support Order (QMCSO). A QMCSO is generally a court order that directs a medical plan covering a parent to provide benefits to the parent's children. The Plan will provide benefits in accordance with such an order. A child covered by a QMCSO is called an Alternate Recipient and is treated as a Dependent under the Plan if he or she meets the criteria specified in the law governing QMCSOs. If you think this law may apply to you, you should contact legal counsel. You may contact the Fund Office if you have questions about the Plan's QMCSO procedures, or if you need a copy of those procedures.
- Coverage provided pursuant to QMCSOs cannot be greater in length, type, and amount of benefits than that provided to other Eligible Dependent children under Plan terms. The contents of QMCSOs and their administration are governed by both ERISA and written procedures adopted by the Fund. You will be required to provide legal documentation, such as a certified birth certificate, for your child.

In the event of your divorce, the General Coordination and Nonduplication of Benefits provisions are used to determine your dependent's status (see page 32).

Emergency Accident

Emergency Accident means a sudden external event resulting in bodily Injury, but does not include physical conditions resulting from Sickness or disease.

Emergency Medical Condition

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Emergency Services

With respect to an Emergency Medical Condition, Emergency Services include:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition
- Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department
- Further services that are furnished by a non-network provider or Non-Network Emergency Facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the hospital in which such further examination or treatment is furnished).

Employee

Employee means:

- A person, represented in collective bargaining by the Union, who works for a contributing Employer;
- Union officers and salaried employees;
- Chapter Manager and employees of the Louisville Chapter, National Electrical Contractors Association (NECA);
- Joint Apprenticeship and Training Committee employees and Director; and
- Fund Office employees.

Employee also includes nonbargaining unit employees (i.e., office clerks, estimators, supervisors, shop personnel, truck drivers, and warehousemen) of participating Employers provided the Employer executes an Assent of Participation form and remits contributions to the Benefit Fund on behalf of all such employees on the basis of 40 hours per week.

Employer

Employer means an employer of labor that:

- Is in the construction industry and that:
  - Is a member of the Association;
  - Employs Employees (as defined by the Plan); and
  - Is bound by an agreement with the Union providing for the payment of contributions to the Trust Fund; or
- Is not a member of the Association, but that:
  - Employs Employees (as defined by the Plan); and
  - Is bound by an agreement with the Union providing for the payment of contributions to the Trust Fund.

An Employer, as defined above, will become a party to the Trust and be bound by all of the provisions, terms, and conditions of the Agreement and Declaration of Trust by paying contributions to the Trust Fund on behalf of an Employee.

In addition, for the purpose of making required contributions into the Trust Fund on behalf of their Employees, Employer includes the:

- Union;
- Board of Trustees of the Electrical Workers Local 369 Benefit Fund;
- Board of Trustees of the Electrical Workers Local Union No. 369 Retirement Fund;
- Louisville Electrical Joint Apprenticeship and Training Committee;
- Louisville Chapter, National Electrical Contractors Association, Inc.; and
- Any participating Employer who executes an Assent of Participation form with the Board of Trustees to remit contributions on behalf of the Employer's non-bargaining unit employees.

Experimental or Investigative

Experimental or Investigative means services, supplies, procedures, drugs or medications that require approval by an agency of the U.S. Government, which has not yet been received. Experimental treatments, services, supplies, drugs or medications are also those that largely have been confined to laboratory or research settings. Investigative treatments, services, supplies, drugs or medications are also those that have progressed to limited human application but lack wide recognition as proven and effective in clinical medicine. The Trustees have the authority to determine whether a treatment, service, supply, drug or medication is Experimental or

Investigative. The fact that a Provider has prescribed, ordered, recommended, or approved the treatment, service, supply, drugs or medication does not in itself make it eligible for payment.

Family Unit

Family Unit means you and your Eligible Dependents, if any. However, if both you and your spouse are eligible for benefits under the Plan as Employees, claims for your Eligible Dependent children, if applicable—and, if you are an MRA Employee, if you make the self-payments for their coverage—will be paid in accordance with the Plan's General Coordination and Nonduplication of Benefit provisions (see page 32).

Fund

Fund means the Electrical Workers Local 369 Benefit Fund.

Home Health Care Agency

Home Health Care Agency means a:

- Service or agency that holds a valid certificate of approval or license as a public home health care agency;
- Provider holding a valid operating certificate authorizing it to provide home health care services; or
- Establishment approved as a home health agency under Medicare.

Home Health Care Plan

Home Health Care Plan means a program for care and treatment of a sick or injured eligible person in his or her home by a Home Health Care Agency. The program must be established by the eligible person's attending Physician who must approve the program in writing, before the start of home health care services. The Physician must also certify that confinement in a Hospital or skilled nursing facility would be required if home health care were not provided.

Hospital

Hospital means a facility that:

- Is a short-term, acute care general hospital;
- Is licensed;
- Is primarily engaged in providing, for compensation from its patients, Inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons by or under the supervision of Physicians;
- Has organized departments of medicine and major surgery;
- Provides 24 hour nursing services by or under the supervision of Registered Nurses (RNs); and
- Has a Physician on 24-hour call.

A facility accredited by The Joint Commission that does not meet the above requirements will still be considered a Hospital under the Plan. However, under no circumstances will Hospital include clinics, convalescent homes, rest homes, nursing homes, long-term care facilities, or homes for the aged.

Independent Freestanding Emergency Department

Independent Freestanding Emergency Department means a health care facility that (i) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) Provides any "Emergency Services" as defined in this document.

Injury

Injury means bodily harm occurring from an unexpected and unavoidable act. Intentionally self-inflicted injuries are not included.

Inpatient

Inpatient means a person who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Medically Necessary

Medically Necessary (or Medical Necessity) means a service or supply that is:

- Consistent with the patient's diagnosis or symptoms; and
- Rendered for the treatment or diagnosis of an Injury or disease, including premature birth, congenital defects and birth defects; and
- Appropriate treatment according to generally accepted standards of medical practice; and
- Not provided only as a convenience to the patient; and
- Not Experimental or Investigative; and
- The most appropriate supply or level of service needed to provide safe, adequate, and appropriate treatment. When applied to confinement in a Hospital or other facility, this means that the eligible person needs to be confined as an Inpatient due to the nature of the services rendered or due to the eligible person's condition and the person cannot receive safe and adequate care through Outpatient treatment.

Medicare

Medicare means the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Mental and Nervous Disorders

Mental and Nervous Disorders mean any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental and nervous disorders include, among other things, autism, depression, schizophrenia, and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by certified mental health practitioners.

Non-Network Emergency Facility

Non-Network Emergency Facility means an emergency department of a hospital, or an Independent Freestanding Emergency Department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service.

Out-of-Network Rate

Out-of-Network Rate will be determined in the following order:

- the amount that the state approves under an All-Payer Model Agreement, if applicable
- the amount determined by a state law, if applicable;
- the payment amount agreed to by the Plan and provider or facility, if applicable;
- the amount approved under the independent dispute resolution (IDR) process.

Outpatient

Outpatient means a person who is a patient, other than as a registered bed patient at a Hospital.

Physician

Physician means a person who is:

- A legally qualified doctor of medicine;
- Acting within the scope of his or her license; and
- Someone that is not a member of the patient's immediate family, which includes the patient's spouse, children, parents, brothers, or sisters.

Plan

Plan means the written schedule of benefits, rules, regulations, and requirements as established by the Trustees.

Plan Year

Plan Year means from July 1 of each year through June 30 of the following year. All Fund records are kept consistent with the Plan Year.

Provider

Provider means a facility, person, or organization that is licensed as required to render covered services to Employees and Eligible Dependents. Providers include:

- Ambulatory Care Facility;
- Certified Advanced Registered Nurse Practitioner;
- Certified Clinical Social Worker (CCSW);
- Community or Hospital Health Care Agency;
- Doctor of Chiropractic;
- Doctor of Dental Medicine;
- Doctor of Dental Surgery;
- Doctor of Podiatry;
- Doctor of Psychology in Clinical Psychology (PsyD.);
- Doctor of Surgical Chiropody;
- Free Standing Renal Dialysis Facility;
- Home Health Aide;
- Hospital;
- Licensed Clinical Psychologist (Ph.D.);
- Licensed Clinical Social Worker (LCSW);
- Licensed Physical Therapist;
- Licensed Practical Nurse;
- Occupational Therapist;
- Pharmacy;
- Physician;
- Psychiatric Facility;
- Registered Nurse;
- Respiratory Therapist;
- Substance Abuse Treatment Facility; and
- Supplier of durable medical equipment, prosthetic appliances, and/or orthotic devices.

Qualified Medical Child Support Order

Qualified Medical Child Support Order (QMCSO) means a medical child support order that creates or recognizes the existence of an alternate recipient's rights to, or assigns to an alternate recipient the right to, receive benefits for which you are covered under this Plan. The medical child support order must clearly specify:

- Your name and last known mailing address, if any, and the name and mailing address of each alternate recipient covered by the order;
- A reasonable description of the type of coverage to be provided by the Plan to your alternate recipient, or the manner in which such coverage is to be determined;
- The period for which the order applies; and
- The plan to which the order applies.

The medical child support order may not require the Plan to provide any type or form of benefit or any option that it would not otherwise provide, except to the extent necessary to satisfy the requirements of any applicable law.

Any benefits paid to an alternate recipient will be at the level of benefits available under the Plan at the time the expense is incurred. In addition, an alternate recipient is eligible for benefits only if you are eligible for benefits. In the event you lose eligibility and are later reinstated, any previous QMCSO, which according to its terms is still in effect, will be automatically renewed.

Qualifying Payment Amount (QPA)

Qualifying Payment Amount (QPA) generally the median amount the Plan has contractually agreed to pay network providers, facilities, or providers of Air Ambulance Services for a particular covered service. This amount is updated annually to account for inflation.

Recognized Amount

For items and services furnished by a Non-Network provider or Non-Network emergency facility, the Recognized Amount will be determined in the following order:

- An amount determined by an All-Payer Model Agreement, if applicable
- An amount determined by a specified state law, if applicable;
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

Sickness

Sickness means a disease, illness, pregnancy, or mental, emotional, or nervous disorder. Sickness does not include an Injury.

Trustees

Trustees mean the Employer Trustees and Union Trustees as appointed in accordance with the terms of the Trust Agreement.

Union

Union means the Local Union No. 369, International Brotherhood of Electrical Workers AFL-CIO.

Electrical Workers Local 369 Benefit Fund

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UNION MARK