

Electrical Workers Benefit Trust Fund
Combination Plan Document
and
Summary Plan Description

April 1, 2025

Electrical Workers Benefit Trust Fund

Summary Plan Description

For further information:

Electrical Workers Benefit Trust Benefits Office

1828 North Meridian Street, Suite 103
Indianapolis, Indiana 46202-1471
Telephone: (317) 923-4577
www.ewbtf.org

Union Trustees
Jeffrey Wheeler
Chris Grider
Carl Williams
Blake Andrews – Alternate

Employer Trustees
Sam Lacher
James Tsareff
Tim Whicker
Larry VanTries – Alternate

Administrative Manager
David M. Ray

Assistant Administrative Manager
Whitney King

Fund Consultant
United Actuarial Services, Inc.

Legal Counsel
Ledbetter Partners LLC

Fund Auditor
Legacy Professionals, LLP

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INTRODUCTION

The Board of Trustees of the Electrical Workers Benefit Trust Fund (Benefit Plan or Plan) is pleased to provide you with this updated combination Plan Document and Summary Plan Description ("SPD"). This SPD is effective April 1, 2025 and replaces prior version provided to you.

The Benefit Plan is designed to protect Eligible Persons from financial hardship in case of serious illness or injury. Health care benefits, including major medical coverage, are provided both to the Participant and Eligible Dependents.

Most of the benefits provided by the Fund are self-funded. When Employees work in covered employment, the Employer makes contributions to the Plan on the Employee's behalf, as required by collective bargaining agreements. These contributions are used to pay benefit claims and administer the Plan on the Participant's behalf.

A Board of Trustees, consisting of an equal number of labor and management representatives, is responsible for the financial management and general operation of the Fund. To accomplish these tasks, the Board of Trustees retains the services and advice of various Plan professionals, including certified public accountants, attorneys, and actuaries. The Trustees employ a full-time staff to administer the Plan and maintain a modern, well-equipped office to provide for the daily operation of the Plan.

The Trustees strive to maintain and improve the benefits available to Participants and their Eligible Dependents. However, the Trustees reserve the right to amend the Plan. Proper notice will be given of changes to the Plan. The Trustees further reserve the right to interpret and apply all provisions of the Plan, including those which relate to eligibility for benefits and the payment of benefits.

IMPORTANT NOTICE

This Combination Plan Document and Summary Plan Description (Booklet) is intended to describe the medical, accidental death & dismemberment, death, weekly disability, dental, vision, hearing aid, prescription drug, and Health Reimbursement Account ("HRA") benefits adopted by the Trustees. Only the full Board of Trustees has the authority to interpret the benefits described in this booklet. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. The Plan contains appeal procedures that may be used if you feel that benefits have been wrongfully denied. The Trustees decision can be challenged in court only after those procedures are exhausted.

No Employer or Union nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan nor can any such person act as an agent of the Trustees. Any formal interpretations regarding this Plan must be communicated in writing signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees in writing, by the Administrative Manager. As a courtesy to you, the Benefits Office may also respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

Trustee Authority

The Board of Trustees, as Plan Administrator, has full authority to increase, reduce or eliminate benefits and to change the Eligibility Rules or other provisions of the Plan at any time. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the Participants and their Eligible Dependents. Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. If the Plan makes any inadvertent, mistaken or excessive payments of Benefits, the Trustees or their representatives have the right to recover the payments. This recovery may include a lump sum payment by you to the Plan, or the Plan shall have the right to offset any future benefits due to you by that amount, until the Plan is fully reimbursed for the overpayment/mistaken payment to you.

Notices of Plan changes will be sent to each Participant's last known address. It is extremely important that you notify the Benefits Office, in writing, of any address change!

Notice of Plan Changes

Notices of changes will be sent to each Participant's last known address. Therefore, it is extremely important to keep the Benefits Office informed regarding any change of address. Plan changes, however, may take effect before notification is received. Therefore, before receiving non-emergency care, contact the Benefits Office to confirm current health benefits if you are unsure what they are.

Defined Terms

Certain words have specific meaning and are capitalized when used in the Plan. These words are listed in Article XIII – Definitions. It is important to understand the meanings of the defined terms while using this Booklet.

CONTACT INFORMATION

If You Need To …	Contact …
Check your eligibility, file an enrollment form, update your dependents, or inform the Plan of any other life events	Benefits Office www.ewbtf.org (317) 923-4577
Locate An In-Network Medical Provider…	United HealthCare www.whyuhc.com/uhss
Find information on the Plan's Medicare Advantage and Prescription Drug Plan ("MA-PD") for Medicare-Eligible Retirees and their Medicare-Eligible Dependents…	RetireeFirst www.retireefirst.com 833-237-3376
Obtain Prior Authorization and other Medical Management Services	Conifer Health Solutions 1-800-757-0391
File a Prescription, Vision, AD&D, Death Loss of Time - Weekly, Hearing Aid or HRA claim	Benefits Office www.ewbtf.org (317) 923-4577
Find a Participating Pharmacy or inquire about a Prescription Drug clinical program, including MyPath	Sav-Rx www.savrx.com (800) 228-3108
To Register For and Access Telehealth Benefits	Teladoc www.teladochealth.com (800) 835-2362
To Register for Virtual Physical Therapy	Sword Health www.swordhealth.com
To Register for Digital Coaching for Eligible Persons At-Risk for Heart Disease	Hello Heart www.helloheart.com
To file Dental Claims or find a dental provider	Delta Dental www.deltadental.com 1-800-524-0149

FILING A PARTICIPANT ENROLLMENT FORM

When first becoming eligible under the terms of the collective bargaining or participation agreement, Participants should have received a **Participant Enrollment Form (PEF)** from the Benefits Office.

The enrollment form requests certain basic information that is needed for Benefits Office records. This information includes the Participant and Eligible Dependents' full legal name, address, Social Security numbers, dates of birth and information about other insurance coverage.

This information is vital! Without it, the Benefits Office may have difficulty knowing what you and your family are entitled to under the Plan. If you are not sure whether you have a completed form on file, contact the Fund Office. You may also complete the PEF online on your member portal.

LIFE EVENTS AT A GLANCE

There are several significant events that may occur while you are covered under the Plan. Please contact the Benefits Office, in writing, if any of the following occurs:

- **YOUR CONTACT INFORMATION CHANGES.**
- **YOU MARRY, DIVORCE OR OBTAIN A LEGAL SEPARATION FROM YOUR SPOUSE.** You must also submit the appropriate legal documents (for example: marriage certificate, legal separation order, divorce decree, custody agreement).
- **YOU CHANGE YOUR BENEFICIARY.**
- **THE STATUS OF A DEPENDENT CHANGES.**
- **YOU ACQUIRE A NEW DEPENDENT.** You must also submit the child's state-certified birth certificate, decree of adoption or a Qualified Medical Child Support Order.
- **YOU OR YOUR DEPENDENT(S) ARE COVERED UNDER ANOTHER MEDICAL PLAN.**
- **YOU GO INTO OR RETURN FROM MILITARY SERVICE.**
- **YOU BEGIN RECEIVING WORKER'S COMPENSATION BENEFITS.**
- **YOU BECOME ELIGIBLE FOR MEDICARE.**
- **YOU RETIRE.**

A WORD ABOUT CONFIDENTIAL INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) provides stringent requirements for the Plan, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable 'Protected Health Information' (“PHI”). Broadly speaking, PHI includes personal information about Participant's and/or their Eligible Dependents, such as their name, address, telephone number and Social Security Number, in conjunction with information concerning the Participant and/or their Eligible Dependents, such as: (1) eligibility for Benefits, (2) medical treatment provided or (3) payment for such medical treatment. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care and health care operations or as otherwise allowed or required by law.

The Plan's use and disclosures of PHI is set out in detail in the Privacy Notice previously mailed to all Participants and summarized in this booklet. Please contact the Benefits Office for a copy of the notice.

The Plan and the Trustees are committed to observing these privacy rules and ensuring the confidentiality of all PHI. The Trustees appreciate cooperation and understanding in working with the Plan to achieve compliance with these federal requirements.

ARTICLE I - SCHEDULE OF BENEFITS

The following chart highlights the benefits offered through the Benefit Plan. Other Plan maximums and limitations may apply to specific benefits. Please refer to the appropriate sections of this Booklet or contact the Benefits Office for more information.

The Plan offers Benefits to the following groups of participants:

- Eligible Employees and their Eligible Dependents
- Retired Participants not Eligible for Medicare and non-Medicare-eligible Dependents of Retirees
- Medicare-Eligible Retirees and/or Medicare-eligible Dependents of Retirees

Retirees and/or Dependents of Retirees who are eligible for Medicare shall have their benefits provided through the separate, fully-insured MA-PD program administered by UHC, with member services provided by Retiree First. The schedule of benefits, general limitations, exclusions, claims and appeals procedures applicable to the MAPD benefits are governed solely by the terms of the separate MA-PD Evidence of Coverage. Those individuals are not eligible for other Plan benefits, except as noted in this document.

Benefits Available to Eligible Employee Only

Accidental Death and Dismemberment Benefit (Employee Only)	**Plan Pays**
Loss of:	
Life	$ 10,000
Both Hands, Both Feet, Both Eyes or combination of any Two	$ 10,000
One Hand, One Foot or One Eye	$ 5,000
Death Benefit	
Active Employee	$ 10,000
Retired	$ 2,000
Weekly Disability Benefit (Employee Only)	
Subject to Social Security Taxes	
Maximum Benefit: 52 weeks per Injury or Sickness	
Occupational	$ 65
Non-occupational	$ 500
Maternity Leave Benefit (Employee Only)	
Maximum Benefit Eight Weeks	
Benefit Calculation	100% of Employee's wages (hourly rate received day before maternity leave) for 40 hours per week

Benefits Available to Eligible Employees & Dependents and Non-Medicare Retirees and non-Medicare Dependents of Retirees

MEDICAL BENEFITS

Certain items and services or treatments may require prior authorization or are otherwise subject to benefit maximums, limitations and exclusions. Generally, an Eligible Person is required to use a PPO or In-Network Provider for medical benefits. However, please see Sections 3.01 and 10.17 for more information regarding coverage of certain Out-of-Network items and services.

Deductible - with prior year Completed Wellness Incentive	
Individual Deductible Amount (per calendar year)	$ 800
Family Maximum (per calendar year)	$ 2,400
Deductible - without prior year Completed Wellness Incentive	
Individual Deductible Amount (per calendar year)	$ 1,200
Family Maximum (per calendar year)	$ 3,600
In-Network Medical Benefit Out-of-Pocket Maximum	
Individual (per calendar year)	$ 4,500
Family (per calendar year)	$ 9,000
Major Medical Benefit	
Certain services may require precertification	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered♦
Approved Clinical Trials	
As required by the ACA	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered♦
Disease Education Benefit	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered♦
Emergency Room Benefit	
In addition to Deductible – Copayment will be waived if admitted to the hospital or kept under observation longer than 24 hours.	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered♦
Individual Copayment (per emergency room visit)	$ 250

* Subject to Annual Deductible Amount and cost-share applies to In-Network Medical Benefit Out-of-Pocket Maximum

♦ Certain Out-of-Network services may covered as described in Sections 3.01 & 10.17.

Hearing Aid Benefit *$2,400 maximum every rolling four years per individual*	Plan pays 80% UCR; subject to maximum
Home Health Care Benefit *Certain services may require precertification*	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered♦
Hospice Care Benefit *Certain services may require precertification*	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered♦
Maternity Benefit	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered♦
Mental Health Benefit *Certain services may require precertification*	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered**
Alcohol and Substance Use Benefit *Certain services may require precertification*	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered♦
Organ Transplant Benefit *Certain services may require precertification*	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered**
Surgical Benefit *Certain services may require precertification*	
In-Network	Plan pays 80% UCR*
Out-of-Network	Not Covered♦
Chiropractic Benefit *Maximum of $750 per Eligible Person per Calendar Year*	
In-Network	Plan pays 80% UCR*, subject to yearly maximum
Out-of-Network	Not Covered

* Subject to Annual Deductible Amount and cost-share applies to In-Network Medical Benefit Out-of-Pocket Maximum

♦ Certain Out-of-Network services may covered as described in Sections 3.01 & 10.17.

Telemedicine Benefits	
Teladoc Doctor Visits	Plans pays 100%
In-Network Physicians, not through Teladoc	Plan pays 80% UCR*
Out-of-Network	Not covered
Virtual Physical Therapy through Sword Health	Plans pays 100%
Digital Coaching for Persons at-risk for Heart Disease	Plans pays 100%
Podiatry Benefit	Plan Pays 100% UCR,
$4,000 maximum per individual per lifetime	subject to lifetime maximum
Preventive Care Benefit	
In-Network	Plan Pays 100% UCR
Out-of-Network	Not covered

* Subject to Annual Deductible Amount and cost-share applies to In-Network Benefit Out-of-Pocket Maximum

PRESCRIPTION DRUG BENEFIT

Please note coverage of a particular prescription drug item may subject to plan limitations, exclusions or the prescription drug clinical programs as described in Section 4.05.

Prescription Drug Benefit

Individual Deductible Amount (per calendar year) ..... $ 50

Prescription Drug Out-of-Pocket Maximum

Expenses for prescription drug items and services not covered by the Plan, or incurred due to the requirements of certain clinical programs may not accumulate towards the In-Network prescription drug maximum out-of-pocket

Individual (per calendar year)	$ 3,350
Family (per calendar year)	$ 6,700

Coinsurance	**Eligible Person Pays**
Retail is up to 30-day supply; Mail Order through Sav-Rx is 90-day supply	
Prescription Costing $3 or less	Full Cost
Generic	Greater of $3 or 10% of cost of drug
Brand (no generic available)	Greater of $5 or 20% of cost of drug
Brand (generic available and Brand not Medically Necessary)	Greater of $5 or 20% of cost of drug plus the difference in cost between brand and generic

The Plan provides Medicare retirees and Medicare Dependents of Retirees fully insured Medicare Part D coverage through the MA-PD program. The Plan also provides additional prescription drug benefits (a "wraparound benefit") to supplement the coverage from the MA-PD program. Individuals covered by the MA-PD program should contact the Benefits Office if they have questions about the prescription drug benefits

VISION CARE BENEFIT

Vision Exams
Maximum applies every rolling two-year period per individual ..... $200 maximum

Vision Materials
Maximum applies every rolling two-year period per individual ..... $600 maximum
Includes Lasik eye surgery

DENTAL BENEFIT

The Plan utilizes the Delta Dental network. All dental benefits will be paid based upon the "allowed fee," which may depend upon the provider's level of network participation with Delta Dental. See Section 6.01 for further explanation of the different levels of network participation.

General Dental Benefits
***Annual Limit**: $1,000 per person* ..... Plan pays 100% of allowed fee, subject to annual limit

Orthodontia Benefit
***Lifetime limit**: $2,000 per person* ..... Plan pays 100% of allowed fee, subject to lifetime limit

Implant Benefit
***Lifetime Limit**: $4,500 per person* ..... Plan pays 50% of allowed fee, subject to lifetime limit

Periodontia Benefit
***Lifetime Limit:** $2,000 per person* ..... Plan pays 100% of allowed fee, subject to lifetime limit

Periodontia charges over the Lifetime Periodontia Maximum will be payable under the Dental Benefit, if the General Dental Benefit Annual Maximum has not been met.

TMJ/TMD Treatment
Lifetime Limit: $750 per person ..... Plan pays 50% of allowed fee, subject to lifetime limit

Oral Surgery ..... Plan pays 80% of allowed fee

ARTICLE II - ELIGIBILITY RULES

THE TRUSTEES OF THE PLAN HAVE THE AUTHORITY AND ALL DISCRETION TO INTERPRET, CONSTRUE AND APPLY THE PROVISIONS OF THE BENEFIT TRUST FUND IN DETERMINING YOUR ELIGIBILITY FOR ENTITLEMENT TO BENEFITS. BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE PLAN ADMINISTRATOR DECIDES IN ITS DISCRETION THAT THE PARTICIPANT IS ENTITLED TO THEM.

The following topics are discussed under this Article on Eligibility Rules:

2.01. Initial Eligibility for Bargaining Unit Employees
2.02. Continuation Of Eligibility Through Credited Hours And The Hour Bank System
2.03. Continuing Eligibility Through Alternative Self-Payments For Bargaining Employees Family Medical Leave Act
2.04. Termination Of Coverage For Bargaining Unit
2.05. Reinstatement Of Eligibility For Bargaining Unit Employees
2.06. Non-Bargaining Unit Employees
2.07. Minimum Contributions For Working Owners
2.08. Special Continuing Eligibility Provisions
2.09. Eligibility For Senior (Retired) Or Disabled Employee
2.10. Retiree Pre-Funding Self-Payment Rates
2.11. Monthly Payments
2.12. Calculating Retiree Pre-Funding Credits
2.13. Benefits for Individuals Covered by the Retiree and Disabled Employee Program
2.14. Termination Of Benefits For A Senior (Retired) And Disabled Employee Participant
2.15. Eligibility for Dependent Coverage
2.16. Working Spouse Rule
2.17. Termination of Coverage for a Dependent of an Employee or Retiree
2.18. Eligibility to Continue Coverage under Surviving Spouse Program
2.19. Continuation Coverage under COBRA

Section 2.01 - Initial Eligibility for Bargaining Unit Employees

A bargaining unit Employee first becomes eligible to participate in one of two ways:

A. An Employee will become eligible for benefits from the Plan on the first day of the second calendar month following the completion of up to six consecutive months of employment under the jurisdiction of the Plan, provided that, the Employee has a total of 700 or more hours of Employer contributions made to the Plan on their behalf

during that period. Officers and Employees of Local No. 481 and Employees of the Trust Fund shall be eligible for benefits from the Plan under the same requirements as for other Employees provided that contributions are made to the Trust Fund.

B. An Employee may establish accelerated eligibility under the following conditions:

1. The Employee has, or has had, within the immediate past 30 days, bona fide medical coverage of their own under a group health plan or an individually purchased policy from the Patient Protection and Affordable Care Act ("ACA") marketplace, and not as a dependent under a group health plan. Individual policies not purchased from the ACA marketplace and government sponsored Plans, except TRICARE, do not meet the requirements of this provision; and

2. The Employee provides proof of existing or immediate past coverage, established and evaluated for suitability in the sole and exclusive discretion of the Trustees, an example of which is a HIPAA Certificate attesting to prior coverage.

Employees who meet the requirements for accelerated eligibility shall be enrolled and eligible for benefits on the first day of the second calendar month following the completion of up to two consecutive months of covered employment under the jurisdiction of the Plan, provided that the Employee has had a total of 160 hours or more of Employer contributions made to the Plan on his/her behalf during that period. Employees unable to satisfy the initial eligibility requirements set forth herein shall meet the initial eligibility criteria in Section 2.01 Paragraph A prior to enrollment in the Plan. Officers and Employees of Local No. 481, Employees of the Trust Fund, and others approved by the Trustees for Plan participation under supplemental participation agreements, shall also be eligible for accelerated eligibility.

Section 2.02 - Continuation Of Eligibility through Credited Hours and the Hour Bank System

Generally, if a Bargaining Unit Employee has satisfied the Initial Eligibility Rules in Section 2.01, the Employee will continue to be eligible for each successive month if they have received credit for 140 hours of Employer contributions on the Plan records in the first month of the three months immediately preceding the month for which eligibility is sought.

However, the Plan also utilizes an hour bank concept whereby any hours in excess of the required hours to maintain eligibility will be credited to the Employee's hour bank each month. Employees begin accruing hours in the hour bank once the Initial Eligibility Rules in Section 2.01 have been met. An Employee can bank up to 840 hours maximum. If an Employee does not have at least 140 hours reported on his/her behalf for the applicable "lookback month," any hours in the hour bank will be used to continue coverage. The hour bank is merely a bookkeeping entry and neither you nor your Dependents have any right to any particular Plan assets or any vested or accrued right to the hour bank. The Trustees can modify, reduce, forfeit or terminate the hour bank at any time.

The chart below illustrates the Plan's continuing eligibility requirements based upon credited hours and the Hour Bank system .

Continued Eligibility Requirements

To Be Eligible in:	An Employee Must Work or Have Bank Hours of 140 hours in:
January	October
February	November
March	December
April	January
May	February
June	March
July	April
August	May
September	June
October	July
November	August
December	September

If an Employee is unable to satisfy the continuing eligibility tests because they are called to duty in the uniformed services for less than 30 consecutive days, the Employee will be credited with eight hours per day for each day the Employee is on duty in the uniformed services. Additionally, apprentices who are absent from work during a weekday as a result of time spent in classroom instruction at the IBEW/NECA Electrical Training Institute will be credited with work hours for such training. Credit will only be given for attendance at class during a weekday and will be credited 8 hours per day.

In the event the Employer does not timely submit contributions to the Plan according to the Collective Bargaining Agreement for work in covered employment and it causes an Employee to lose eligibility; upon submission of paycheck stubs or other evidence of hours worked, the Employee will be credited with a maximum of two months of hours in order to maintain eligibility. If an Employee has reciprocal hours that are not submitted timely, credit cannot be given until the hours and contributions are reported via the Electronic Reciprocal Transfer System ("ERTS").

If an Employee is unable to satisfy the above eligibility test because they are on Worker's Compensation, the Employee will receive credit for 140 hours of Employer contributions for the month in which the Employee is out on Worker's Compensation. Hours in the Employee's hour bank will not be used to continue coverage.

Note: When determining eligibility, the Plan's records are based on the monthly hours reported on each Employers' monthly remittance report. Since payroll periods may not always start on the first day of the calendar month and end on the last day of the

calendar month, the number of hours you work in a particular month may vary from the number of hours reported.

Section 2.03 - Continuing Eligibility through Alternative Self-Payments for Bargaining Employees

Bargaining Employees are allowed to make Alternative Self-Payments if:

A. The Employee is in danger of losing eligibility due to a period of underemployment or temporary unemployment. Employees must be working or on the out of work list maintained by the Union and actively seeking covered employment in order to make Alternative Self-Payments; or

B. the Employee is working within the jurisdiction of another IBEW Local and does not have enough hours to continue coverage or is waiting for hours to be reciprocated; or

C. The Employee is unable to work due to a disability. An employee in this case does not have to be on the out-of-work list. Proof of the disability and application for Social Security disability must be submitted to the Benefits Office and updated annually.

To the extent an Employee is working in the electrical industry for an entity that is not associated with the IBEW and/or NECA, such Employee will not be eligible for any type of Alternative Self-Payments or coverage via remaining hours in hour bank.

Alternative Self-Payments are allowed for continuation of eligibility only and are not counted toward establishing initial eligibility or reinstatement of eligibility with the Plan once terminated. No credit will be given under the Retiree Pre-Funding Benefit or Health Reimbursement Account (HRA) for Alternative Self-Payments. Alternative Self-Payment eligibility includes Health, Prescription, Dental and Vision Benefits for the Employee and Eligible Dependents. Alternative Self-Payment eligibility also includes Death, Accidental Death and Dismemberment and Weekly Disability Benefits for the Employee only.

Generally, an Employee's monthly self-payment is equal to the number of hours required to maintain eligibility (the least amount of hours required in Section 2.02) times the hourly rate as determined from time to time by the Board of Trustees. However, the maximum monthly amount that an Employee will have to pay for Short-Hour self-payment coverage is 120 hours times the hourly rate as determined from time to time by the Board of Trustees. An Employee who is working in covered employment but lacks the required hours to maintain eligibility may use Alternate Self-Payments to continue coverage indefinitely.

An Employee with no work hours in covered employment is limited to 12 consecutive months of full Alternative Self-Payments unless the Employee is disabled and has applied for Social Security disability award. In that case, the Employee can stay on Alternative Self-Payments until Medicare Disability Benefits are awarded.

Alternative Self-Payments must be received at the Benefits Office by the end of the month for which you are self-paying. For example, if you are making a self-payment for the month

of January, your payment must be received at the Benefits Office or postmarked by January 31. All Alternative Self-Payments must be made by credit card, debit card, check or money order made payable to "Electrical Workers Benefit Trust Fund" and postmarked within the prescribed time to the Benefits Office. If paying by debit or credit card, payments will only be accepted by phone, on the member portal or in person. Please do not send debit or credit card information through the mail.

Alternative Self-Payment coverage is offered when the Employee initially loses coverage under the Plan. This is the same time that COBRA Continuation Coverage may be offered to the Employee and his or her Eligible Dependents. The Employee can choose either Alternative Self-Payments or COBRA Continuation Coverage. **If Alternative Self-Payments are chosen, COBRA Continuation Coverage will no longer be available**.

Section 2.04 - Termination of Coverage for Bargaining Unit Employees

You will no longer be covered by the Plan as a bargaining unit Employee:

A. If you are continuing eligibility through the Credited Hours and the Hour Bank System in accordance with Section 2.02, the first day of the month in which you do not meet those requirements for the applicable work month;

B. If you are continuing eligibility through the Alternative Self-Payment in accordance with Section 2.03, the first of the month in which you fail to meet those requirements;

C. On the last day of the month in which the Employee begins non-covered employment in the electrical industry for an entity that is not associated with the IBEW and/or NECA,

D. The day the Plan is terminated; or

E. The day of your death.

Upon termination, the Employee may be eligible for COBRA continuation coverage to the extent required by law or otherwise provided in this SPD. However, if an Employee continues coverage through the Alternative Self-Payment rules in Section 2.03, COBRA Continuation Coverage will no longer be available.

Section 2.05 - Reinstatement Of Eligibility for Bargaining Unit Employees

If an Employee loses eligibility for benefits under the Plan, the bargaining unit Employee may reestablish eligibility for benefits by working a minimum of 160 hours within two consecutive months with a Contributing Employer. Employees will be eligible for benefits on the first day of the third calendar month following the completion of the required 160 hours of Employer contributions made to the Plan on his/her behalf during that period.

If a retired Employee who has maintained coverage under the Plan by making self-payments returns to work in covered employment, the retired Employee may reestablish eligibility for

benefits by working a minimum of 160 hours within two consecutive months with an Employer. Employees will be eligible for benefits on the first day of the second calendar month following the completion of the required 160 hours of Employer contributions made to the Plan on his/her behalf during that period. The Retiree must notify the Benefits Office, in writing, when they return to covered employment.

If a retired Employee who has not maintained coverage under the Plan by making self-payments returns to work in covered employment, the retired Employee must satisfy the Initial Eligibility requirements set forth in Section 2.01 Paragraph A. The Retiree must notify the Benefits Office, in writing, when they return to covered employment.

Section 2.06 - Non-Bargaining Unit Employees

A. Individuals Eligible To Participate

Only full-time bona fide Non-Bargaining Unit Employees of an Employer may participate in the Benefit Plan under the rules for Non-Bargaining Unit Employees. A "full-time employee" shall mean one who performs at least 20 hours of work each week on a regular basis for an Employer. An Employer wishing to enroll his Non-Bargaining Unit Employees for participation in the Benefit Plan must enroll all full-time employees performing similar work. However, an Employee who is a spouse of a bargaining unit participant or spouse of alumni or Non-Bargaining Unit Employee already covered under a Participation Agreement with the Fund can choose to opt out of non-bargaining unit coverage. Managers and highly compensated employees may not participate unless all Non-Bargaining Unit Employees participate. Violation of this rule may result in disqualification of all the Employer's Non-Bargaining Unit Employees from continued participation.

Employees who are retired from covered employment and eligible for benefits through the Senior Employee Program can return to work as a Non-Bargaining Unit Employee and be eligible for benefits under this Article but shall not accumulate any Retiree Pre-Funding Credits under Section 2.10 for performing such work.

B. Initial Eligibility for Non-Bargaining Unit Employees

To initiate and maintain eligibility for covered Non-Bargaining Unit Employees, the Employer shall execute a participation agreement and pay the necessary contributions by the due date directed by the Trustees. Covered Non-Bargaining Unit Employees shall become initially eligible on the first day of the fourth month after the Employer initially makes two consecutive months of contributions on behalf of such Employees. For example, if contributions are first received for the month of January, eligibility will commence April 1st.

C. Continuation Of Eligibility

A Non-Bargaining Unit Employee who satisfies the initial Eligibility Rules shall continue to be eligible during each successive month if the Employee is credited with the required

amount of Employer contributions in the first month of the immediately preceding three months in which the Employee is to be eligible for benefits. For example, if contributions are received for May, eligibility is provided for August.

D. Termination Of Eligibility

A covered Non-Bargaining Unit Employee shall lose eligibility for benefits on the earliest of the following:

1. As of the last day of the third month for which the Plan receives no contributions from an Employer. For example, if contributions are last received for May, eligibility will terminate on September 1st;

2. Once a participating Employer withdraws from participation in the Plan, either with regard to Bargaining Unit Employees or Non-Bargaining Unit Employees, all participating Non-Bargaining Unit Employees coverage shall terminate on the last day of the month in which the Employer withdrawal occurs and for which contributions are due. No claims of any nature arising after the last day of said month will be paid;

3. On the last day of the month in which the Employee begins non-covered employment in the electrical industry for an entity that is not associated with the IBEW and/or NECA,

4. The day the Plan is terminated; or

5. The day of your death.

It shall be the Employer's responsibility to notify the Plan immediately when a Non-Bargaining Unit Employee is no longer employed or is otherwise ineligible for continued participation in this program. In the event that the Employer fails to make the required notification, said Employer may be held responsible for any coverage extended by the Plan after the termination date.

Upon termination, the Employee may be eligible for COBRA continuation coverage to the extent as required by law or otherwise provided in this SPD.

Section 2.07 - Minimum Contributions for Working Owners

Effective for work hours on and after January 1, 2016, a minimum of 160 hours of monthly contributions must be paid on behalf of any Employee with a direct or indirect ownership interest in an Employer. For purposes of this section, an indirect ownership interest will be defined as any ownership interest in a participating Employer regardless of corporate form (sole proprietorship, corporation, partnership, limited partnership, limited liability company, etc.) by an Employee's Spouse, child, parent or grandchild. For purposes of this 160 hour rule, any ownership interest of a Spouse, parent, child, adopted child or grandchild will be attributed to the IBEW Local 481 member. Ownership by a significant other, step-child or a separated spouse will not be attributed to the IBEW Local #481 member. Employers must

cooperate and provide the information necessary to allow the Trustees to determine participation rights and contribution rates.

Section 2.08 - Special Continuing Eligibility Provisions

This section contains a description of special circumstances that may affect your continuing eligibility and coverage under the Plan.

A. Reciprocity

The Fund is signatory to the Electrical Industry Health and Welfare Reciprocal Agreement. The purpose of the reciprocity agreement is to permit you to retain eligibility when contributions are made for you to another IBEW welfare fund. If you want this Fund to be your home fund when you travel outside of its jurisdiction, you should register with the ERTS at your home local IBEW Union office.

B. Family Medical Leave Act

When an Employee qualifies for leave under the Family and Medical Leave Act of 1996 ("FMLA") the Plan will recognize eligibility for such leave and the Employee will not lose health benefits under this plan as a result of such leave, provided the Employer properly grants the leave under the FMLA and the Employer makes the required payments to the Plan. The determination of whether an Employee is entitled to FMLA-qualified leave shall be made by the Employee's Employer. The Employer contribution rate for FMLA coverage is the same as the base contribution rate, not taking into consideration HRA contributions or any Retiree Prefunding in effect at the time of the Employee's FMLA leave.

C. Uniformed Services Employment and Reemployment Rights Act (USERRA)

1. Return to Work Coverage Guaranteed

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") or other applicable federal law, an Employee and his/her Dependents may be entitled to continued eligibility and coverage from the Plan during certain periods of service in the United States Uniformed Services. This coverage, referred to as USERRA continuation coverage, is nearly identical to COBRA continuation coverage.

Future accrued eligibility can be used immediately or can be "frozen" when entering military service. If frozen, eligibility is fully restored when the Employee re-applies for work, with any Employer who is signatory to the collective bargaining agreement with the timeframes outlined in the subsection entitled "***Reemployment Requirements When Returning from Service***" below. If an Employee enters military services, rather than having to make this election, the Trustees have agreed to allow this extension both immediately following this reduction of hours worked and when the Employee returns from active duty and reapplies for work.

When an Employee returns from service, no exclusion or waiting period may be imposed in connection with the restoration of health care coverage that would not otherwise apply if the Employee had not entered military service.

2. Continuation of Coverage While in the Military

USERRA requires a group health care plan to offer identical health care coverage for **up to 24 months** to persons who have coverage in connection with their employment but who are absent from such employment due to military service. In effect, military service is treated as if it is a "Qualifying Event" for COBRA purposes and continuation coverage is offered to the Employee and Eligible Dependents at a cost established by the Trustees.

YOU MUST NOTIFY THE BENEFITS OFFICE IMMEDIATELY WHEN YOU KNOW YOU ARE ENTERING MILITARY SERVICE.

If notification to the Benefits Office is delayed for several months, the extension of coverage for a maximum of 24 months begins with the initial date of entry into military service and a retroactive payment to that date may be charged. An Employee has an obligation to notify the Benefits Office as soon as the Participant knows they are entering military service if the Employee or Eligible Dependents wishes to take advantage of continuation coverage. Failure to notify the Benefits Office may be taken as an indication that the Employee does not wish to purchase coverage for themselves or their Eligible Dependents.

3. Reemployment Requirements When Returning from Service

The application period for reemployment is based on a time schedule keyed to the length of time spent in military service. *For service of less than 31 days*, an application for reemployment with a signatory Employer must be filed at the beginning of the next regular scheduled work period on the first day after release from service, taking into account safe transportation plus an eight hour rest period. *For military service of 31 days or more but less than 181 days*, an application for reemployment must be filed within 14 days (calendar days not work days) after release from the service. *For service over 181 days*, an application for reemployment must be submitted within 90 days (calendar days not work days) after an honorable discharge.

Section 2.09 - Eligibility for Senior (Retired) or Disabled Employee

For all Participants after December 31, 2002, a Senior (Retired) or Disabled Employee who has been employed under the jurisdiction of the Plan may become eligible under the Senior (Retired) and Disabled Employee Program, if **ALL** of the following eligibility requirements are met:

A. The individual meets one of the following:

1. An Employee that was eligible for benefits from the Plan for at least 24 months within the 48 month period immediately preceding the effective date of the Employee's retirement and be at least 55 years of age and have 25 Retiree Pre-Funding Credits or 25 Years of Service and, if eligible, is drawing a benefit from the Indiana Electrical Workers Pension Trust Fund, IBEW; or

2. An Employee that was eligible for benefits from the Plan for at least 24 months within the 48 month period immediately preceding the effective date of the Employee's retirement and be at least 60 years of age with 10 Retiree Pre-Funding Credits or 10 Years of Service and, if eligible, is drawing a benefit from the Indiana Electrical Workers Pension Trust Fund, IBEW; or

3. An Employee that was eligible for benefits from the Plan for at least 24 months within the 48 month period immediately preceding the effective date of the Employee's retirement and be at least 65 years of age with 5 Retiree Pre-Funding Credits or 5 Years of Service and, if eligible, is drawing a benefit from the Indiana Electrical Workers Pension Trust Fund, IBEW; or

4. An inactive Employee must be at least age 55 years of age with at least 20 Retiree Pre-Funding Credits or 20 Years of Service and, if eligible, is drawing a benefit from the Indiana Electrical Workers Pension Trust Fund, IBEW. If eligible under this subsection, a reduction factor will be applied based on the Employee's Retiree Pre-Funding Credits as described in Section 2.10(C). The Pre-Funding Credit Value will be 70% for 20 Pre-Funding Credits and one additional percent for each Pre-Funding Credit over 20 with a maximum benefit of 80% of the Pre-Funding Credit Value for 30 Pre-Funding Credits. Eligibility under this section must be elected on the date of retirement; or

5. If disabled, the Employee must have been approved for Total and Permanent Disability Benefits in accordance with the restated Plan Document of the Indiana Electrical Workers Pension Trust Fund, IBEW and must have been eligible for benefits as a Covered Employee for at least 24 months within the 48 month period immediately preceding the effective date of the Employee's receiving disability benefits and must have been eligible for benefits as a Covered Employee at the time the Social Security disability was awarded.

B. The individual must make a written application for the program to participate; And

C. If the Employee was eligible as a Covered Employee at the time of application to the Senior (Retired) and Disabled Program, the Employee must make the required payment on or before the end of the month during the month in which eligibility under the active coverage terminates.

If the individual meets all of the criteria for coverage under the Senior (Retired) and Disabled Program, the initial eligibility date for coverage shall be the first day of the first benefit month

following the date of the individual's request to be covered under this Program and receipt of proper payment by the Benefits Office.

Retirees who meet all of the criteria for coverage under the Senior (Retired) and Disabled Program, but then return to active employment and regain active eligibility through bargaining unit work as described in Section 2.01 are not required to once again meet the eligibility rules in this Section 2.09 to return to the Senior (Retired) and Disabled Program when their active eligibility expires. The Benefits Office will provide notice to the individual of their eligibility to re-enter the Senior (Retired) and Disabled Program.

Section 2.10 - Retiree Pre-Funding Self-Payment Rates

The Trustees shall determine, at least annually, the value of each Retiree Pre-Funding Credit. Such value shall be based on actuarial studies commissioned by the Trustees. However, The Trustees reserve the right to change the amount of the self-contribution payment from time to time.

A. Self-Payment Amount for Retiree not Eligible for Medicare

The retiree self-payment amount for each retiree not eligible for Medicare for any given month shall be not less than $100 per month, nor more than:

1. The expected average monthly cost of retiree coverage as determined by the Trustees based on past non-Medicare retiree claims experience, economic factors, and other factors deemed relevant to such calculation by the Trustees; less,

2. One hundred percent of the value of each Retiree Pre-Funding Credit in effect for such month multiplied by the number of Retiree Pre-Funding Credits earned by the Retiree.

B. Self-Payment Amount for Retiree Eligible for Medicare

The retiree self-payment amount for each retiree eligible for Medicare for any given month shall be not less than $50 per month, nor more than:

1. The expected average monthly cost of retiree coverage as determined by the Trustees based on past Medicare-eligible retiree claims experience, economic factors, and other factors deemed relevant to such calculation by the Trustees; less,

2. One hundred percent of the value of each Retiree Pre-Funding Credit in effect for such month multiplied by the number of Retiree Pre-Funding Credits earned by the Retiree.

C. Special Rules Regarding Retiree Pre-Funding Self-Payment Rates

Retiree Pre-Funding Credits for married Participants can be added together as long as both Participants would have otherwise been eligible for the Retiree Pre-Funding Credit on their self-payments. The minimum $50 or $100 monthly payment will still apply.

If a Senior or Disabled Employee returns to work in the electrical industry for any entity that is not affiliated with the IBEW and/or NECA, he will no longer be eligible for any Retiree Pre-Funding Credits. The Employee engaging in such non-covered employment will still be able to participate in the Senior (Retired) Employee and Disabled Employee Program but will be required to pay the entire self-payment rate. If the Employee is able to adequately establish to the Board that he is no longer engaging in such non-covered employment, the applicable Retiree Pre-Funding Credits will be restored 90-days after furnishing such proof.

Section 2.11 - Monthly Payments

The required self-payment for this program must be made monthly in advance and will provide one month of coverage. Failure to make timely payments will terminate the individual's right to make future payments and be covered under this program.

LATE PAYMENTS SHALL NOT BE ACCEPTED.

Retirees who regain active eligibility through bargaining unit work may discontinue their self-payments under the Senior (Retired) or Disabled Employee Program until their active eligibility expires and they receive notice of their eligibility to re-enter the Senior (Retired) or Disabled Employee Program.

Section 2.12 - Calculating Retiree Pre-Funding Credits

Retiree Pre-Funding Credits shall be calculated as follows:

A. Prior to 2000

For each pension vesting credit earned under the Indiana Electrical Workers Pension Trust Fund, IBEW, the Employee will earn one Retiree Pre-Funding Credit under this Plan. Communication and Non-Bargaining workers will receive Retiree Pre-Funding Credits based on the post-2000 formula below, based on hours reported.

B. After 2000

The Retiree Pre-Funding Credit for any Employee with less than 30 Retiree Pre-Funding Credits or under age 55 will be calculated as follows:

1. Less than 500 Hours of Employer Contributions in a Plan Year, the Employee will not earn any credits.

2. 500 to 999 Hours of Employer Contributions in a Plan Year, the Employee will earn one-half a credit.

3. 1,000 or more Hours of Employer Contributions in a Plan Year, an Employee will earn one credit.

A maximum of one Credit per Plan Year may be earned under the above rules.

C. After 2000

The Retiree Pre-Funding Credits for Employees age 55 or older with 30 or more Retiree Pre-Funding Credits will be calculated as follows:

1. Less than 500 Hours of Employer Contributions in a Plan Year, the Employee will not earn any credits.

2. 500 to 999 Hours of Employer Contributions in a Plan Year, the Employee will earn one Credit.

3. 1,000 or more Hours of Employer Contributions in a Plan Year, an Employee will earn two Credits.

A maximum of two Credits per Plan Year may be earned under the above rules.

Effective January 1, 2007, a retired Employee will not receive Retiree Pre-Funding Credits for any hours reported after the Retiree's original retirement date.

Section 2.13 - Benefits for Individuals Covered by the Retiree and Disabled Employee Program

A. Individuals Not Eligible for Medicare

Medical and Prescription Benefits (including dental and vision benefits) for individuals in the Senior (Retired) and Disabled Employee Program who are not eligible for Medicare shall be the same as provided to active Employees and their Eligible Dependents. Death Benefits shall be payable in the amount of $2,000. No Accidental Death and Dismemberment or Weekly Disability Benefits shall be payable.

B. Individuals Eligible for Medicare

Medical and Prescription Benefits (including vision benefits) for individuals in the Senior (Retired) and Disabled Employee Program who are eligible for Medicare shall be provided through the MAPDprogram. Death Benefits shall be payable in the amount of $2,000. Dental benefits are provided through Delta Dental. No Accidental Death and Dismemberment or Weekly Disability Benefits shall be payable.

For details of the medical and prescription benefits provided under this program, refer to your MAPD Evidence of Coverage document. The MAPD program provides Medicare eligible Participants with Medicare Part D coverage. This Plan also provides a supplement to Part D to cover certain things not covered under a basic Part D Plan. Under the MAPD program, UnitedHealthcare ("UHC") will provide the basic Medicare Part D program and Sav-Rx will provide the supplement to Medicare Part D coverage.

Initial Enrollment
All current and future Medicare eligible participants will be automatically enrolled in the Plan's Medicare Advantage program when first eligible to enroll, so long as the individual is properly enrolled in Medicare Parts A and B. If an individual does not enroll in Medicare Parts A and B at least 90 days prior to losing coverage as an Active Employee, the individual will not be eligible for the MAPD program.

Special Enrollment
If you are not enrolled in the Medicare Advantage and Prescription program when you first become eligible for Medicare due to coverage through active employment, you will be able to enroll yourself and your Eligible Dependents in this Plan if you or your Eligible Dependents lose eligibility for that other coverage (or if the employer stops contributing toward you and your Eligible Dependents' other coverage). However, you must request enrollment within 30 days after you or your Eligible Dependents' other coverage ends.

In addition, if you have a new Medicare eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll that Medicare eligible dependent. Enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption.

If there is any conflict between this Plan and the UHC certificate, the UHC certificate will control. To request special enrollment or obtain more information, contact the Benefits Office at (317) 923-4577.

Disenrollment from Coverage (Opt Out)
You may only be enrolled in one Medicare Advantage or Prescription Drug plan at a time. If you enroll in a different Medicare Advantage plan or Medicare Part D Prescription Drug Plan, you will be automatically disenrolled from this plan.

You will be disenrolled from this MA-PD program if you fail to make timely monthly contribution payments.

If you disenroll in this MA-PD program, you will not be allowed to re-enroll in the future unless you re-establish eligibility via the Initial Eligibility requirements as described in Section 2.01.

You should be aware that you may switch Medicare Advantage Plans only during certain times. During the Open Enrollment Period (October 15 – December 7 each year), you can join, switch, or drop a plan. If you're enrolled in a Medicare Advantage Plan, during the

Medicare Advantage Open Enrollment Period you can switch to a different Medicare Advantage Plan or switch to Original Medicare (and join a separate Medicare drug plan) once during this time. You may also make changes to your Medicare Advantage and Medicare prescription drug coverage during Special Enrollment Periods, which is when certain events happen in your life, like if you move or you lose other insurance coverage.

Section 2.14 - Termination Of Benefits for a Senior (Retired) and Disabled Employee Participant

Benefits under the Senior (Retired) and Disabled Employee Program shall terminate on the earliest of:

A. The first day of any month for which no required self-payment is received;

B. The first day of the month that the individual gains active coverage from this Plan by receiving credit for working sufficient hours in Covered Employment;

C. The date the program is terminated or modified to exclude the class of retirees for which the individual belongs;

D. The date of the individual's death. If you have Eligible Dependents covered by the Plan, those dependents may be eligible to continue coverage from the Plan pursuant to the rules found in Section 2.18;

E. If the individual is Medicare-Eligible, the first of the month in which the individual is eligible for Medicare Parts A and B and do not properly enroll in the same; or

F. If the individual is Medicare-Eligible and enrolled in the MA-PD plan, the date the individual enrolls in a Medicare Supplement Plan, Medicare Advantage Plan, and/or a Medicare Part D Plan that is not the MA-PD Plan offered by the Plan.

Section 2.15 - Eligibility for Dependent Coverage

Covered Employees and Retirees must enroll their Eligible Dependent(s) to be covered by the Plan. To enroll, an enrollment form must be completed and returned to the Benefits Office, along with any requested documentation.

A. Enrollment Process for Dependents of Covered Employee at Initial Eligibility

Eligible Dependents of Covered Employees will be covered by the Plan as of the Covered Employee's Initial Eligibility Date if the Benefits Office receives a properly completed enrollment form and any other requested documentation, including any information regarding availability of Spousal coverage necessary to determine compliance with the Plan's Working Spouse rule, as described in Section 2.16, within 30 days of the Employee's Initial Eligibility Date. If enrollment forms are received after the 30 days, the Eligible Dependents will be covered prospectively upon enrollment, unless subject to the Special Enrollment provisions found in 2.15(C).

B. Enrollment Process for Dependents of Retirees

If you are a Retiree and you elect coverage under this Plan, you may also elect coverage for your Eligible Dependents. Generally, if you are a Retiree, your eligible Dependents will be automatically enrolled in coverage at the time you elect retiree coverage from this Plan. If your Dependent opts out of coverage, your Dependents may re-enroll in coverage during open enrollment.

C. Special Enrollment Provisions

Newly acquired Eligible Dependents, including Spouses, should be enrolled no later than 60 days following the date of marriage, the birth of a natural born child, the date a child is placed with the Employee for adoption, the date which the Employee incurs a legal obligation for support in anticipation of adoption or the date coverage for a child is mandated by a Qualified Medical Child Support Order. Additionally, a Dependent can be added within 61 days if coverage under a State Children's Health Insurance Program ("CHIP") is lost, or if the Dependent becomes eligible for CHIP or Medicaid Coverage. Employees should contact the Benefits Office for more information.

If a Participant fails to timely enroll a new dependent or provide evidence of a dependent's eligibility, coverage will begin on the first of the month following the completion of enrollment and will not be retroactive to the date of birth, marriage, adoption or placement for adoption. The Plan will not be responsible for any bills or charges incurred prior to the first of the month following completion of enrollment. Please contact the Benefits Office for more information.

D. Special Opt-Out Provisions

A Spouse or child of an Employee may opt out of the Plan's coverage due to eligibility under a high deductible health plan (such as a Health Savings Account or "HSA") through their employer or through their Spouse's employer, by completing the Plan's appropriate form with proof that the Spouse or child has a high deductible healthcare plan. A Spouse or child of an Employee may rejoin this Plan by completing the Plan's appropriate form with proof that the Spouse or child is no longer being covered under the high deductible healthcare plan and that the Employee is still eligible under this Plan. Eligibility will commence on the first day of termination under the high deductible plan.

Section 2.16 - Working Spouse Rule

Spouse Coverage: If the Spouse of an Employee is working for an employer which offers a "qualified" employer-sponsored health plan as defined under this Section, the Employee's Spouse must enroll in that employer-sponsored coverage to be eligible for coverage under the Plan as an Eligible Dependent. The Spouse of an Employee will not be an Eligible Dependent unless the Employee and Spouse provide information about the employment status of the Spouse and whether the Spouse is eligible to enroll in an employer-sponsored healthcare plan whenever requested by the Electrical Workers' Benefit Trust Fund ("EWBTF").

During any period when an Employee's Spouse is employed and eligible to enroll in a "qualified" employer-sponsored health care plan, the Spouse must enroll in the employee-only coverage offered through the Spouse's employer provided the Spouse's cost share for the least expensive Qualifying Plan coverage option does not exceed $125 per month. When the Spouse enrolls in Qualifying Plan coverage through their employer, such Spouse's coverage under their employer-sponsored health care plan will be primary and coverage under the EWBTF will become secondary.

Qualified Plan Coverage – Enrollment Options: For purposes of this Working Spouse Rule, "Qualified Plan Coverage" means an employer-sponsored health plan that:

1. Offers coverage that, at a minimum, satisfies ACA-minimum coverage standards for essential health benefits;

2. Is subject to state or federal regulations of the insurer of an insured plan or the employer of a self-insured plan;

3. Is available to the working Spouse at an employee cost that does not exceed $125 per month (excluding the cost of any voluntary benefit options, e.g., dental, life insurance or vision benefits) for the least expensive coverage option available to the employee.

In the event a Spouse has coverage options, a working Spouse is required to enroll in at least single (employee only) qualified coverage under a plan that meets the minimum coverage requirements set forth by the ACA. The Trustees reserve the right to modify the provisions of this program at any time.

Exceptions: A working Spouse is not required to enroll in an employer-sponsored health care plan in order to maintain eligibility if the following situations apply:

1. If the Spouse is self-employed and has no other employees.

2. If the Spouse is not employed full time within the meaning of Section 4980H of the Internal Revenue Code (generally less than 30 hours per week or on average less than 130 hours per month).

3. The coverage does not satisfy the terms of "Qualified Plan Coverage" described above.

4. If the Spouse is eligible and elects to continue coverage under the Plan in accordance with the Surviving Spouse Program set forth under Section 2.18.

Facilitation of Enrollment: The Fund Administrator is authorized to terminate eligibility of a dependent Spouse for benefits from the EWBTF, if necessary, to enable the Spouse to enroll in the spouse's employer-sponsored health care coverage. The Fund Administrator is also authorized to reinstate eligibility in the EWBTF after the Spouse has enrolled in their

employer-sponsored health care plan. Coverage under the EWBTF will then be paid secondary and will only be reinstated effective the first day of the following month after receipt of the completed and signed verification form. No retroactive coverage will be granted.

Verification of Enrollment: The Trustees will require written verification from a working Spouse's employer regarding satisfaction of all requirements of this Plan to maintain the working spouse's eligibility. Verification will be required at least annually, however, the Trustees can initiate random audits more frequently.

Failure to Enroll: If an Employee's working Spouse fails to enroll in an employer-sponsored health care plan when required, or if the Employee, working Spouse or Spouse's employer fails to provide required information requested by the EWBTF, the Spouse's eligibility for primary coverage under this Plan will terminate immediately. If the Spouse thereafter enrolls in the spouse's employer-sponsored health care plan, or if the required information is received, the spouse's eligibility under the EWBTF will be reinstated effective the first day of the following month after receipt of the required enrollment or information is completed. No retroactive coverage will be granted. Coverage under the EWBTF will then be paid secondary.

The program requires a working spouse, who is not considered "Exempt" under the EWBTF, to enroll in Qualifying Plan Coverage offered by their own employer as a condition of receiving benefits from the EWBTF.

Special Notice for Participants enrolling in a High Deductible Healthcare Plan ("HDHP"): The EWBTF is not an IRS-qualified HDHP, which means coverage under the EWBTF (even if only on a secondary basis) disqualifies such working Spouse from making or receiving pre-tax contributions into a HSA, even if the working Spouse's employer-sponsored Qualifying Plan Coverage is a HDHP.

Therefore, a working Spouse who enrolls in a HDHP may wish to either:

1. Not make or receive pre-tax contributions into an HSA during any time when the Spouse is also covered by the EWBTF on a secondary basis; or

2. Voluntarily opt-out of secondary coverage under the EWBTF in order to remain eligible to make and/or receive pre-tax HSA contributions

To further explore the rules and regulations surrounding HDHPs and HSAs, please contact a qualified tax professional as the EWBTF cannot offer tax advice.

Definitions	
Self Employed:	An individual, doing business as a sole-proprietor or partner, who either has no employees or offers no health coverage to employees.
Part-Time Employee:	Part-time is defined by the EWBTF for the Working Spouse Rule as working an average of less than 30 hours per week.

Qualified Plan:	For purposes of the Spousal Coverage Program, a "Qualified Plan" means an employer-sponsored health plan: 1. Offers coverage that, at a minimum, satisfies ACA-minimum coverage standards for essential health benefits; 2. Is subject to state or federal regulations of the insurer of an insured plan or the employer of a self-insured plan; 3. Is available to the working Spouse at an employee cost that does not exceed $125 per month (excluding the cost of any voluntary benefit options, e.g., dental, life insurance or vision benefits) for the least expensive coverage option available to the employee.
Open Enrollment:	The time or times during the year when an employee may normally enroll for coverage in an employer-sponsored health plan.
Waiting Period:	The period following initial employment that must elapse before an employee can commence coverage in an employer-sponsored health plan.
Opt-Out:	Voluntarily choosing to decline (or terminate) any spousal dependent coverage in the EWBTF.
Exempt:	An Employee's Spouse who is not eligible for a Qualifying Plan through their own employer, or an Employee's Spouse who is not employed.
Non-Exempt:	An Employee's Spouse who is eligible to enroll in a Qualifying Plan.
Non-compliance:	An Employee's Spouse who is eligible to enroll in a Qualified Plan through their own employer and choose not to enroll in the Qualified Plan, or an Employee's Spouse who does not properly complete the Verification Form for the Spouse Coverage Program.

Other Insurance: The working Spouse's employee health care plan will pay claims as "primary" and the EWBTF will pay claims as "secondary.' If a working spouse has coverage in the form of a Health Reimbursement Account "HRA", all charges covered by that HRA must be processed prior to submitting to the EWBTF for reimbursement. The EWBTF will pay as "primary" only if a spouse is considered "Exempt" in the EWBTF Working Spouse Rule.

Open Enrollment Period: A working Spouse who elected not to enroll during their employer's one-time Open Enrollment period should be allowed another Open Enrollment period once coverage has been terminated by the EWBTF. You can contact the EWBTF for a letter of termination to present to your employer. When enrollment has been established with the employer's health care plan, the EWBTF will pay as "secondary."

Verification Form Required: All dependent Spouses eligible for coverage in the EWBTF must submit a fully completed and signed verification form showing either they are "Exempt" or they have obtained Qualifying Plan health coverage through their own employment. All dependent Spouse benefits under the EWBTF will be terminated (or suspended in the case of

a new spouse) from the time the form is due until the completed and signed form is received by the EWBTF. Coverage will only be reinstated the first day of the following month after receipt of the completed and signed verification form. No retroactive coverage will be granted.

Opting Out: Spouses may elect to "Opt Out" of coverage in the EWBTF by checking the appropriate box on the Verification Form for the Spousal Coverage Program. A dependent Spouse who elects to "Opt Out" of coverage is terminating their coverage in the EWBTF

How the Claim is Paid: If a spouse is eligible to enroll in Qualifying Plan coverage AND does not elect coverage, no claims will be paid on the spouse's behalf. If a spouse is eligible to enroll in Qualified Plan coverage AND elects coverage under that plan, the EWBTF will pay all claims on a "secondary" basis.

Program Audit: There will be various types of audits conducted by the Plan to verify the availability of employer-sponsored health care coverage to a working Spouse.

- Ongoing Dependent Re-enrollments – as the employment status of Spouses can change throughout the year, quarterly reminders could be mailed to households of married Employees.

- Targeted Audits/Threshold Audit – When any non-working spouse's year-to-date submitted claims exceed a pre-defined threshold, e.g., $5,000, the Benefits Office reserves the right to follow a protocol similar to that involving potential accident claims where subrogation issues may apply. Specifically, the Benefits Office may pend or deny any outstanding claims and mail the Spouse a targeted follow up letter requiring the return of updated re-enrollment paperwork before the claims could be released for processing.

Noncompliance – Recovery: In the event either a working Spouse's availability of outside employer health care coverage is discovered by the Benefits Office after the Plan's last timely-completed (re)enrollment, or the Covered Employer or spouse preemptively self-report any past misrepresented availability of outside employer-sponsored coverage, the Plan will terminate the Spouse's coverage under the Plan. The Fund will seek reimbursement of claims paid in error.

Section 2.17 - Termination of Coverage for a Dependent of an Employee or a Retiree

An Eligible Dependent's coverage will terminate on the earliest of the following dates:

A. The date in which an Employee's or Retiree's coverage from the Plan terminates, unless the Dependent is eligible to continue coverage after the Employee's or Retiree's death;

B. The last day of the month in which the dependent ceases to be an Eligible Dependent;

C. The date the Eligible Dependent properly opts-out of coverage from the Plan;

D. If the Eligible Dependent is a Medicare-Eligible dependent of a Retiree, the first of the month in which the dependent is eligible for Medicare Parts A and B and does not properly enroll in the same; or

E. If the Eligible Dependent is a Medicare-Eligible dependent of a Retiree, the date the Dependent enrolls in a Medicare Supplement Plan, Medicare Advantage Plan, and/or a Medicare Part D Plan that is not the MA-PD Plan offered by the Plan.

Upon termination, the individual may be eligible for COBRA continuation coverage to the extent required by law or otherwise provided in this SPD.

All individuals covered by the Plan are responsible for promptly notifying the Benefits Office when a dependent ceases to meet the definition of an Eligible Dependent. For example, this means a covered individual must notify the Benefits Office immediately in the event of divorce, dissolution of marriage, legal separation or separate maintenance, or when a dependent child is no longer an Eligible Dependent.

Misrepresenting eligibility criteria for dependents (for example, marital status, age, relationship status), to obtain or continue coverage for an individual who would not otherwise meet the dependent eligibility criteria will be considered an act or an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. The Plan may recover any payments made for claims incurred on behalf of the former Dependent after the Dependent was no longer eligible for Plan coverage.

Section 2.18 - Eligibility to Continue Coverage under the Surviving Spouse Program

A Surviving Spouse program is available to the Surviving Spouse and Eligible Dependent children of a deceased eligible participant who died March 1, 1985 or later pursuant to the rules in this section.

A. Eligibility for Participation in the Surviving Spouse Program

Eligibility for the program will begin on the first day of the benefit month immediately following the termination of the Spouse's coverage as a result of the eligible Participant's death in accordance with the following rules:

1. A Surviving Spouse program is available to the Surviving Spouse and Eligible Dependents of a deceased eligible Employee or Retiree;

2. Eligible Dependent children shall be eligible for coverage only while the Surviving Spouse is eligible for coverage;

3. Coverage in the Surviving Spouse Program is NOT automatic and shall be offered to the Surviving Spouse only once. Surviving Spouses must elect coverage from the Surviving Spouse Program and pay the applicable self-payment by the end of the month following the month in which their dependent coverage from the Plan

terminates. For example, if the Surviving Spouse would have otherwise had coverage through the Plan through June 30, 2024, the Surviving Spouse must elect and pay the self-premium for the Surviving Spouse Program by July 31, 2024 to be covered.

4. The Surviving Spouse shall be required to make monthly self-payments; and

5. A Surviving Spouse may initially elect the Continuation coverage under COBRA and remain in that program for 36 months. At the end of the 36 months or at any time within that period the Surviving Spouse may enroll in this Surviving Spouse Program. If, however, the Surviving Spouse initially enrolls in this Surviving Spouse Program, the Surviving Spouse may NOT later elect the Continuation Coverage under COBRA.

The Working Spouse Rules set forth in Section 2.16 are not applicable to the Surviving Spouse Program. If a Surviving Spouse is enrolled in Qualified Coverage as defined under Section 2.16 and maintains such coverage after electing coverage under the Surviving Spouse Program, the EWBTF will pay all claims on a "secondary basis."

B. Self-Payments for the Surviving Spouse Program

The amount of the Surviving Spouse's monthly self-payment will not exceed the lower of the Alternative Self-Payment or Retiree Pre-Funding rate in effect for the month the coverage is being purchased. The Trustees reserve the right to change the amount of the self-contribution payment from time to time.

C. Benefits Available

If the deceased Participant was an Active Employee, the Plan of benefits for the Surviving Spouse and Eligible Dependent children shall be the same as that offered to Eligible Dependents of Covered Employees.

If the deceased Participant was a retired Employee, the Plan of benefits for the Surviving Spouse and Eligible Dependent children shall be the same as that offered to dependents of Retirees, except that there shall be no Maternity Benefits for conception after the Participant's death.

D. Termination of Coverage in the Surviving Spouse Program

Benefits under the Surviving Spouse Program shall terminate on the earliest of:

1. The first day of any month for which no required payment is received;

2. The date the Surviving Spouse re-marries;

3. For non-Spouse Eligible Dependents, the first day of the month after the dependent is no longer an Eligible Dependent; or

4. The date the program is terminated.

Once coverage from this Plan terminates, it may not be reinstated unless the termination of coverage was due to the Surviving Spouse becoming eligible for coverage under an employer's group plan and such employer group coverage is terminated. In such a case, the surviving spouse may re-enroll in this Plan within 60 days of the termination of the Surviving Spouse's coverage under the employer's group plan.

Section 2.19 - Continuation Coverage Under COBRA

In compliance with a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Plan offers certain Employees and Eligible Dependents (dependent Spouses and/or dependent children) the opportunity to continue their health benefits, dental and vision benefits, where applicable, by making self-payments in certain instances where the eligibility for these benefits would otherwise terminate. This coverage is "Continuation Coverage."

You may have other options available to you when you lose your 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 doesn't accept late enrollees.

A. Eligibility For Continuation Coverage

An Employee or Eligible Dependent who becomes eligible for Continuation Coverage shall be known as a "Qualified Beneficiary." An event that causes a Participant or Eligible Dependent to become a Qualified Beneficiary is known as a "Qualifying Event." In order to become a Qualified Beneficiary, a Participant or Eligible Dependent must be eligible for benefits on the date of the Qualifying Event.

A Participant will become a Qualified Beneficiary on the date eligibility for benefits terminates due to the occurrence of one of the following Qualifying Events:

1. A reduction in the hours worked; or

2. A termination of employment for any reason other than gross misconduct.

An Eligible Dependent (Spouse and/or dependent child) will become a Qualified Beneficiary on the date their eligibility for benefits terminates due to the occurrence of one of the following Qualifying Events:

- The Employee's death;
- A reduction in the hours worked by the Employee;

- A termination of the Employee's employment for any reason other than gross misconduct;
- The Employee's divorce or legal separation;
- The Employee's entitlement to Medicare; or,
- The loss of Eligible Dependent status.

B. Continuation Coverage Options

The following options are available under the Continuation Coverage:

- Option 1 - Health Benefits Only; or
- Option 2 - Health Benefits, Dental and Vision Benefits

The Qualified Beneficiaries will be limited to those options set forth above as they are provided under the terms of the Plan in effect on the date of the Qualifying Event.

An election of a Continuation of Coverage option will be final and cannot be changed during the period that Continuation of Coverage is in effect unless the Schedule of Benefits for that Qualified Beneficiary's group is changed by the Trustees.

C. Procedure For Obtaining Continuation Coverage

When the Benefits Office receives notice that a Qualifying Event has occurred, the Plan Administrative Manager will send an Election Notice to the Qualified Beneficiary no later than 14 days after the date of the loss of coverage. The Election Notice shall inform the Qualified Beneficiary what coverage may be continued, the cost of the coverage and what the Qualified Beneficiary must do in order to obtain the Continuation Coverage. The Election Notice shall also contain an application form for the Continuation Coverage that must be completed and returned along with the proper payment to the Benefits Office within the time period set forth in the Election Notice.

The Election Notice shall be sent by first class mail to the Qualified Beneficiary's last known address as listed on the Benefits Office records. ***Therefore, it is important to notify the Benefits Office, in writing, if your address changes.*** In the case of multiple Qualified Beneficiaries of the same family, a single Election Notice shall be sent to all Qualified Beneficiaries at that address. It shall be the responsibility of each Qualified Beneficiary to read the Election Notice. However, the parent or guardian of a minor child may read the Election Notice for the minor child and take action on said child's behalf.

Each Qualified Beneficiary shall be entitled to individually elect the Continuation Coverage if the Employee or dependent Spouse rejects coverage for the entire family. If the Qualified Beneficiary, or a parent or guardian acting on behalf of a minor Qualified Beneficiary, elects the Continuation Coverage, the Qualified Beneficiary must make sure

that a completed and signed application is returned to the Benefits Office within 60 days of the date on the Election Notice. Each qualified family member who elects the Continuation Coverage must be named on the application form or a separate application form must be submitted for any person not named. If, for any reason, the completed application is not received in the Benefits Office within the 60 day period, with respect to any particular Qualified Beneficiary, that Qualified Beneficiary's eligibility for the Continuation Coverage shall expire and the Qualified Beneficiary's health benefits and dental and vision benefits, if any, shall terminate as of the date on which the Qualified Beneficiary first lost coverage. The Benefits Office shall be held blameless in the event that a parent or guardian, acting on behalf of a minor Qualified Beneficiary, fails to inform the minor Qualified Beneficiary of the minor Qualified Beneficiary's rights to the Continuation Coverage and/or fails to elect the Continuation Coverage for the minor Qualified Beneficiary within the 60 day period.

Each Eligible Dependent shall be responsible for notifying the Benefits Office whenever any of the following Qualifying Events occur:

- Divorce or legal separation from the Employee; or
- Loss of Eligible Dependent status.

The notification shall take place immediately after any of the preceding Qualifying Events occur. If a Qualifying Event is not reported to the Benefits Office within 60 days after it occurs, the Continuation Coverage shall NOT be provided.

The monthly self-payment rate for the Continuation Coverage shall be determined by the Trustees from time to time and shall be based upon the cost of the coverage provided by the Plan to a similar group of Participants. Separate rates shall be calculated for the health benefits, as well as for the dental and vision benefits, where applicable. The monthly self-payment rate and frequency of payment shall be indicated on the Election Notice at the time it is sent to the Qualified Beneficiary. The self-payment rate may change due to changes in the benefits offered by the Plan and, in certain circumstances, to reflect changes in the cost of the coverage.

The first self-payment shall be due on the first day of the calendar month following the date on which a Qualifying Event occurs. The first self-payment shall cover the Qualified Beneficiary from the date of the Qualifying Event through the last day of the calendar month following the date of the Qualifying Event. Subsequent self-payments shall be due on the last day of each preceding calendar month in an amount equal to the monthly self-payment rate.

Examples of Qualifying Events, Continuation Coverage self-payment due dates and Continuation Coverage periods:

Date of Qualifying Event	First Payment Due	First Payment Coverage	Next Payment Due	Next Payment Coverage

February 28 (reduction in hours)	April 1	March 1 – April 30	May 1	May 1 – May 31
May 15 (divorce from Employee)	June 1	May 15 – June 30	July 1	July 1 – July 31

When the Benefits Office is properly notified of an election to purchase the Continuation Coverage, it will send a bill to the Qualified Beneficiary showing the self-payments due from the date of the Qualifying Event through one month in advance of the month in which the Election Notice was received. The entire amount shown on the bill must be received by the Benefits Office within 45 days of the date the Qualified Beneficiary first signed the Election Notice. No other bills or invoices will be sent. The Continuation Coverage shall NOT be effective and medical expenses incurred after the Qualifying Event will NOT be paid unless and until the full bill is paid. It shall be the responsibility of each Qualified Beneficiary or each person acting on behalf of a Qualified Beneficiary, to ensure that correct payment is received by the Benefits Office on a timely basis. The Benefits Office shall be held blameless by the Qualified Beneficiary in the event that a parent or guardian, acting on behalf of a minor Qualified Beneficiary, causes said person to lose the Continuation Coverage through a failure to submit the correct payment in a timely fashion.

D. Maximum Period Of Continuation Coverage

An Employee or Eligible Dependent who becomes a Qualified Beneficiary due to the Employee's reduction in hours worked or termination of employment (for reasons other than gross misconduct) may elect to make self-payments for the Continuation coverage for a maximum period of 18 months from the date of the Qualifying Event or for a maximum period of 29 months from the date of the Qualifying Event if the Qualified Beneficiary is or becomes disabled during the first 60 days after the Qualifying Event.

An Eligible Dependent who becomes a Qualified Beneficiary due to any Qualifying Event other than the Employee's reduction in hours worked or termination of employment (for reasons other than gross misconduct) may elect to make self-payments for the Continuation Coverage for a maximum period of 36 months from the date of the Qualifying Event.

An Eligible Dependent who qualifies for 18 months of Continuation Coverage, as provided in the first paragraph of this subsection, may also qualify for an additional 18 months of Continuation Coverage. In order to qualify for the additional coverage, the Eligible Dependent must suffer a second Qualifying Event that, in the absence of the first Qualifying Event, would have qualified that person for 36 months of Continuation Coverage. The second Qualifying Event must come after the first Qualifying Event and while the Continuation Coverage is in effect. This additional Continuation Coverage shall be applicable to those individuals who were Qualified Beneficiaries under the Plan on the date the first Qualifying Event occurred and shall run concurrent with the 18-month period of Continuation Coverage attributable to the first Qualifying Event. Under no

circumstances shall the total Continuation Coverage for an Eligible Dependent exceed 36 months from the date of the first Qualifying Event by which an Eligible Dependent first became a Qualified Beneficiary.

In the event that an Employee becomes a Qualified Beneficiary and subsequently is reemployed by an Employer within 18 months from the date the Employee became a Qualified Beneficiary, the Employee's eligibility for further Continuation Coverage shall terminate on the last day of the calendar month prior to which the Employee becomes eligible for benefits under the Plan as a result of Employer contributions. The Continuation Coverage of an Eligible Dependent of a reemployed Employee shall also terminate on the earlier of the last day of the eighteenth month following the Qualifying Event or date the Employee becomes eligible for benefits under the Plan as a result of Employer contributions.

An additional six month extension will be granted to those active Employees whose eligibility terminated due to lay-off or reduction of hours worked. This extension of COBRA coverage will be allowed only to those Employees who the Union can confirm are unemployed and available for work within the jurisdiction of the Plan.

E. Termination Of Continuation Coverage

With respect to each Qualified Beneficiary, the Continuation Coverage shall terminate on the first date any of the following events occur:

1. The Plan Sponsor no longer provides group health coverage to any of its Participants;

2. The date on which a self-payment for the Continuation Coverage is not made in a timely manner;

3. The date on which a Qualified Beneficiary becomes covered under another group health plan (as a member otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the “other plan” has applicable exclusions or limitations, your Continuation Coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). The rule applies only to the individual who becomes covered by another group health plan. Note that under federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion, or limitation of the other group health plan might not apply at all to the Qualified Beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan;

4. The date on which a Qualified Beneficiary becomes entitled to Medicare benefits after electing Continuation Coverage. This will apply only to the individual who becomes entitled to Medicare;

5. The Qualified Beneficiary who became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary is no longer disabled (however, Continuation Coverage will not end until the month that begins more than 30 days after the determination;

6. The occurrence of any event that permits termination of coverage for cause (i.e., submission of fraudulent benefit claims) with respect to the Participant or their Eligible Dependents who have coverage under the Plan for a reason other than the Continuation Coverage requirements of federal law ; or

7. The date on which a Qualified Beneficiary completes the maximum period of Continuation Coverage for which the Qualified Beneficiary is eligible.

F. COBRA Continuation Coverage Notification Procedures

1. Initial (General) COBRA Notice

   The general notice required by federal law is provided as part of this Combination Plan Document and Summary Plan Description (Booklet). A Booklet will be mailed to the home address of each new Participant within 90 days after coverage begins.

   If the Participant adds a Spouse to coverage later (such as by getting married after he already has coverage), a separate Booklet will be available to the new Spouse at the Benefits Office or will be mailed to the new Spouse upon request.

   If the Booklet is provided to new Participants in any other fashion, a stand-alone initial COBRA notice will be mailed to the home of each new Participant within 90 days after coverage begins, and it will be addressed to the Participant and all Eligible Dependents. If an Eligible Dependent lives at a different address from the Participant, the Booklet and the general notice will be mailed to them at the separate address, if known by the Benefits Office.

2. Employer Qualifying Event Notice

   Under this Plan, Employers are not required to provide notice of Qualifying Events to the Administrative Manager. This Booklet provides that the Administrative Manager shall determine whether a Qualifying Event has occurred due to the Employee's termination of employment or reduction in hours of employment, the Employee's death, or the Employee becomes entitled to Medicare. In order to make such determinations, the Administrative Manager shall use Plan records to determine loss of eligibility due to termination of employment or reduction in employment hours, and shall rely on timely notice from the Participant of other Qualifying Events.

3. Employee Qualifying Event Notice

A Participant must give written notice to the Administrative Manager within 60 days after a Qualifying Event that is a divorce or legal separation of the Employee (or Retired Participant) and Spouse or a dependent child's ceasing to meet the Plan requirements for Eligible Dependent status. The Plan has a standard form that may be used to provide such notice. Use of the standard form is not required.

4. COBRA Election Notice

   The Plan has adopted a standard form for the Administrative Manager to use to furnish notice of a Qualified Beneficiary's eligibility for COBRA Continuation Coverage.

   The notice will be sent to each Qualified Beneficiary within 14 days after receipt of notice from an Employee of a Qualifying Event that is a divorce or legal separation or a child's ceasing to qualify as an Eligible Dependent under the terms of the Plan.

   When a Qualifying Event occurs that is the Employee's termination of employment, reduction of hours, death, or becoming entitled to Medicare, the notice will be sent to each Qualified Beneficiary within 44 days after the earlier of:

   - The date on which the Participant or Beneficiary would lose coverage due to a Qualifying Event, or

   - The date of the Qualifying Event (if coverage is to terminate immediately as of the Qualifying Event instead of at the end of the coverage period in which the Qualifying Event occurs).

5. Unavailability of COBRA Notice

   When the Administrative Manager receives a notice from an Employee or Beneficiary relating to a Qualifying Event, second Qualifying Event, or determination of disability by the Social Security Administration regarding a Covered Employee, Qualified Beneficiary, or other individual, and the Administrative Manager determines that the individual is not entitled to COBRA Continuation Coverage, the Administrative Manager shall provide a notice explaining why the individual is not entitled to COBRA Continuation Coverage.

   The unavailability notice shall be sent within 14 days from receipt of the notice from the Employee or other individual.

6. Early Termination of COBRA Continuation Coverage Notice

   Whenever COBRA Continuation Coverage is terminated prior to the latest date shown on the Election Notice, notice must be sent to all affected Qualified

Beneficiaries explaining the reason for the termination, the date of termination, and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage, such as a conversion right. The termination notice will be provided as soon as practicable following the administrator's determination that continuation coverage shall terminate.

ARTICLE III –MEDICAL BENEFITS

This Article is designed to educate you about how to access medical care covered by the Plan. It addresses topics like accessing care through an In-Network provider, explains the meanings of certain terms, provides additional information regarding certain types of medical services in the Schedule of Benefits, and includes information regarding precertification for certain services.

NOT ALL BENEFITS ARE AVAILABLE TO ALL ELIGIBLE PERSONS. PLEASE CONSULT THE APPLICABLE SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

AS A REMINDER, MEDICARE-ELIGIBLE RETIREES AND MEDICARE-ELIGIBLE DEPENDENTS OF RETIREES ARE COVERED UNDER THE PLAN'S MA-PD PROGRAM. PLEASE REFER TO THE MA-PD PROGRAM'S EVIDENCE OF COVERAGE DOCUMENT.

Section 3.01 - Use of Preferred Provider/In-Network Providers

The Plan has negotiated special contracts with an organization of Physicians, Hospitals and pharmacies ("Preferred Providers") known as a Preferred Provider Organization ("PPO") or In-Network ("In-Network") providers. **Generally, an Eligible Person is required to use a PPO or In-Network Provider.** However, in certain cases, services provided by an Out-of-Network provider will be subject to the In-Network cost-sharing levels set forth in the Schedule of Benefits. The following exceptions will qualify for benefits:

A. Out-of-Network Emergency Services will be covered in accordance with the *No Surprises Act ("NSA")*, as described in Section 10.17.

B. If an In-Network Facility subcontracts services to a non-preferred provider for which the Eligible Person has no control, the services will be covered in accordance with the *NSA*, as described in Section 10.17.

C. If an In-Network Provider is not located within 30 miles of your home or where the injury/accident/illness occurred, the services will be covered at the In-Network rate, subject to the Usual, Customary and Reasonable ("UCR").

D. Other services considered life-threatening under the ACA will be considered as Preferred Providers for benefit determinations and services will be covered at the In-Network rate, subject to the UCR. Air Ambulance Services will be covered in accordance with the NSA, as described in Section 10.17.

E. Ground ambulance services will be covered at the In-Network rate, subject to the UCR, plus up to $1,000.

Section 3.02 - Coinsurance/Copayments/Deductibles/Maximums

A. **Coinsurance**. The term Coinsurance refers to a type of cost-sharing whereby the Participant assumes responsibility for a percentage of the Covered Expenses. It is the amount a Participant must pay for covered medical services after the Participant has satisfied any applicable Copayment or Deductible. The Coinsurance rates for specific covered services are listed in the Schedule of Benefits.

B. **Copayments or Copays**. The term Copayment refers to a type of cost-sharing whereby the Participant pays a flat dollar amount each time a Covered Service is provided. The Copayment rates for specific covered medical services are listed in the Schedule of Benefits.

C. **Deductible Amount.** The term "Deductible" or "Deductible Amount" refers to the amount of Covered Expenses that an Eligible Person must pay each calendar year before the Plan pays benefits. A Deductible will not be applied to any covered family member once that covered family member has satisfied the individual Deductible, or once the family Deductible has been satisfied for all covered family members combined. Separate deductibles apply to items covered under the Plan's Prescription Drug benefit.

Wellness Incentive: To qualify for a reduced Deductible Amount for medical benefits, effective on and after January 1, 2025, each Employee or Pre-Medicare retiree will need to have completed a wellness physical, including standard lab work, within the 12-month period ending December 31 of the year before the Deductible Amount applies.

If the Employee or Pre-Medicare retiree does not obtain the physical, including standard blood work, the Employee and all Eligible Dependents will be subject to the higher Deductible Amount in the following calendar year, as shown in the Schedule of Benefits.

Please note, participation in the EWBTF's annual health fair screening event or other wellness physical and lab work by physician can only be used to satisfy the Wellness Incentive for the following calendar year. For example, participating in the annual health fair screening event in 2024 will satisfy the Wellness Incentive and the Employee will have a reduced Deductible Amount in 2025. The Employee must either participate in the annual health fair screening event again in 2025 or receive a wellness physical and lab work by their physician in order to continue the reduced Deductible Amount in 2026.

D. Maximums

1. *Out-of-Pocket Maximum*. The Plan limits your responsibility to pay for Covered Expenses to the Annual Out-of-Pocket Maximums noted in the Schedule of Benefits. After the amount you or your family pays meets the applicable Out-of-

Pocket Maximum, the Plan will cover 100% of all applicable Covered Expenses for the remainder of the calendar year.

2. *Types of Annual Out-of-Pocket Maximums*. The Plan has two separate annual Out-of-Pocket Maximums. These include:

    - The In-Network Medical Benefit Out-of-Pocket Maximum; and
    - The Prescription Drug Benefit Out-of-Pocket Maximum. The Prescription Drug Benefit Out-of-Pocket Maximum is described further in Article IV, Prescription Drug Benefit.

The Plan does not have an Out-of-Pocket Maximum for Out-of-Network Medical or Prescription Drug Benefits.

3. *Expenses that Apply Towards the In-Network Medical Benefit Annual Out-of-Pocket Maximum:* In-Network Major Medical Benefit Copayments, Coinsurance payments, and Deductibles apply towards the In-Network Medical Benefit Out-of-Pocket Maximum. In addition, the Plan will apply participant cost-share towards the Annual Out-of-Pocket Maximum if required by the *NSA*.

4. *Expenses that DO Not Apply Towards the In-Network Medical Benefit Annual Out-of-Pocket Maximum:* Services provided under the Plan's vision and/or dental benefit are subject to those specific benefit maximums. Hearing aids do not apply to the Medical Out-of-Pocket maximum, nor do expenses for benefits not covered by the Plan. If a prescription drug benefit or service is provided under the Medical Benefit and not the Prescription Drug benefit, then that prescription drug benefit or service is subject to the Medical Benefit Annual Out-of-Pocket Maximum.

Section 3.03 - Major Medical Benefit

Subject to Deductible

Medical expenses included under the Major Medical Benefit will be payable based on the UCR for Medically Necessary care and services that are ordered and prescribed by a Physician according to the Schedule of Benefits, unless otherwise excluded or limited by the Plan.

Some items listed in this Section 3.03 may also be subject to pre-certification. Please see Section 3.21 for more information on the Plan's pre-certification requirements.

Allowed Charges

Medical expenses included under the Major Medical Benefit will be payable for the following Medically Necessary care and services which are ordered and prescribed by a Physician:

A. Hospital for room and board charges when provided by a Hospital in the PPO Network,

B. Hospital charges for all necessary services and supplies furnished by the Hospital during the period benefits are payable for room and board when provided by a Hospital in the PPO Network,

C. Private duty service of a registered graduate/licensed practical nurse, except when the nurse is related to the Eligible Person,

D. X-ray and laboratory services for diagnostic purposes,

E. Anesthesia,

F. Administration and cost of blood or blood plasma,

G. Doctor's office visit, up to one office visit charge per session,

H. Crib care benefits for a newborn child for the Hospital Room and Board and for other miscellaneous services and supplies when provided by a Hospital in the PPO Network. Benefits will also be payable the same as any other Sickness for special care and treatment required by a newborn child as a result of:

   1. A Sickness contracted or injury suffered;

   2. A congenital defect; or

   3. A premature birth.

I. Surgery performed on an out-patient basis,

J. Services of a licensed physiotherapist or occupational therapist,

K. Durable Medical Equipment ("DME"):

   Examples of DME shall include, but shall not be limited to, artificial eyes and limbs to replace lost or natural eyes and/or limbs; oxygen concentrator units and the rental of equipment to administer oxygen, delivery pumps for tube feedings, surgical dressings and bandages, casts, splints, trusses, crutches or braces that stabilize an injured body part, mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions and rental, up to the purchase price of a standard wheelchair, standard Hospital type bed, or an iron lung. Nondurable supplies (i.e., tubing, connectors and masks) are a Covered Expense when used with Covered DME. This Plan does not cover maintenance fees (i.e., batteries or warranties) related to Covered DME.

   Rental of DME is covered up to the purchase price. **Certain DME is subject to pre-certification, contact Conifer before purchasing or renting DME.**

L. Placement of artificial lenses due to cataract surgery,

M. Services for cosmetic and reconstructive surgery for injuries received: (a) as a result of a Surgical Procedure for which Benefits were paid under the Plan, or (b) for reconstruction of a breast on which a mastectomy has been performed, for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all states of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient, (c) or for the treatment of gender dysphoria.

N. Voluntary sterilization.

O. Smoking cessation not otherwise covered under preventive care benefits.

P. Immunizations and inoculations not covered under the Preventive Care Benefit "PCB").

Q. Physical therapy to restore or improve movement or function impaired due to an acute episode of disease, injury or trauma, or a congenital anomaly that is expected to achieve measurable improvement within a reasonable timeframe (usually four - six months). Physical therapy includes outpatient and Inpatient Services. Inpatient Services are those which are provided by a facility in the PPO Network in an acute hospital, rehabilitation unit or skilled nursing facility for short-term, active progressive service that cannot be provided in an outpatient or home setting. Services may also be provided by any Medicare approved skilled nursing facility when following an inpatient stay of at least three days.

R. Emergency Services. For more information on coverage of Out-of-Network Emergency Services, refer to Section 10.17 - Protections from Surprise Medical Bills.

S. Orthodontia, if Medically Necessary for ongoing treatment for a cleft lip and/or palate.

T. Formula, when delivered by total parenteral nutrition (TPN), J-Tube or G-Tube.

U. Implantable hearing devices, such as cochlear implants. Hearing aid maximum does not apply to implantable hearing devices.

V. Outpatient charges for advanced imaging, such as PET, CT, MRI and Nuclear Medicine.

W. Speech therapy.

X. Allergy services and injectables.

Y. Chelation Therapy.

Z. Sclerosing of spider veins.

AA. Sleep disorders/sleep studies.

BB. Varicose veins.

CC. Bariatric surgery.

DD. Wigs, toupees, hairpieces for cancer treatment or a medically necessary condition such as alopecia areata.

Section 3.04 - Approved Clinical Trials

- General: The ACA requires that the Plan provide coverage for certain "Routine Patient Costs" related to an "Approved Clinical Trial" for a "Qualified Individual."

- For the purposes of this subsection, a "Qualified Individual" is a Participant or Eligible Dependent who is eligible to participate in an "Approved Clinical Trial" because either the individual's doctor has concluded that patient is appropriate for the Approved Clinical Trial or the patient provides medical and scientific information establishing that his or her participation in the Approved Clinical Trial is appropriate.

- An "Approved Clinical Trial" is a clinical trial for which coverage is required under federal law, PHSA Sec. 2709, which is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition (i.e. any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted) and is a federally funded trial or is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration ("FDA") (or is exempt from investigational new drug application requirements);

- Routine Patient Costs for the purpose of this subsection means services and supplies incurred by an Eligible Person during participation in a clinical trial if such expenses would be covered for a Participant or Eligible Dependent who is not enrolled in a clinical trial.

  Routine patient costs do not include (1) the investigational item, device or service itself being studied as part of the Approved Clinical Trial; (2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

- The Plan reserves the right to use reasonable medical management techniques in interpreting and applying the coverage provisions related to Approved Clinical Trials.

Section 3.05 - Disease Education Benefit
Subject to Deductible
Charges for disease education or counseling for the Eligible Person, whoever has the disease, will be covered according to the Schedule of Benefits

To qualify for this benefit, the education must be ordered in writing by a Physician and must be provided by a licensed, registered, or certified professional who has specialized training in the management of the disease.

Section 3.06 - Emergency Room Benefit
Subject to Copayment and Deductible
When an Eligible Person incurs charges at an Emergency Room, the Eligible Person will be responsible for a $250 copayment before the deductible and other benefits apply. The Trustees encourage you to first use the Teladoc Benefit or an urgent care center prior to utilizing an emergency room.

The Emergency Room Benefit copayment will be waived if the visit results in admission into the hospital for an inpatient stay, or if the Eligible Person is kept for observation for a period of more than 24 hours.

Section 3.07 - Hearing Aid Benefit
Deductible Does Not Apply
When an Eligible Person incurs expenses for hearing aids, services or supplies the Plan will pay benefits according to the Schedule of Benefits, subject to $2,400 maximum every rolling four years per individual. The Fund will pay 80% UCR for hearing aids.

Implantable hearing devices, such as cochlear implants may be covered under the Plan's Major Medical Benefit described in Section 3.03.

Section 3.08 - Home Health Care Benefit
Subject to Deductible
Benefits for home health care services and supplies provided by an organization or agency which meets the requirements for participation as a Home Health Agency in the PPO Network are payable according to the Schedule of Benefits provided the treatment is pre-certified as Medically Necessary and provided it is the most cost effective treatment. For purposes of this section, a "Home Health Agency" is a public agency or private agency that specializes in giving skilled nursing services and other therapeutic services in the home.

Each visit by an authorized representative of a Home Health Agency shall be considered as one Home Health care visit. A minimum of one hour of home health aide services must be rendered in order to constitute one Home Health Care visit and qualify for benefit payment. If the visit is less than one hour it shall NOT qualify for benefit payment.

Benefits shall be provided for:

A. Services of a certified Advanced Registered Nurse Practitioner or Registered Nurse employed by or functioning pursuant to a contractual arrangement with a Home Health Care Agency up to one hour per day;

B. Services of a licensed Practical Nurse employed by or functioning pursuant to a contractual arrangement with a Home Health Care Agency up to one hour per day;

C. Home health aide services rendered by home health aides employed by a Home Health Care Agency up to four hours per day;

D. Services of a licensed Occupational Therapist, a licensed Physical Therapist or a licensed Respiratory Therapist, all of whom are employed by or functioning pursuant to a contractual arrangement with a Home Health Care Agency; and

E. Medications and medical supplies.

Home Health Care services shall NOT be considered eligible expenses unless the Eligible Person's attending Physician certifies, in writing, that hospitalization or confinement in a skilled nursing facility would otherwise be required.

Section 3.09 - Hospice Care Benefit
Subject to Deductible
Benefits on behalf of an Eligible Person for covered services for Hospice Care shall be payable as set forth in the applicable Schedule of Benefits.

Hospice care is a coordinated program intended to meet the special physical, psychological, spiritual and social needs of a terminally ill person and the immediate family. A terminally ill person is defined as one who (1) has no reasonable prospect of cure; and (2) as estimated by the Physician, has a life expectancy of less than six months.

Hospice services include providing the dying person with palliative and supportive medical nursing and other health services through home or in-patient care.

Allowed Charges include:

A. Room and board for confinement in a Hospice facility in the PPO Network;

B. Physician services available by consultation;

C. Services and supplies furnished by the Hospice facility while the patient is confined therein;

D. Intermittent nursing care by a registered professional nurse or licensed practical nurse under the supervision of a Registered Nurse (RN)

E. Home health aide services and supplies;

F. Nutritional guidance given by a registered nutritionist;

G. Counseling services by a licensed social worker or a licensed pastoral counselor; and

H. Up to forty-eight (48) hours of respite care.

Charges Not Allowed include:

1. Care for patients with a greater than six month life expectancy;

2. Care beyond palliative care management;

3. Services or supplies for any medical condition other than the life threatening illness;

4. Custodial Care or services, i.e., room and board or other institutional or nursing services which are provided to or for an Eligible Person due to his/her age, mental or physical condition, mainly to aid the person in daily living; or medical services to maintain the person's present state of health and which cannot reasonably be expected to improve the Eligible Person's medical condition; and

5. Room and board for confinement in a Hospice facility which is not in the PPO Network.

Hospice Care benefits shall only be paid if the patient's attending Physician certifies, in writing, that the patient is terminally ill and that the patient's life expectancy is six months or less.

Hospice benefits shall be payable for Expenses for covered Hospice services whether the services were performed in a Hospice facility or at the Eligible Person's home.

Please refer to Section 3.21– Pre-Certification and Case Management prior to incurring any Hospice Care expenses.

Section 3.10 - Maternity Benefit – Medical Services
Subject to Deductible
Maternity Benefits include all maternity-related medical services for prenatal care, postnatal care, delivery and any other related complications. When a pregnancy (including resulting childbirth or complications) causes an eligible Employee or dependent Spouse to incur expenses, including for licensed mid-wives and birthing centers, the Plan will pay benefits for the pregnancy on the same basis as any other Accident or Sickness. Maternity Leave Benefits shall be made to eligible female Employees in accordance with the provisions in Section 7.04. An inpatient stay is covered when provided by a Hospital or facility in the PPO Network.

MATERNITY BENEFITS ARE PAYABLE UNDER THE MAJOR MEDICAL BENEFIT ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.

The Plan complies with a federal law known as the Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act") which requires that the Plan may not restrict any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a cesarean. However, the Plan may pay for a shorter stay if the attending provider (i.e., the Physician, nurse midwife, or Physician's assistant), after consultation with the mother, agrees to an earlier discharge date for a mother and her newborn.

Under the Newborns' Act, the Plan may **NOT** set the level of benefits or out-of-pocket expenses so that any later portion of the 48 hours (or 96 hours for a caesarean) stay is treated in a manner less favorable to the mother or newborn than any other portion of the stay. Additionally, under the Newborns' Act, the Plan may not require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours for a caesarean). However, the Plan may require pre-certification to use certain providers or facilities or to reduce out-of-pocket expenses.

Maternity benefits are **NOT** payable on behalf of Eligible Dependent children for expenses incurred due to pregnancy, childbirth or miscarriage, except as other required by law.

Section 3.11 - Mental Health Benefit
Subject to Deductible
When a mental or nervous Sickness or illness causes an Eligible Person to incur expenses for treatment, the Plan will pay benefits on the same basis as any other Accident or Sickness provided the treatment was provided by a duly licensed clinical psychiatrist, psychologist, licensed counselor or licensed clinical social worker.

Section 3.12 - Alcohol and Substance Use Benefit
Subject to Deductible
When alcoholism, chemical dependency or substance use causes an Eligible Employee or Eligible Dependent to incur expenses for inpatient or outpatient treatment at a Hospital or Substance Use Treatment Center, the Plan shall pay benefits at 80% of the UCR Charges for the Hospital, Substance Use Treatment Center and Physician's charges (including psychiatrists, psychologists and licensed clinical social workers) incurred for treatment of alcohol and drug related Sicknesses. An inpatient stay is covered only when provided by a Hospital or facility in the PPO Network.

IBEW Local Union 481 has an employee assistance program available at no cost to the eligible Employee or Eligible Dependent. Please contact your Local Union for more information regarding these programs.

Detoxification Services
Treatment for detoxification will be covered if performed in a Hospital or Substance Use Treatment Center that is licensed for this level of care, has a Physician on staff and have registered nurses on staff 24/7. Inpatient treatment is covered as long as the Hospital or Substance use Treatment Center is in the PPO Network.

Substance Use Treatment Conditions
Substance use treatment including detoxification, inpatient rehab, a partial Hospital program or intensive outpatient program will be covered provided the services are Medically Necessary under the direction of a Physician. An inpatient stay is covered when provided by a Hospital or facility in the PPO Network.

Section 3.13 - Organ Transplant Benefit
Subject to Deductible
If an Eligible Person incurs expenses in conjunction with an organ transplant, including stem cell and bone marrow transplants, the Plan will pay benefits as follows:

Organ Recipient:	Benefits will be paid according to the Schedule of Benefits for Allowable Charges by the organ recipient only if such recipient was an Eligible Person under the Plan at the time the expenses were incurred.
Organ Donor:	Benefits will be paid according to the Schedule of Benefits for Allowable Charges by the organ donor only if such donor was an Eligible Person under the Plan at the time the expenses were incurred.

Under no circumstances will benefits be paid for expenses incurred for both the organ donor and organ recipient unless both were eligible under the Plan at the time the expenses were incurred. Benefits will **NOT** be paid for expenses incurred for Experimental or Investigative procedures or charges connected therewith.

Section 3.14 - Surgical Benefit
Subject to Deductible
Surgical Benefits are payable to a Physician or Surgeon as a result of a surgical procedure performed on an Eligible Person in accordance with the Schedule of Benefits, including pre-operative and post-operative care. Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth are covered under the medical surgical benefit.

Surgical procedures may be performed in the Hospital, the doctor's office or elsewhere. If a surgery causes an overnight stay, Hospital services will be covered if the Hospital or facility participates in the PPO Network.

Section 3.15 - Chiropractic Benefit
Subject to Deductible
Chiropractic Benefits shall be paid according to the Schedule of Benefits for all services provided by a chiropractor, subject to a maximum of $750 per Eligible Person per Calendar Year.

Section 3.16 - Telemedicine Benefits

A. Teladoc Benefit

Not subject to Deductible

The Teladoc Benefit utilizes UHC's Teladoc program to give covered persons the capability to speak with a certified physician online using a tablet or computer with a webcam or through a smartphone in order to get quick access to certain prescriptions or other advice regarding a medical or behavioral health situation. This online doctor visit benefit is available 24 hours a day, 7 days a week and can be accessed at www.teladochealth.com. This benefit is not meant for emergency situations but it can help in deciding whether a medical situation is an emergency.

Benefits for Teladoc Visits are payable according to the Schedule of Benefits. There is no cost-sharing that applies when the Teladoc Benefit is utilized.

B. All other Telemedicine Visits

The Plan will pay for telemedicine visits with a Physician not through Teladoc, on the same basis, to the same extent, and subject to the same schedule of benefits and cost-sharing as in-person provider visits.

Section 3.17 - Podiatry Benefit

Deductible Does Not Apply

When an Eligible Person incurs expenses for podiatry services or supplies the Plan will pay benefits in accordance with the Schedule of Benefits, subject to a lifetime maximum of $4,000 per Eligible Person. The Podiatry Benefit will only cover non-surgical services provided by a podiatrist. Any Medically Necessary surgeries will be considered for payment under the Plan's Major Medical Benefit.

Section 3.18 - Virtual Physical Therapy through Sword Health

No Cost Share

The Plan will provide virtual physical therapy for the majority of qualified musculoskeletal diagnosis to Eligible Persons who qualify through the Plan's preferred musculoskeletal virtual provider Sword Health at NO COST to the Eligible Person.

An Eligible Person must be suffering from pain in his or her neck, lower back, shoulder, knee, hip, ankle, wrist, or elbow, or has undergone surgery in these areas. In order to be eligible to participate in this benefit, an Eligible Person must meet the following criteria:

A. is able to perform 20 minutes of light to moderate physical activity

B. does not have recent onset fever, chills, or visible inflammation in the affected area

C. does not have signs of progressive neurological issues in the area of pain

D. does not have an active cancer or is receiving treatment for cancer, and

E. pain is not related to significant trauma to that area.

Section 3.19 - Digital Coaching for Eligible Persons At-Risk for Heart Disease
No Cost Share
The Plan will provide a digital coaching solution to Eligible Persons who are identified by Hello Heart with or at-risk for heart disease (with prehypertension and hypertension). This digital coaching solution is at NO COST to the Eligible Person. The Digital Coaching for persons At-Risk for Heart Disease is also available to Medicare-eligible Retirees.

This digital solution is provided through a connected device and mobile app that uses Artificial Intelligence, behavioral science, and personalized digital coaching to drive lifestyle changes to empower patients to embrace healthier behavior, which can reduce the risks of high blood pressure and heart disease.

Each Eligible Person who is identified by Hello Heart receives a wireless blood pressure monitor and access to Hello Heart's easy-to-use digital coaching app, which is HIPAA compliant and compatible with Android and iPhone devices. The monitor also detects hypertensive crisis-level readings and an irregular heartbeat while taking a blood pressure reading, encouraging the Eligible Person to talk to their doctor about potential risks based on their readings.

In addition to tracking their blood pressure, API integrations allow Covered Individual to pull in lab information, such as lipid (cholesterol) panels, blood work, and cardiovascular-related testing, as well as data from Apple Health and Google Fit.

Section 3.20 - Preventive Care Benefits
Deductible Does Not Apply

Benefits for Preventive Care as detailed below will be paid at 100% when received from an In-Network Provider without application of the Deductible Amount or coinsurance. These benefits will be provided to all eligible non-Medicare Eligible Person regardless of benefits previously paid or applied to the Deductible Amount under the Major Medical Benefit.

Preventive Care Benefits are available for the following items and services:

A. Evidence-based items or services that have in effect rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;

B. Immunizations for routine use in children, adolescents and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. A recommendation is considered to be for "routine use" if it appears on the Immunization Schedules of the CDC;

C. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

D. With respect to women, to the extent not already included in recommendations from USPSTF, evidence-informed preventive care and screenings provided for in comprehensive guidelines by the Health Resources and Services Administration.

The Plan will rely on established techniques and relevant evidence to determine the frequency, method, treatment or setting for which a recommended preventive service will be available without cost-sharing requirements. If preventive services are received as a part of a regular office visit, the Plan can require you to pay a portion of the costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your provider bills you for the preventive services separately from the office visit.

For a list of Preventive Care items and services that may be covered by the Plan, please see:

- https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
- https://www.cdc.gov/vaccines/schedules/index.html
- Periodicity Schedule found here: https://mchb.hrsa.gov/programs-impact/bright-futures
- https://www.hrsa.gov/womens-guidelines

Please note that the Plan is generally not required to cover a new or updated Preventive Care Benefit item or service until the first day of a plan year beginning one year after the final issue date of recommendation about the new or updated Preventive Care Benefit item or service. This means that a new or updated item or service may be listed on one of the above resources, but is not yet covered by the Plan. If you have questions about whether a new or updated Preventive Care item or service is covered by the Plan, please contact the Benefits Office.

The following preventive care service is also currently covered under the Plan:

- The prescription drug Synagis is covered at 100% for children under the age of one as a Preventive Care Service required by the ACA. Synagis is covered at 100% for individuals over the age of one, when Medically Necessary and preapproved by the Plan's PBM.

BENEFITS WILL NOT BE PROVIDED UNDER THIS PREVENTIVE CARE BENEFIT FOR THE TREATMENT OF ANY ILLNESS OR INJURY.

Section 3.21 - Pre-Certification And Case Management

Pre-Certification

The Plan has entered into an agreement with a professional medical review firm to pre-certify certain medical services. Non-emergency stays, such as those for elective procedures, should be pre-certified at least seven days prior to admission. Emergency admissions should be certified within 48 hours of admission or on the first business day following a weekend (Friday, Saturday or Sunday) or holiday admission.

The following is a list of treatment/services that require pre-certification:

Inpatient

- Acute Care
- Hospice
- LTAC Admissions
- Inpatient and Residential Behavioral Health/Substance Abuse Services
- Rehabilitation Facility Admissions
- Skilled Nursing Facility Admissions
- All inpatient stays, including OB Delivery stays beyond the Federal Mandate minimum (including newborn stays beyond mother's stay)

Surgical Procedures (Ambulatory)

- Bariatric Surgery
- Blepharoplasty/Blepharoptosis
- Bone-Anchored Hearing Aids
- Cardiac Resynchronization Therapy (CRT) with or without Implantable Cardioverter Defibrillator (CRT/ICD) for Treatment of Heart Failure
- Cartilage Transplant Knee
- Cervical Spine Surgery
- Cochlear Implant
- Computer Navigation for Orthopedic Surgery
- Cosmetic and Reconstructive Services
- Elective Total Hip Arthroplasty
- Elective Total Knee Arthroplasty
- IDET Procedure
- Implantable Cardioverter-Defibrillator (1CD)
- Lumbar Spine Surgery
- Mandibular/Maxillary Surgery (Orthognathic) (TMJ is not reviewed –may be covered under dental benefit)
- Mastectomy for Gynecomastia
- Breast Procedures
- Nasal Septoplasty
- Reduction Mammoplasty
- Rhinoplasty
- Sacroiliac Joint Fusion
- Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty
- Treatment of Varicose Veins (Lower Extremities)

Ancillary Services

- Botulinum Toxin–Review for Migraine Use Only
- Home Health Services
- Home Hospice
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Home Infusion Services (Provider must contact PBM for precert and claims submission for drug itself)
- Occupational Therapy (after 20 visits combined with PT)
- Physical Therapy (after 20 visits combined with OT)
- Private Duty Nursing
- Speech Therapy
- Transcranial Magnetic Stimulation (TMS)
- Partial Hospital Program (PHP)
- Intensive Outpatient Program (IOP)

Durable Medical Equipment

- Any DME over $1,000
- Bone Stimulator
- Cardio/External Defibrillator
- Left ventricular assistance device (LVAD-)
- Limb Prosthetics
- Myoelectric prosthetics

• Cooling Devices • Electric Scooters • Infusion Pumps • Insulin Pumps	• Neuromuscular Stimulators • TENS Unit • Wheelchairs (Custom) • Wheelchairs (Power • Wound Vacs
Diagnostic Imaging – Ambulatory	
• Coronary CT Angiography (CCTA) • Coronary MRA • Cardiac MRI • MRA of the Head and/or Neck	• MRI of the Brain • MRI of the Spine – Cervical, Thoracic, Lumbar, Sacral • PET Scan
Specialty Infusion Drugs	
Providers must contact PBM for precertification and claims submission of infusion medication	

Although there is no penalty for not calling the medical review firm before receiving these benefits, the claim will be denied pending a medical necessity review. Eligible Persons are encouraged to take advantage of the pre-certification process prior to obtaining the service. The medical review firm will work with such Eligible Persons to make sure they receive the appropriate care and information relevant to such benefits. The medical review firm will make sure the services requested are medically necessary in order to avoid a denied claim.

Case Management

The Plan's contracted medical review firm provides case management services. If the Eligible Person qualifies for case management services, the medical review firm will contact them to enroll in the case management program. For acute conditions (i.e. conditions and health circumstances that are worsening or have the potential to worsen or change rapidly) covered by case management, the services provided through case management may include, but are not limited to, collaborating with treating provider, identifying the treatment plan and/or resources to support the treatment plan, coordinating necessary clinical and community services, facilitating movement from one level of care to another, supporting member through care transitions, where appropriate, and working with provides to adjust any treatment plans.

If the Eligible Person is contacted by the Plan's case management firm, the Eligible Person must cooperate and work with the case manager to manage your illness. If the Eligible Person does not participate in this program, Plan benefits for the Eligible Person and their family will be reduced by 10% for the remainder of the calendar year. If the illness is still present at the beginning of the next calendar year and the Eligible Person continues to not cooperate with the case managers, the Eligible Person and their family will again have reduced benefits for that calendar year.

ARTICLE IV - PRESCRIPTION DRUG BENEFIT

When a non-occupational injury or Sickness causes an Eligible Person to need prescription drugs, the Plan will pay benefits according to the Schedule of Benefits. Prescription drugs can be legally obtained only by the written prescription of a Physician.

Section 4.01 - Prescription Benefit Manager (PBM)

A. PBM for Covered Employees and non-Medicare Eligible Retirees

For Covered Employees and non-Medicare eligible retirees, the Plan has contracted with a Sav-Rx, to provide participants and Eligible Dependents with prescription drugs through both a retail pharmacy program and a mail order program.

The Plan has implemented cost and benefit management programs that may apply to certain medications. Those programs are explained in further detail in this Article.

B. PBM for Medicare-eligible Retirees

The Plan has contracted with two companies to provide Prescription Benefits for Participants eligible for Medicare. UHC administers the Electrical Workers Benefit Trust Fund's Medicare Advantage and Prescription Drug ("MAPD") program which will cover your medical and prescription Medicare Part D Prescription benefits. The Plan also offers a self-funded supplemental prescription drug benefit (called a "wraparound" benefit) for the to the Part D plan to close the gaps between the prescription drug benefits offered by Medicare Part D plan and the prescription drug plan offered to Covered Employees and non-Medicare retirees. The wraparound benefit is administered by Sav-Rx.

Section 4.02 - Prescription Drug Deductible and Maximum Out-of-Pocket for Active Employees and non-Medicare Eligible Retirees

A. Deductibles (Calendar Year)

- Prescriptions are subject to a $50 deductible per calendar year per individual.

B. Annual Maximum Prescription Drug Out-of-Pocket (Calendar Year)

The Plan's annual maximum out-of-pocket for in-network prescription drug expenses is:

- $3,350/individual
- $6,700/family

For the purposes of the Annual Maximum In-Network Prescription Drug Out-of-Pocket, expenses for prescription drug items and services not covered by the Plan, or incurred due to the requirements of certain clinical programs may not accumulate towards the Eligible Person's maximum out-of-pocket for prescription drug expenses. For example:

- An individual may be required to cover the cost difference between a generic and the brand drug, if a generic is available and the brand drug is not medically

necessary. In that case, the cost difference between the generic and brand drug will not apply toward the annual prescription out-of-pocket maximum.

- Financial assistance provided by the drug manufacturers for drugs subject to the High-Impact Advocacy (HIA) Program does not accumulate towards an Eligible Person's maximum out of pocket.

C. Prescription Drug Copayments and Coinsurance

The following table describes the Plan's prescription drug copayments and coinsurance levels. Please note coverage of a particular prescription drug item may subject to other plan limitations, including but not limited to, Plan deductibles, exclusions or the Plan's clinical programs.

Pharmacy *Retail is up to 30-day supply; Mail Order through Sav-Rx is 90-day supply*	**Eligible Person Pays**
Prescription Costing $3 or less	Full Cost
Generic	Greater of $3 or 10% of cost of drug
Brand (no generic available)	Greater of $5 or 20% of cost of drug
Brand (generic available and brand is not Medically Necessary)	Greater of $5 or 20% of cost of drug plus the difference in cost between brand and generic

Section 4.03 - Covered Prescription Drugs

Prescription drugs include:

A. All Federal Legend drugs;

B. Self-administered injectables;

C. Syringes for self-administered injectables;

D. Compound medication containing at least one Federal Legend ingredient;

E. Pre-natal vitamins prescribed during pregnancy;

F. Infusion drugs under the M2P program. For more information on the M2P Program, see Section 4.05.

Section 4.04 - Prescription Drug Exclusions

No benefits shall be payable for any of the following:

A. The Plan will not pay more for a brand name drug when a generic equivalent is available than the Plan would pay for the generic equivalent, unless the Physician or Surgeon provides a letter of medical necessity. In this situation the difference between the

generic and the brand drug will not apply toward the annual prescription out-of-pocket maximums;

B. Investigational or Experimental drugs, except for Rituxin for treatment of dermatomyositis as well as any drug mandated by law for Approved Clinical Trials, as described in Section 3.04;

C. Over the counter drugs, except as required under the ACA and payable under the Preventive Care Benefit;

D. Vitamins and Supplements (prescription and over the counter), except for pre-natal vitamins prescribed during pregnancy and as required under the ACA and payable under the Preventive Care Benefit as described in Section 3.20 and Medically Necessary vitamin injections, if pre-authorized by the Prescription Benefit Manager (PBM);

E. Agents or treatment related to baldness or thinning hair (prescription or over the counter);

F. Fertility drugs;

G. All injectable products except for those that can be self-administered;

H. Therapeutic devices or appliances;

I. Birth control, except as required under the ACA and payable under the Preventive Care Benefit as described in Section 3.20;

J. Non-sedating antihistamines (including, but not limited to, Claritin, Zyrtec, etc.);

K. Prescriptions over the 90 day supply maximum; or

L. "Off-label" usage of a FDA approved drug, except as provided in this subsection for oncology or MH/SUD related drugs. To be covered for off-label usage, the FDA approved drug must be recognized for the applicable treatment by one of the following:

1. the American Medical Association Drug Evaluations;
2. the American Hospital Formulary Service Drug Information;
3. the United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional";
4. two articles from major peer reviewed medical journals that present data supporting the proposed off label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

M. Infusion medications, unless filled by a Sav-Rx pharmacy or a pharmacy that has partnered with Sav-Rx to provide infusion medications. Oncology drugs may be covered under the medical benefit. Contact the Benefits Office for questions related to this exclusion.

N. TNF Inhibitors, unless:

1. a biosimilar does not exist or the participant cannot utilize the biosimilar; and

2. There is no patient assistance programs available through the manufacturer.

O. Medications for weight loss, unless all off the following criteria are met for Active Employees and non-Medicare retirees and their dependents:

1. The individual must have a body mass index (BMI) of 30 or greater, or BMI of 27 or greater along with one or more related risk factors as determined by Sav-Rx;

2. The medication is subject to Sav-Rx clinical review, including prior authorization and step therapy;

3. The individual is enrolled and actively engaged in the MyPath Program as described in Section 4.05(H).

NOTWITHSTANDING ANY OTHER PLAN PROVISIONS, THE PRESCRIPTION DRUG BENEFIT IS NOT AVAILABLE TO PERSONS ENROLLED IN A MEDICARE PART D PLAN OTHER THAN THE PART D PLAN SPONSORED BY THIS FUND.

Section 4.05 - Clinical Programs

The Plan's Prescription Benefit Manager (PBM) has various clinical programs designed to improve health outcomes for members while managing overall healthcare costs. These programs are focused on things such as effective disease management, utilization management and medication adherence. For example, certain medications may be subject to prior authorization, step therapy, and quantity fill limits, among others. The clinical programs are designed to educate participants and ensure the Plan's pharmacy benefit is being operated as efficiently as possible. You may contact the Benefits Office for more information on these programs

A. Specialty Prescription Drug Program

The Specialty Prescription Drug Program includes prior authorization and patient assistance for certain specialty prescription drugs. The purpose of this program is to:

1. ensure that these often high-cost prescription drugs are being prescribed for an appropriate patient and condition at an acceptable dose and quantity, and

2. ensure that the high-cost prescription drugs are provided through the PBM pricing program only. Certain specialty prescription drugs are required to be obtained through Sav-Rx. Medical buy and bill will not be allowed in the event that you or your provider refuse to participate in this program. Obtaining these specialty prescription drugs through Sav-Rx 'is the only available option. A list of these certain specialty prescription drugs can be provided by calling the Sav-Rx directly.

As part of the specialty program, the High-Impact Advocacy 90 day program allows certain selected specialty drugs to be filled up to a 90-day supply, upon Sav-Rx authorization .

B. High-Impact Advocacy (HIA) Program

The HIA Program includes specialty medications in certain classes that have a manufacturer's coupon or other financial assistance available. The HIA program includes specialty medications in certain classes that have a manufacturer's coupon or other financial assistance available. These prescription drug classes and supply limits are subject to change. The HIA Program utilizes manufacturer's coupons and other financial assistance to lower costs to you and the Plan. You may contact Sav-Rx with any questions about this program. If you choose to not participate, your prescription drugs will not be covered under the Plan.

C. Mandatory Generic Program

The Mandatory Generic Program encourages the use of generic prescription drugs equivalents whenever available. If the Eligible Person or his Physician requests a brand name prescription drug instead of its generic equivalent, the Eligible Person will be charged the brand name prescription drug Copayment PLUS the difference between the brand name prescription drug and the generic alternative. If you require the brand name prescription drug for Medically Necessary reasons, your Physician may request a waiver of the difference in cost, to be reviewed and considered, by submitting a Letter of Medical Necessity to Sav-Rx. If you choose to not participate, your prescription drugs will not be covered under the Plan.

D. Prior Authorization Program

The Prior Authorization Program targets prescription drugs that are not specialty drugs but do benefit from additional clinical management. This program helps to ensure that Eligible Persons are receiving an appropriate prescription drug for the treatment of specific conditions and in quantities as approved by the FDA.

E. Step Therapy Program

The Step Therapy Program requires Eligible Persons to use a more cost-effective prescription drug prior to the approval of a less cost-effective brand name prescription drug. Prescription drugs that qualify for Step Therapy are often high priced and largely advertised. The goal of the Step Therapy Program is to use the most cost-effective

sequence – beginning with Step 1 prescription drugs and moving to Step 2 prescription drugs, based on accepted medical guidelines and standards.

Prescription drug classes that qualify for the Step Therapy Program include, but are not limited to, cholesterol-lowering statins, ARB antihypertensives, SSRI/SNRI antidepressants, oral osteoporosis, migraine, Cox 2 and Non-Steroidal Anti-Inflammatory Agents, steroid nasal sprays, Proton Pump Inhibitors, Beta and Calcium Channel Blockers and Glaucoma Eye Drop. This list is subject to change. If you choose to not participate, your prescription drugs will not be covered under the Plan.

F. Therapeutic Quantity Limits Program

The Therapeutic Quantity Limits Program ensures proper dosing and dispensing of certain prescription drugs based on FDA and manufacturer's guidelines. The program monitors prescription utilization and helps identify potential overuse or misuse of prescription drugs such as narcotic pain relievers and sedative hypnotics, migraine treatments, respiratory and nasal prescription drugs. If you choose to not participate, your prescription drugs will not be covered under the Plan.

G. M2P Program

Under this clinical program, specialty infusions and injections are covered through the Prescription Drug Benefit instead of provided directly from medical providers. Prior authorization will be required for any specialty infusion or injection that you are prescribed.

H. MyPath , offered through Wanda and SavRx

Effective July 1, 2024, a new program, MyPath, is available from the Plan's Pharmacy Benefit Manager, Sav-Rx. MyPath promotes a healthy lifestyle with a Wellness Coach supported by registered dieticians and exercise experts. Participants will track their wellness goals with an easy-to-use remote cellular smart scale shipped to the patient's home. MyPath is available to all non-Medicare Participants and is mandatory for all Participants with weight loss medication prescriptions.

Participants taking weight loss medication as of July 1, 2024 will have until December 31, 2024 to enroll and engage with MyPath. If participants do not enroll with MyPath or fail to remain engaged, they will be unable to continue filling their weight loss medication prescription until they re-engage with MyPath.

MyPath is also available for non-Medicare Participants who are not currently taking weight loss medication but wish to voluntarily engage to maintain a healthy lifestyle.

ARTICLE V - VISION CARE BENEFIT

Unless otherwise provided, benefits provided in this Article are available to the following groups of Participants:

- Eligible Employees and their Eligible Dependents;
- Non-Medicare eligible retirees; and
- Eligible Dependents of retirees not entitled to Medicare

The Plan will pay benefits for vision care services or supplies according to the Schedule of Benefits subject to a $200 maximum for vision exams and a $600 maximum for materials each rolling two-year period.

Lasik eye surgery is covered for a Participant or his/her Eligible Dependents. The Lasik eye surgery benefit is payable only under the Vision Care Benefit, and requires the material benefit to be maximized.

No Vision Care Benefits shall be payable for the following:

A. Expenses in excess of the maximum amount stated in the Schedule of Benefits;

B. Routine examinations or supplies required by an Employer in connection with the occupation of the Eligible Person;

C. Non-prescription supplies, such as sunglasses;

D. Expenses resulting from an accidental bodily injury arising from or in the course of employment or from a disease compensable under any Worker's Compensation, Occupational Disease or similar law;

E. Expenses incurred in a Hospital owned or operated by the federal government or any of its agencies if the injury or disease giving rise to the expenses were military service related; or

F. Expenses that the Eligible Person is **NOT** required to pay.

Any vision services or vision hardware not covered under the Plan may be eligible for reimbursement through your Health Reimbursement Account (HRA).

Opt Out Provision

Upon written request to the Benefits Office, Eligible Persons may opt out of (and, if applicable, opt back in to) Vision Care Benefits from this Plan. Because contribution rates to the Fund are included in Collective Bargaining Agreements, the contribution on behalf of an individual Participant or Dependent who has opted out will not be reduced. Any such opt out (or, if applicable, opt in) will be effective the first day of the second calendar month after the written request is received by the Benefits Office.

ARTICLE VI - DENTAL BENEFITS

Unless otherwise provided, benefits provided in this Article are available to the following groups of Participants:

- Eligible Employees and their Eligible Dependents;
- Non-Medicare eligible retirees;
- Eligible Dependents of retirees not entitled to Medicare; and
- Medicare retirees and their Eligible Dependents enrolled in the EWBTF MAPD Plan.

Section 6.01 - Dental Benefit Network

The Plan contracts with Delta Dental to provide a dental network. Individuals shall have the option of seeking treatment either from dentists who have contracts with Delta Dental for the provision of dental services (In-Network) or a dentist of their own choosing (Out-of-Network).

A. In-Network

Delta Dental has two levels of network participation, PPO Dentists and Premier Dentists.

If you utilize a **Delta Dental PPO dentist,** the Plan will pay benefits described in this Article according to Delta Dental's *PPO Maximum allowed fee* for the covered service rendered subject to any applicable annual or lifetime limits described in this Article and the Schedule of Benefits. You will not be balance billed however, you may be responsible for co-insurance depending on the benefit provided.

If you utilize a **Delta Dental Premier dentist**, the Plan will pay benefits described in this Article according to Delta Dental's *Premier Maximum allowed fee* for the covered service rendered, subject to any applicable annual or lifetime limits described in this Article and the Schedule of Benefits. You will not be balance billed; however, you may be responsible for co-insurance depending on the benefit provided.

B. Out-of-Network

If you utilize an **Out-of-Network provider**, the Plan will pay benefits described in this Article according to Delta Dental's *Nonparticipating Dentist allowed fee* (i.e. an amount based on Delta Denta's out-of-network fee schedules) for the covered service rendered, subject to any applicable annual or lifetime limits described in this Article and the Schedule of Benefits. As the Nonparticipating Dentist allowed fee may be less than the amount charged by the provider, the provider may balance bill the patient up to the charged amount. In addition, the individual may be responsible for co-insurance depending on the benefit provided.

Please see the below example for an illustration of how the Plan would cover a $90 dental charge for the same dental service, depending on whether the service was provided by a

Delta Dental PPO Provider, Delta Dental Premier Provider, or an Out-of-Network Provider. The allowed fees in the chart below are for illustrative purposes only.

Level of Participation	Dentist Charge	Allowed Fee	Plan Pays	Patient Responsibility
Delta Dentist PPO Dentist	$90	$54	$54	$0
Delta Dental Premier Dentist	$90	$77	$77	$0
Out-of-Network Dentist	$90	$47	$47	$43

In order to receive Dental Benefits, then you must have your dentist submit a claim form to Delta Dental. Payment of Dental Benefits shall be made directly to the dentist, unless the Eligible Person provides proof of payment to Delta Dental.

SCHEDULE OF DENTAL BENEFITS	
	PLAN PAYS
General Dental Benefits *Annual Limit: $1,000 per person*	100% of *allowed fee***
Orthodontia Benefit *Lifetime Limit: $2,000 per person*	100% of *allowed fee**
Implant Benefit *Lifetime Limit: $4,500 per person*	50% of *allowed fee**
Periodontia Benefit *Lifetime Limit:* $2,000 per person *Periodontia charges over the Lifetime Periodontia Maximum will be payable under the General Dental Benefit, if the General Dental Benefit Annual Limit has not been met.	100% of *allowed fee**
TMJ/TMD Treatment *Lifetime Limit:* $750 per Person	50% of *allowed fee**
Oral Surgery	80% of *allowed fee**

***The allowed fee is based upon the provider's relationship with Delta Dental. See subsections 6.01(A) & (B) for more explanation of the allowed fees for dental benefits.*

Section 6.02 - Opt-Out Provision

Upon written request to the Benefits Office, Eligible Persons may opt out of (and, if applicable, opt back in to) Dental Benefits from this Plan. Because contribution rates to the Fund are included in Collective Bargaining Agreements, the contribution on behalf of an individual Participant or Dependent who has opted out will not be reduced. Any such opt out (or, if applicable, opt in) will be effective the first day of the second calendar month after the written request is received by the Benefits Office.

Section 6.03 - General Dental Benefits

The Plan will pay General Dental Benefits according to the Schedule of Benefits, subject to an annual limit of $1,000 per person. Covered services under the General Dental Benefit consist of the following:

A. Preventive & Diagnostic Services

1. Routine periodic examinations, up to four per calendar year;
2. Bitewing x-rays, twice in any calendar year;
3. Full mouth x-rays, including bitewing x-rays, or a panorex once every five years;
4. Dental prophylaxis (cleaning, scaling and polishing)), up to four per calendar year;
5. Topical fluoride application for patients under age 15 twice in any calendar year;
6. Sealants, once per tooth per year to age nine for first molars; once per tooth per year to age 15 for second molars;
7. Patient screening once per calendar year;
8. Emergency, palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain); and
9. Space maintainers under age 15.

B. Other Dental Services

1. Restorative services using amalgam material.
2. Composite resin and porcelain crowns;
3. Provisional splinting;
4. Relines and rebases to bridges and dentures, once every 12 months for same tooth, same provider;

5. Stainless steel crowns for baby teeth only once every 24 months; and

6. Antibiotic drug injections.

C. Additional Dental Services for participants with special health care needs:

The Plan covers additional dental services for participants with special health care needs. The enhanced dental benefits include:

1. An additional exam benefit will be allowed prior to the first treatment to help patients learn what to expect and what is needed for a successful dental appointment;

2. Up to four total dental cleanings in a benefit year;

3. Treatment delivery modifications necessary for dental staff to provide oral health care for patients with sensory sensitivities, behavioral challenges, severe anxiety or other barriers to treatment;

4. The use of silver diamine fluoride; and

5. The use of anesthesia necessary to provide dental care.

For the purposes of these enhanced dental benefits, "special health care needs" includes any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in major live activity

Section 6.04 - Orthodontia Benefit

In addition to the other dental benefits described in this Article, the Plan will pay an Orthodontia Benefit for Eligible Person according to the Schedule of Benefits.

Method and Schedule of Orthodontia Benefit Payment: A Dental Claim Form must be completed by the dentist providing the treatment and submitted to Delta Dental. The Dental Claim Form must carry eligibility dates to coincide with the date of the treatment performed and separate claim forms must be submitted for the procedures outlined below.

Payment for Orthodontic Service: When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on % of the Maximum Payment for Orthodontic Services. Delta Dental will make additional payments as follows: Delta Dental will pay 100% of the per month fee charged by your Dentist based upon

the agreed upon payment plan provided by Delta Dental to your Dentist, subject to the maximum Orthodontia Benefit

The maximum Orthodontia Benefit is separate from and in addition to any other maximum Dental Benefit set forth in the Schedule of Benefits.

Section 6.05 - Dental Implant Benefit

In addition to the other dental benefits described in this Article, the Plan will pay a dental implant benefit according to the Schedule of Benefits, subject to a lifetime limit per person. The dental implant lifetime limit is not considered part of the General Dental Benefit annual limit.

Section 6.06 - Periodontia Benefit

The Plan shall pay for periodontal services according to the Schedule of Benefits, subject to the lifetime limit per person. The Periodontia Benefit shall be separate from and in addition to the annual limits applicable for other benefits in this Article. However, any charges for covered periodontal services that exceed lifetime limit as detailed in the Schedule of Benefits will be payable under the General Dental Benefit, if the General Dental Benefit annual limit has not been met. Periodontal maintenances are payable under the periodontia benefit.

Section 6.07 - Temporomandibular Joint Dysfunction (TMJ/TMD) Benefit

When TMJ/TMD, regardless of other conditions, causes an Eligible Person to incur expenses for treatment other than physical therapy which is covered under the Medical Benefit, the Plan will pay benefits according to the Schedule of Benefits, subject to a lifetime limit per person. The TMJ lifetime maximum is not considered a part of the General Dental Benefit annual limit..

Section 6.08 - Oral Surgery Benefit

Oral surgery services not due to Accident or injury will be payable according to the Schedule of Benefits and will not apply to the General Dental Benefit annual limit. .

Section 6.09 - Dental Benefit Limitations

No payment for dental benefits shall be made:

A. For any professional fees whatsoever other than the fees of the dentist performing the treatment;

B. For dental fees incurred for any treatment:

    1. Due to Accident or Sickness resulting from occupational disease. For the purpose of this section the term "Occupational Disease" shall mean a disease for which an Eligible Person is entitled to benefits under an applicable Worker's Compensation Law, Occupational Disease Law or similar legislation;

2. Performed in a Hospital owned or operated by the federal government or elsewhere at federal expense, or by a dentist employed by the federal government, or for which the person is not required to pay;

3. Performed in any federal, state, county or municipal institution by a dentist employed by the institution, or by a dentist using the facility.

C. For expense incurred due to Dental Treatment for cosmetic purposes, or for unnecessary care or treatment;

D. For dental expense incurred after the termination of eligibility or for prosthetic devices and the fitting thereof which were ordered while the individual was not eligible;

E. For replacement of a bridge, partial denture, or full denture which meets, or can be made to meet, commonly held dental standards of functional acceptability, or for replacement of a partial denture or full denture which is lost or stolen;

F. For replacement of a bridge, partial denture, or full denture within two years following the date of its original installment, unless such replacement is made necessary by the placement of an original opposing full denture;

G. For relining and re-basing of full or partial dentures within two years following the date of the previous relining or re-basing;

H. For appliances or restoration, other than full dentures, whose primary purpose is to increase vertical dimension or stabilize periodontal involved teeth;

I. For fees which the individual is not legally required to pay or for charges which would not have been made had this Plan not existed;

J. To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the individual resides at the time expenses are incurred;

K. To the extent that reimbursement is available under the mandatory portion of any "No-Fault" automobile policy;

L. For charges which are not Medically Necessary or are unreasonable.

ARTICLE VII - ACCIDENTAL DEATH & DISMEMBERMENT, DEATH BENEFIT, DISABILITY BENEFIT, AND MATERNITY BENEFIT

Section 7.01 - Accidental Death And Dismemberment Benefit (Employee Only)

When bodily injury caused solely through accidental means on or off the job results in any of the following losses within 90 days after the date of the Accident, the Plan will pay the amount specified in the Schedule of Benefits.

The term "Loss" as used in this section with reference to hand or foot means the complete severance through or above the wrist or ankle joint, and with reference to the eye means the irrecoverable loss of the entire sight thereof. If more than one loss is suffered the Plan will pay the benefit for the greatest loss.

Benefits will **NOT** be payable for any loss caused by:

A. Injuries intentionally self-inflicted while sane; or due to combat during war, or as a result of an act of war;

B. Physical or mental illness or infirmity, food poisoning, or any kind of poisoning; or

C. Aircraft, except while a passenger in a licensed aircraft (other than a chartered aircraft) operated by a licensed pilot on a regularly scheduled passenger flight offered between specified airports by a licensed passenger carrier.

In the event that the deceased Employee dies without designating a Beneficiary or in the event that the designated Beneficiary has predeceased the Employee, the amount of the Accidental Death and Dismemberment Benefit shall be paid to any one or more of the following surviving individuals, in descending order:

> The deceased Employee's Surviving Spouse; child or children in equal shares; father; mother; brothers or sisters; or failing these, to the deceased Employee's estate.

An eligible Employee may designate any natural person or persons or legal entity as the Beneficiary of any Accidental Death and Dismemberment Benefit payable from the Plan by filing the designation, in writing, with the Benefits Office. An eligible Employee may designate a new Beneficiary at any time by filing a new Beneficiary Designation Form with the Benefits Office. Any change shall **NOT** become effective until it is received in the Benefits Office, and neither the Plan nor the Trustees shall be liable for any payment made before the change was received in the Benefits Office.

Section 7.02 - Death Benefit (Participant Only)

Upon the death of an eligible Participant, unless intentionally self-inflicted, the Plan will pay a Death Benefit in the amount set forth in the Schedule of Benefits to the designated

Beneficiary of the deceased Participant. The payment of any such Death Benefit shall be contingent upon the receipt by the Benefits Office of proper proof of the eligible Participant's death.

In the event that the deceased Participant dies without designating a Beneficiary or in the event that the designated Beneficiary has predeceased the Participant, the amount of the Death Benefit shall be paid to any one or more of the following surviving individuals, in descending order:

> The deceased Participant's Surviving Spouse; child or children in equal shares; father; mother; brothers or sisters; or failing these, to the deceased Participant's estate.

An eligible Participant may designate any natural person or persons or legal entity as the Beneficiary of any Death Benefit payable from the Plan by filing the designation, in writing, with the Benefits Office. An eligible Participant may designate a new Beneficiary at any time by filing a new Beneficiary Designation Form with the Benefits Office. Any change shall **NOT** become effective until it is received in the Benefits Office, and neither the Plan nor the Trustees shall be liable for any payment made before the change was received in the Benefits Office.If an eligible Participant designates more than one Beneficiary without specifying their respective interests, the Death Benefit will be paid in equal shares.

Notwithstanding the foregoing, a Participant's designation of his/her spouse as Beneficiary shall become null and void automatically upon divorce. Should the Participant wish to maintain the Beneficiary designation of an ex-spouse, he/she must fill out a new beneficiary form after the divorce.

Section 7.03 - Loss of Time Benefit – Weekly (Employee Only)

When an Accident or Sickness shall disable and prevent an eligible Employee from engaging in the Employee's regular occupation, the Plan will pay the weekly benefit as set forth in the Schedule of Benefits with supporting Physician's orders. Accident benefits begin on the first day of disability and Sickness benefits begin on the eighth day of illness. For purposes of this Benefit, if treatment for an injury is not sought within seven days of sustaining the injury, the disability will be treated as a Sickness and Benefits will not commence until the eighth day.

Successive periods of disability due to the same or related causes shall be considered as the same period of disability, unless separated by a return to full-time work for at least two weeks. For the purposes of this benefit, any injury which arises out of or in the course of any occupation or employment for wage or profit will be considered an Occupational Disability. All other disabilities will be considered a Non-occupational Disability.

Requirement for Medical Treatment: No benefits shall be payable under this section unless the eligible Employee is under the regular care and attention of a Physician or Surgeon. The Plan may require reasonable proof of initial and continuing disability.

Section 7.04 - Maternity Leave Benefit (Employee Only)

The Plan provides a Maternity Leave Benefit for all Employees who give birth. The Plan will pay 100% of the Employee's wages (at the hourly rate the Employee was receiving the day before the maternity leave begins, for 40 hours per week), for up to 8 weeks of maternity leave. The Plan will also freeze the hour bank while the Employee is receiving the Maternity Leave Benefit, which means that hours will not be pulled from the hour bank to continue eligibility for healthcare coverage. Employees may not receive Weekly Disability Benefits while receiving the Maternity Leave Benefit. Spouses and Dependent Children are not eligible for the Maternity Leave Benefit.

ARTICLE VIII – HEALTH REIMBURSEMENT ACCOUNT

Section 8.01 - Health Reimbursement Account

The Health Reimbursement Account component of the Plan allows for a designated amount per hour from your Employer contributions to be allocated into a Health Reimbursement Account (HRA or Account) to reimburse Participants for certain expenses as allowed by law. That rate will be set by the Board of Trustees. No Employee contributions are permitted.

A. Establishment of Separate Account

The Plan Administrator will establish and maintain a separate Account for each eligible Employee. This account will be used to receive the Employer HRA contributions and to reimburse allowable expenses. Although each Participant's Account will be separately identified, the combined assets of all Accounts will be held by the Plan and identified in the Plan's financial statements as the HRA reserves. The Account established for an Employee will merely be a record-keeping account for the purpose of keeping track of Employer HRA contributions and available reimbursement amounts from the Plan. The Accounts shall not be credited with any interest income earned on the HRA reserves. The Accounts will not be charged with any expenses for administration of the HRA, except as otherwise noted in Section 8.11. The Accounts are not a vested benefit and are not the property of the Employee except for the purposes set forth herein.

B. Crediting of Accounts

A Participant's Account will be credited at the end of the month with contributions made for work performed by the Participant in the preceding month. For example, Employer contributions made for Participant hours worked in March will be contributed to a Participant's Account by April 30th. Only amounts actually received by the Plan will be credited to a Participant's Account.

Additional monthly allocations will be made to the HRA of Participants who have reached the Maximum Account Balance in the IBEW 481 Supplemental Unemployment Benefit Fund (SUB Account) provided they have not made an election to transfer surplus SUB contributions to the IBEW Local 481 Defined Contribution Plan. Retirees will automatically have any remaining assets in their SUB Account transferred to their HRA.

C. Debiting of Accounts

A Participant's Account will be debited for the amount of monies reimbursed upon payment of the reimbursement. You have the option of having your qualifying out-of-pocket medical expenses automatically reimbursed from your available HRA balance. Contact the Benefits Office to enroll in this auto-adjudication option.

Section 8.02 - Eligibility

In order to be eligible for reimbursements from the HRA, Participants must meet the following eligibility rules:

A. For medical claim reimbursements, Participants must have previously satisfied the Plan's initial eligibility rule; and,

B. To use the HRA for self-payments (see Section 8.08 below), Participants must have been eligible the preceding month; and,

C. Participants must have a balance in their HRA.

Section 8.03 - Medical Care Expenses Eligible for Reimbursement

Medical Care Expenses eligible for reimbursement under the HRA are all expenses incurred by (1) the Participant, (2) the Participant's spouse and/or (3) the Participant's dependent child through the end of the year of the dependent child's 26th birthday, for medical care as that term is defined in Section 213(d) of the Internal Revenue Code or otherwise eligible for reimbursement due to the CARES Act, if the medical care expenses have not be reimbursed by another source.

For a listing of expenses that may be covered by the HRA, refer to IRS Publication 502. The Publication can be found on the Internet at http://www.irs.gov/pub/irs-pdf/p502.pdf. If you do not have Internet access, contact the Benefits Office for a copy of Publication 502.

Section 8.04 - Expenses that Do Not Qualify for Reimbursement

Some of the expenses listed in IRS Publication 502 that do not qualify for reimbursement from a Participant's HRA include but are not limited to:

- Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby
- Controlled Substances that are illegal under federal law
- Cosmetic Surgery, including electrolysis, hair removal, and hair transplants
  (unless necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.)
- Dancing and Swimming Lessons, if the lessons are only for the improvement of general health
- Diaper Service
  (unless diapers are needed to relieve the effects of a particular disease.)
- Funeral Expenses
- Future Medical Care
- Health Club Dues or gym memberships
- Household Help
  (you may be able to include certain expenses paid to a person providing nursing-type services.)
- Illegal Operations and Treatments

- Maternity Clothes
- Medicines and Drugs From Other Countries
  (you can include the cost of a prescribed drug you purchase and consume in another country if the drug is legal in both the other country and the United States.)
- Nutritional Supplements
  (unless they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician.)
- Personal Use Items
- Surrogacy Expenses
- Teeth Whitening
- Veterinary Fees
- Weight-Loss Programs, unless the program treats a specific disease diagnosed by a physician

Section 8.05 - How to File a Claim for Reimbursement of a Medical Expense

A Participant must have satisfied the Plan's initial eligibility rule at some point on or before the date of the claim to be eligible for reimbursement from the HRA. The Participant can either first pay the medical bill for which he or she seeks reimbursement or can submit the medical bill to the Benefits Office and the Benefits Office will pay the medical provider directly.

The Participant must follow the payment procedures as stated herein. Claims must be filed on the appropriate claim form submitted with the medical bill (if payment will be made directly to the medical provider) or the medical bill with evidence of payment (if payment will be made to the Participant).

If a claim is submitted for direct payment or reimbursement and that claim is returned to the Participant with no payment made, that claim can be resubmitted within the twelve-month filing time limit. Claims will be processed in a timely manner as they are received.

Section 8.06 - Filing Time Limit

Claims for reimbursement from the HRA or for direct payment to the medical provider must be filed within twelve months of the date the expense was incurred. Late filed claims will not be eligible for reimbursement.

Section 8.07 - Appeals of Denied HRA Claims

Participants have the right to appeal any denial, in whole or part, of an HRA claim in accordance with the Plan's claims and appeals procedures.

Section 8.08 - How to Apply HRA Amounts for Self-payments

Participants may use the HRA to make self-payments for continuous coverage under the Plan. When the Participant receives the monthly self-payment notice, he or she must contact the Benefits Office to request any eligible HRA account balance be transferred to cover the self-payment obligation.

Section 8.09 - COBRA

Continued coverage in the HRA account is provided through COBRA continuation coverage with the Plan. COBRA cannot be purchased for the HRA alone. The HRA can be used to pay the Plan's COBRA premium when requested on the appropriate form.

Section 8.10 - Forfeiture of HRA

Any balance in the HRA will be forfeited upon any one of the following events:

A. Termination of coverage from the Plan and no activity for a period of 36 months. For the purposes of the HRA forfeiture rules, "activity" means no Employer contributions or claim reimbursements;

B. Termination of the Plan or the HRA program,

C. Death of the Participant with no surviving dependents;

D. Permanently opting out of participation in the HRA Account; or

E. Forfeiture for Industry Employment. To the extent a Participant or Retiree accepts employment in the Electrical Industry for any entity that is not affiliated with the IBEW and/or NECA, he shall be ineligible to participate in this Plan and any remaining assets in the HRA will be immediately forfeited.

Forfeitures will be used to offset the administration expenses of the Plan and will be processed on the first of the month following the calendar month in which the event prompting the forfeiture occurs

Notice of Forfeiture for Inactive HRA Account: The Plan will send notices to Participants with HRA accounts that may be subject to forfeiture because of no activity (i.e. HRA accounts that have no Employer contributions or claim reimbursements) at the following intervals: 12 months with no activity, 24 months with no activity and a final notice after 36 months if there has been no activity in your HRA account prior to the final forfeiture date.

A Participant that receives a final forfeiture notice may appeal the action using the Plan's claims and appeals procedures. All notices relating to forfeiture will be sent via regular U.S. first class mail to a Participant's last known address on file with the Benefits Office. **It is the Participant's responsibility to keep the Benefits Office updated of any change of address.**

Section 8.11 - Administration Fees

If a Participant is not eligible under the Plan and has an HRA account balance, the Trustees have the right to impose a monthly fee to each HRA account to cover the costs of administration.

Section 8.12 - Statements

Each Participant with an HRA account will receive notification in the first quarter of each year regarding availability of an annual statement.

Section 8.13 - Permanent Opt-out of Participation

An individual who is eligible to participate in the HRA may elect to permanently opt-out of participation in the HRA. By permanently opting-out out of participation in the HRA, the Participant forfeits all amounts accumulated in his HRA Account and waives all future contributions to his HRA Account. All individuals eligible to participate in the HRA shall be given the option of permanently opting-out of participation at least annually and upon termination of participation in the Electrical Workers Benefit Trust Fund.

ARTICLE IX - BENEFIT EXCLUSIONS & LIMITATIONS

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.** Exclusions, including complications from excluded services, supplies or equipment are not considered Covered Expenses and will not be payable, except when required to be covered under federal law, including the Consolidated Appropriations Act of 2021 (CAA).

IF YOU ARE UNSURE WHETHER A SERVICE OR PROCEDURE IS EXCLUDED, PLEASE CONTACT THE BENEFITS OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.

In addition to any other limitations, either specific or general, set forth in the Plan, benefits shall **NOT** be paid or payable for any loss caused by, incurred for, or resulting from:

1. Treatment, services or supplies that are not Medically Necessary, unless specifically covered under the Plan;

2. Cosmetic or reconstructive surgery, except: 1) to repair damage caused by or a result of an Accident; 2) to repair a congenital defect; 3) for reconstruction of a breast on which a mastectomy has been performed; 4) for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance; 5) for coverage for prostheses; 6) for physical complications of all states of mastectomy (including lymph edemas) in a manner determined in consultation with the attending Physician and the patient; and 7) for medically necessary surgeries related to gender dysphoria.

3. Dental or gum work except where necessary to repair damage due to injury to natural teeth or jaw or as provided under the Dental benefit;

4. Acupuncture;

5. Diet or weight loss clinics or programs unless the clinical criteria set forth by the prescription benefit manager is met;

6. Food supplements for weight loss;

7. Child development classes or programs;

8. Injury or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit, or which would entitle the individual to benefits under a Worker's Compensation or occupational Disease law;

9. Injuries or Sicknesses suffered or contracted while in the Armed Forces of any country;

10. Pregnancy and complications from pregnancy for dependent children, except as required under ACA and payable under the Preventive Care Benefit;

11. Birth control devices, except as required under ACA and payable under the Preventive Care Benefit;

12. Fertility treatments, artificial insemination, in vitro fertilization, penile prosthesis and treatments related to sexual dysfunction;

13. Non-prescription drugs or over-the-counter drugs and medications, even though prescribed by a Physician;

14. Personal items while in the Hospital, such as but not limited to, telephone, T.V., Hospital admission kits;

15. Personal hygiene and convenience items, such as but not limited to, air conditioners, humidifiers, hot tubs or whirlpools, sun beds, saunas, steam baths, waterbeds, physical fitness equipment or like items, health club or country club memberships, or services by a masseuse or massage therapist, even though a Physician may prescribe them. However, notwithstanding the foregoing, equipment necessary for Medically Necessary Durable Medical Equipment to work properly may otherwise be covered;

16. Charges in excess of the Usual, Customary and Reasonable Charge;

17. Treatment which is considered experimental or which is not provided in accordance with generally accepted professional medical standards, except for services mandated by law for Approved Clinical Trials as described in Section 3.04.

18. Holistic medicine;

19. Personal injury claims, unless you have complied with the requirements described in Section 10.10;

20. Services provided before the member or dependent became eligible for benefits;

21. Services or supplies provided by a provider or institution acting outside the scope of his/her/its license;

22. Research studies;

23. Sterilization reversal;

24. Services provided by a person who resides in the household of the person being treated;

25. Services or supplies for which the patient is not required to pay;

26. Eye exams refractions or fitting of eyeglasses (except as allowed under Vision Benefits only); Vision screenings required to be covered as a Preventive Care Benefit are covered under the Medical Benefit;

27. A person providing services as an assistant surgeon who is not duly licensed to perform surgery;

28. Housekeeping or custodial care;

29. Corrective shoes, unless covered under the podiatry benefit ;

30. Charges for telephone consultations (other than approved telemedicine charges), failure to keep a scheduled appointment, completion of a claim form or to obtain medical records or other information;

31. Genetic or chromosomal testing or counseling unless it is necessary to determine the course of treatment and was pre-determined to be Medically Necessary;

32. Services or supplies for growth hormone medications and similar biopharmaceuticals unless they are determined to be Medically Necessary;

33. Services, supplies or treatment required as a result of complications from a treatment not covered by the Plan;

34. Charges for court-ordered treatment, unless such treatment would otherwise be covered under this Plan as medically necessary;

35. Maternity charges incurred by a covered person acting as a surrogate mother are not covered . For the purpose of this Plan, "surrogacy" means that the mother has entered into a contract or other understanding pursuant to which she relinquishes a child or children following birth. All expenses paid by the Plan in such cases may be recovered from the Participant, the Participant's spouse and/or the third party or any related parties. Care, services or treatments required as a result of complications from a surrogate pregnancy by the Participant or Participant's spouse will not be covered under the Plan;

36. Services or treatment resulting from injuries due to combat during war or as a result of an act of war; declared or undeclared.

37. Services or treatment resulting from participation in or consequences of having participated in a riot, or willful participation of a criminal act, assault or felony.

38. Non-emergency services or treatment outside of the United States.

39. Formula or other supplemental feedings unless it is delivered by total parenteral nutrition (TPN), G-Tube and J-Tube.

40. Gene therapy, including any services, supplies and/or drugs related to gene therapy.

41. Infusion medications will be covered only under the prescription drug benefit (subject to limitations described in this document), except if administered in a medically necessary inpatient or emergency room setting, of if there are special circumstances as determined by the Board of Trustees in their sole discretion.

ARTICLE X - MISCELLANEOUS PROVISIONS

The following topics are discussed under this Article on Miscellaneous Provisions:

10.01. Payment of Benefits
10.02. Deadline for Filing Claim
10.03. Claim Forms
10.04. Hospital Bill Audit Program
10.05. Initial Claims Decisions and Claims Appeal Procedures
10.06. No Assignment or Attachment Of Benefits
10.07. Construction by Trustees
10.08. Coordination of Benefits
10.09. How Medicare Affects Medical Benefits Under the Plan & Coordination with Medicare
10.10. Subrogation
10.11. Health Care Fraud
10.12. Right of Recovery
10.13. Preservation of Plan Provisions
10.14. Termination of Plan
10.15. HIPAA Privacy Rule
10.16. HIPAA Security Rule
10.17. Protections from Surprise Medical Bills

Section 10.01 - Payment Of Benefits

All benefits shall be payable through the employees or agents of the Trustees acting under their authority. The Trustees reserve the right to change, alter or amend the benefits from time to time as the conditions dictate. No benefits shall be payable except those specifically provided under the Plan and no person shall have any claim for any other benefits against either the Union, the National Electrical Contractors Association (NECA), any Employer or the Trustees. The Trustees, Employers, NECA or the Union cannot be held liable for any contributions or benefits except those provided for in either the collective bargaining agreement or this Booklet.

Section 10.02 - Deadline for Filing Claim

Claims for Medical Benefits, Prescription Drug Benefits, Vision, Dental must be filed within six (6) months from the date of service. Claims for Accidental Death & Dismemberment or Loss of Time benefits must be filed within six (6) months from the date of the accident or sickness. Claims for Death Benefits must be filed within six (6) months of the date of death. Late submission of claims may result in disqualification of the claim.

Section 10.03 - Claim Forms

The Benefits Office, upon request, will furnish all necessary forms for the filing of proof of loss. If the forms are not furnished within 15 days of the request, the claimant shall be deemed to have complied with the Plan provisions requiring the giving of notice of proof of loss upon submitting written proof covering the occurrence, the character and extent of the loss for which the claim is made.

Section 10.04 - Hospital Bill Audit Program

The Hospital Bill Audit Program pays up to $500 a year to any Participant who discovers and recovers overcharges on his or her Hospital bills. Any Participant who discovers an overcharge and arranges for its recovery will be paid the lesser of 30% of the overcharged amount that the Hospital agrees to correct or $500.

To be eligible for this Program, the overcharge must be more than $25 and be for covered charges under this Plan. If benefits are being coordinated with another plan, this Program applies only if this Plan is the primary plan and pays benefits first. To receive payment, the claimant must submit a copy of the adjusted bill within 45 days after being discharged.

Section 10.05 - Initial Claims Decisions and Claims Appeal Procedures

As a non-grandfathered plan under the ACA there are three steps in the claims procedures:

- Initial claims decisions
- Internal claims appeal procedures
- External claims appeal review

Each of these procedures are explained below. In addition, ACA requires that all claims and appeals must be handled in a way that is designed to ensure the decision-maker's impartiality.

Initial Claims Decisions: The following procedures govern all claims for benefits.

A. ***Medical Claims***

Non-urgent Medical Claims

The Administrative Manager shall notify the claimant of the Plan's denial (defined as the denial, in whole or in part, of a claim for benefits) within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Administrative Manager both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

Urgent Medical Claims

The Administrative Manager shall notify the claimant of the Plan's denial (defined as the denial, in whole or in part, of a claim for benefits) of an urgent care claim as soon as possible, but not later than 72 hours after receipt of the claim.

B. ***Disability, Accidental Death and Dismemberment and Death Benefit Claims***

In the case of a claim for disability, AD&D or death benefits, the Administrative Manager shall notify the claimant of the Plan's Procedures for Appeals of denials within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Administrative Manager both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrative Manager determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Administrative Manager notifies the claimant, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating Time Periods: For purposes of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit the information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Manner and Content of Notification of Benefit Determination: The Administrative Manager shall provide a claimant with written or electronic notification of any denial. Any electronic notification shall comply with the standards imposed by law. The notification shall set forth, in a manner calculated to be understood by the claimant:

A. The specific reason or reasons for the denial;

B. Reference to the specific Plan provisions on which the denial is based;

C. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

D. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review;

E. The notice shall also include the following if applicable:

1. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion shall be provided to the claimant; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

2. If the denial is based on not being Medically Necessary Medically or on Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the claimant's medical circumstances shall be provided to the claimant, or a statement that such explanation will be provided free of charge upon request.

3. In the case of an adverse benefit determination with respect to disability benefits, the notice shall also include the following in a culturally and linguistically appropriate manner:

    a. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

        i. The views presented by the claimant to the plan of health care professionals and vocational professionals who evaluated the claimant;

        ii. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

        iii. A disability determination regarding the claimant presented by the Social Security Administration.

    b. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and

    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Internal Claims Appeal Procedures: The following are the procedures to be followed by the Plan in reviewing an appeal of a Claim Denial. As part of the claimant's rights of appeal:

A. Claimants shall have 180 days following receipt of a notification of a denial within which to appeal the denial.

B. The review on appeal shall not afford deference to the initial denial and shall be conducted by the Board of Trustees or a designated committee thereof.

C. In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including denials with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

D. The Plan shall provide to the claimant the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit denial; and

E. The appeal review process shall provide that the health care professional engaged for purposes of a consultation under paragraph C of this section shall be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual.

F. With respect to appeals of denied disability benefits, the Plan Administrator shall provide to the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the benefit determination will be decided on appeal and the claimant will be given a reasonable opportunity to respond prior to the date of the appeal determination.

The appeals process of a claim for AD&D or death benefits shall be as set forth above, except that such appeals must be filed within **60** days of receipt of the denial.

Timing of Notification of Benefit Denial on Review: The Trustees shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Administrative Manager shall notify the claimant in writing of the extension. The Administrative Manager shall notify the claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

Calculating Time Periods: The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the

event that period of time is extended as permitted due to a claimant's failure to submit the information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Furnishing Documents: In the case of a denial on review, the Administrative Manager shall provide the claimant such access to, and copies of, documents, records, and other information as is appropriate and required by law.

Manner and Content of Notification of Benefit Denial on Review: The Administrative Manager shall provide a claimant with written or electronic notification of the Trustees' benefit denial on review. Any electronic notification shall comply with the standards imposed by law. In the case of a denial, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

A. The specific reason or reasons for the denial;

B. Reference to the specific Plan provisions on which the benefit denial is based;

C. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits, including diagnosis and treatment codes and the meaning of such codes;

D. A statement of the claimant's right to bring an action under Section 502(a) of ERISA;

E. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion shall be provided to the claimant; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon the request; and

F. If the denial is based on a not Medically Necessary, or being Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the Plan to the claimant's medical circumstances shall be provided to the claimant, or a statement that such explanation will be provided free of charge upon request.

G. In the case of an adverse benefit determination with respect to disability benefits, the notice shall also include the following in a culturally and linguistically appropriate manner:

    1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

a. The views presented by the claimant to the plan of health care professionals the claimant and vocational professionals who evaluated the claimant;

b. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

c. A disability determination regarding the claimant presented by the Social Security Administration.

2. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

Internal Review of Urgent Medical Claims: The Administrative Manager shall notify the Claimant of the Plan's denial (defined as the denial, in whole or in part, of a claim for benefits) of an urgent care claim as soon as possible, but not later than 72 hours after receipt of the claim. Urgent claim appeals may be submitted to the Plan in writing, by telephone or fax.

Other Procedures Required For Internal Claims Processes: The ACA requires non-grandfathered health plans to have specific rules for internal appeals processes. In addition to the procedures listed in this subsection, the following additional standards apply:

- A Claim Denial includes rescissions of coverage, pre-and post-service claim determinations, exclusions, limitations and eligibility determinations.
- Claimants must be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim. The information must be provided as soon as possible and sufficiently in advance to give claimants reasonable opportunity to respond.
- Notices to claimants must provide additional content such as identifying information on the claim, denial codes, any standard used in denying the claim, description of available appeals processes and contact information for any applicable health insurance consumer assistance or ombudsman office.

External Claims Appeal Procedures: The Patient Protection and Affordable Care Act requires non-grandfathered health plans to have specific rules for external appeals processes. A Claimant may request an external appeals review after an initial Claim Denial and subsequent internal review Claim Denial that involves (1) medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without any use of medical judgment); (2) whether the Plan is complying with the nonquantitative treatment limitation provisions which, in general require parity in the application of medical management techniques; (3) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections as detailed in No Suprises Act; or

(4) a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time).

The timeline for an external review is as follows:

Request for External Review: An external appeal must be allowed if the Claimant requests an external appeal within four months after receipt of notice of Claim Denial. An immediate external review must also be allowed if the Plan has failed to adhere to the ACA 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, the claimant is entitled, upon written request, to an explanation of the Plan's basis for asserting the exception. If the external reviewer rejects the claimant's request for immediate review on the basis that the Plan has met the five-element exception, the claimant is 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:

- The Claimant was 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 the Claimant's failure to meet eligibility requirements for eligibility under the Plan;
- The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the regulations; and
- The Claimant has 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 notification in writing to the Claimant. 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 the Claimant 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 the claimant 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 Utilization Review Accreditation Commission ("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). 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. For an urgent care issue, the information must be sent immediately after receipt, electronically, by fax or other expeditious means. 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).

External Review of Urgent Medical Claims: The Administrative Manager shall notify the Claimant of the Plan's denial (defined as the denial, in whole or in part, of a claim for benefits) of an urgent care claim as soon as possible, but not later than 72 hours after receipt of the claim. Urgent claim appeals may be submitted to the Plan in writing, by telephone or fax.

Right to Bring Legal Action: A claimant may not begin any legal action, including proceedings before administrative agencies, until these procedures and the opportunities described in this section have been exhausted. The review procedures described in this section shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined here, a claimant is not satisfied with the result, legal action may be filed within three years of receiving the final review notice under these procedures. A claimant shall only bring action in connection with the Plan in the United States District Court for the Southern District of Indiana.

If a Plan fails to strictly adhere to requirements of the claims and appeals sections of the Plan with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except for de minimums violations explained below. As such, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

The administrative remedies available under the Plan with respect to disability benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing and good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant’s request for immediate review under this section on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan’s receipt of the decision of the court.

Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

Section 10.06 - No Assignment or Attachment Of Benefits

The Plan reserves the right to make payments directly to the Eligible Person. When this occurs, the Eligible Person must pay the provider and the Plan is not obligated to pay additional amounts. The Eligible Person cannot assign their right to receive payment to anyone else nor can the Eligible Person authorize someone else to receive payments for you, including your provider. The Plan will not honor an assignment of the claim to anyone. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to initiate any court proceeding. Nothing contained in the written description of the Plan's medical coverage shall be construed to make the Plan liable to any third-party to whom an Eligible Person may be liable for medical care, treatment or services. All benefits under the Plan are exempt, to the extent permitted by law, from the claims of creditors and from all orders, decrees, garnishments, executions or other legal processes or proceedings.

Section 10.07 - Construction By Trustees

The Trustees have full authority and discretion to construe the provisions of this Plan and any construction made by the Trustees shall be final and binding on all parties. Benefits under this Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

Section 10.08 - Coordination Of Benefits

A. Benefits that are Coordinated

All benefits provided under this Plan, with the exception of Death Benefit, Accidental Death and Dismemberment, and the Weekly Disability, shall be coordinated with any other plan of health care benefits.

B. Definitions

For the purposes of the Plan's Coordination of Benefits rules, the following definitions apply:

1. The term "**Allowable Expense"** means any necessary Allowable Charges incurred by an Eligible Person during a plan year and while eligible under this Plan for medical, prescription drug, dental, and/or vision care or treatment, part or all of which would be covered under any Other Plan.

   When any Other Plan provides services rather than cash payment, the reasonable cash value of each service will be an Allowable Expense.

   The lesser of the amounts allowed by a health care provider to either this Plan or the Other Plan will be considered as the amount such provider accepts as payment in full for the service or supply. If such amount the provider allows to the Other Plan differs from the Allowable Charge for this Plan, Allowable Expenses for the service or supply will not exceed **the lesser of allowed amounts**.

2. The term "**Other Plan**" means any plan besides this Plan providing benefits or services for or by reason of medical, dental or vision care or treatment, which benefits or services are provided by: (a) group, blanket, or franchise insurance coverage; (b) service plan contracts, group practice, individual practice, and other prepayment coverage; (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs; and, (e) any coverage required or provided by any statute.

   For more information on how this Plan coordinates with Medicare, see Section 10.09.

3. The term "**this Plan**" means the EWBTF.

C. Order of Benefit Determination

1. Generally, the plan that covers the person as an employee shall be known as the "Primary Plan" and shall pay its benefits first. The plan that covers the person as a spouse shall be known as the "Secondary Plan" and shall pay its benefits second. Coordination between Eligible Dependent children is as stated below.

2. For Eligible Dependent children that have insurance coverage through their employer, the dependent child's employer provided coverage will pay as the Primary Plan.

3. For Eligible Dependent children that do not have coverage through employment, the Primary Plan is the plan of the parent whose birthday (excluding the year of birth) occurs first in a Calendar Year (birthday rule).

4. For Eligible Dependent biological or adopted children when the parents are separated or divorced: If there is a court decree which establishes the financial responsibility for the health care expenses of the child or children, the benefits shall be determined in accordance with the terms of the court decree, provided that the child meets the definition of Eligible Dependent. Otherwise, the birthday rule, as described in paragraph 2, shall be applied.

5. For Eligible Dependent step-children: this Plan will pay third after the insurances of both biological parents have been determined. If neither biological parent has insurance, this Plan will pay Primary, provided that the child meets the definition of Eligible Dependent.

6. If the above rules do not establish an Order of Benefit Determination, the plan which has covered the person for the longer period of time shall be the Primary Plan, with the following exception: The benefits of a plan covering the person as a laid-off or retired employee, or a dependent of such person, shall be determined after the benefits of any other plan covering the person as an employee.

7. Any plan that does not contain a Coordination of Benefits provision shall automatically be considered the Primary Plan.

8. In addition to the foregoing, if an Eligible Person is eligible to receive benefits or services pursuant to group or individual automobile or homeowners' policy without regard to fault or any other arrangement of insured or self-insured group coverage (other than that provided pursuant to the Eligible Person's own policy of insurance), then this Plan shall be secondary to such coverage.

D. Calculation of Benefits when Coordination of Benefits Applies:

1. When this Plan is the primary plan, there is no change in the way the Plan determines payment. This Plan will determine payment as if it was the only coverage available.

2. When this Plan is the secondary plan, the following rules apply:

   a. When this Plan is secondary, and benefits are eligible expenses under both the Other Plan and this Plan, this Plan will first determine what it would have paid on the claim in the absence of the Other Plan. Then, this Plan will take the amount it would have paid in the absence of the Other Plan and reduce it so that the sum of (1) such reduced benefits payable under this Plan and (2) the benefits payable under all Other Plans, will not exceed 100% of the Allowable Expense determined by this Plan or (2) the Allowable Expense determined by the Other Plan for such claim.

   b. However, this Plan's benefit limits, deductibles, copayments, coinsurance, and Out-of-Pocket Limit amounts remain the same when this Plan is the secondary payer. In addition, this Plan shall credit to its Plan Deductible based upon the allowable amount for the coordinated claim. The Plan shall credit to its Annual Out-of-Pocket Maximum any patient responsibility amounts left on the claim. When payment is made towards a benefit that includes a benefit limit under this Plan, the secondary payment amount will be applied towards the benefit limit.

   c. When this Plan is secondary, and benefits are not an eligible expense under the Other Plan, but are an eligible expense under this Plan, this Plan will pay benefits as if it were the primary payor in accordance with the Plan's benefit limits, deductibles, copayments, coinsurance, and Out-of-Pocket Limit amounts as described in this SPD.

   d. When this Plan is secondary, and benefits are an eligible expense under the primary plan, but **ARE NOT** eligible expenses under this Plan, **NO TRUST BENEFITS WILL BE PAYABLE**.

Section 10.09 - How Medicare Affects Medical Benefits Under the Plan & Coordination with Medicare

Health benefits under this Plan for Eligible Persons who are also eligible for Medicare will be paid as required by law.

Medicare has three relevant parts - Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Coverage (Part D). Part A primarily covers Inpatient Hospital care, although other benefits are also provided and it is generally available to all individuals over age 65 at no cost. Part B covers Physician services, Outpatient Hospital services and other medical supplies and is optional. Part D covers prescription drugs and is also optional. The Electrical Workers Benefit Trust Fund sponsors its own Medicare Advantage and Prescription Drug ("MAPD") program which provides basic coverage for Medicare Parts A, B and D, along with extra coverage that goes beyond the basic coverage levels of Parts A, B and D.

Typically a person becomes eligible for Medicare upon reaching age 65. Under certain circumstances, a person may become eligible for Medicare before age 65 if the person is a disabled worker, dependent widow/widower, has chronic end-stage renal disease (ESRD), or has Amyotrophic Lateral Sclerosis (ALS). 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. If you are retired and are current with your applicable Retiree self-payments, the Plan will automatically enroll you in the Medicare Advantage and Prescription Drug ("MAPD") program as soon as we receive confirmation that you have obtained Medicare Parts A and B. If you do not enroll in Part A and Part B coverage at least 90 days prior to losing coverage as an Active Employee, you will not be able to participate in the Plan's MAPD program.

The way your benefits under the Plan and under Medicare are paid (or are coordinated) is different depending on whether you are an active or a retired employee eligible for Medicare. This Plan will remain primarily responsible for benefits for eligible active employees and their eligible Dependents. This means that when covered medical expenses are incurred by an eligible active employee who is also eligible for Medicare, this Plan will pay benefits first and then Medicare may (but probably will not) pay some of the remaining expense not covered by the Plan.

However, special rules may apply for an eligible Active Employee, and a Dependent of such Active Employee who is first entitled to Medicare because ESRD. Generally, for those individuals, this Plan is primary for a period of thirty (30) months. However, if Medicare is primary for an Eligible Person due to age or Disability and then the Eligible Person becomes entitled to Medicare due to ESRD, Medicare remains primary. An Eligible Person may have more than one (1) thirty (30) month period if he has a kidney transplant that subsequently fails, leading to a second transplant and a second (2nd) period of thirty (30) months.

However, when an employee who is eligible for Medicare retires, Medicare is primary. This means that the Medicare Advantage and Prescription Drug program will pay for benefits. ***Therefore, it is essential that, at least 90 days prior to when your active coverage terminates, you enroll in Part A and Part B coverage as soon as possible.***

If you are a retired employee eligible for Medicare, you must be enrolled in both Medicare Part A and Part B in order to be eligible under this Plan. If you do not maintain enrollment in Medicare Part A and Part B, you will lose all coverage under this Plan and this Medicare Advantage and

Prescription Drug program immediately. If you later enroll or reenroll in Medicare Part A and Part B, you must satisfy the initial eligibility rules for employment in order to regain eligibility in this Plan.

Section 10.10 - Subrogation

Subrogation and reimbursement allows the Plan the ability to recoup the value of any benefits (medical, disability, Rx, etc.) paid on behalf of an Eligible Person covered by this Plan who has an Accident or suffers a Sickness through the actions or omissions of a person or entity accountable for the Accident or Sickness (hereinafter called an "Accountable Person"). The subrogation and reimbursement process helps the overall financial stability of the Plan by ensuring the Plan is not the only entity paying for Accidents and Sicknesses caused by an Accountable Person.

Right to Subrogate

The Plan is subrogated to any and all rights of recovery and causes of action that the Eligible Person covered by this Plan and/or a representative of the Eligible Person (referred to as "claimant" or "claimants" under this Section 10.10) may have against any Accountable Person, whether by suit, settlement, or otherwise, that may be liable for a claimant's Accident or Sickness for which the Plan has paid or is obligated to pay benefits on the claimant's behalf.

Payment of benefits is conditional upon the claimant's written agreement to fully cooperate and reimburse the Plan for any benefits paid should the claimant recover monies or damages, or be compensated for the Sickness or Accident from the Accountable Person or any other source. The claimant must sign forms assigning subrogation and reimbursement rights to the Plan. The Benefits Office may withhold payment of any benefits due under the Plan until it receives the signed forms. Payment of medical expenses before the signed forms are received does not modify or invalidate the Plan's subrogation and reimbursement rights. By accepting benefits from the Plan, every claimant shall be deemed to have conclusively agreed to cooperate with the Plan to enforce its subrogation and reimbursement rights, and to hold any recovery in trust for benefit of the Plan.

Rights to Reimbursement With Source of Funds Specifically Identified

In situations where an Accountable Person is liable, the claimant must reimburse the Plan the full value of the claims paid in connection with the Accident or Sickness, but only to the extent he or she recovers settlement, judgment or insurance proceeds (from any source) connected with the Accident or Sickness. A source includes, but is not limited to, an Accountable Person and/or an Accountable Person's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law, an individual policy of insurance maintained by a claimant and organization, corporation or government agency.

The Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement, or otherwise even though the claimant may not have been fully compensated or "made whole" for all physical, psychological and/or financial damages. This provision rejects any "make whole" doctrine which would require a claimant to be "made whole" before the Plan is entitled to assert its subrogation rights. Even though the subrogation rights of

the Plan are specifically unequivocally due from the first dollar received by the claimant or claimant's beneficiary, the Plan reserves the right to exercise judgment as to the facts of each case. In determining each individual case, even though the Plan has the right to recover from the first dollar received, the Trustees may consider and allow for the cost of collection from the Accountable Person, including reasonable attorney's fees incurred by the claimant, in the sole discretion of the Trustees.

The Plan's rights also apply to any recovery received by a claimant regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

Equitable Lien by Agreement

Once the Plan makes or is obligated to make payments on behalf of a claimant, the Plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the claimant or claimant's beneficiary from any source to the extent of payments made or to be made by the Plan on the claimant's behalf.

Claimant Must Set Aside Funds

The claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made. The claimant shall reimburse the Plan immediately upon recovery.

Claimant's Duty to Reimburse

The claimant shall immediately notify the Plan if he is involved in or suffers an Accident or Sickness for which an Accountable Person may be liable. The claimant shall again notify the Plan if he or she pursues a claim to recover damages or other relief relating to an Accident or Sickness for which the Plan may make payments on the claimant's behalf. The claimant shall do nothing to impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement.

Reduction of Future Benefits

The claimant has the responsibility to seek damages for future accident-related benefit expenses. The Plan reserves the right to deny future accident-related care with the understanding that the claimant shall be responsible for any future accident-related claims, as those benefits should be paid directly from the claimant's settlement proceeds. The Plan has the discretion to take into consideration future accident-related medical expenses in negotiating a settlement. The Plan may settle all accident-related claims (past, present and future) in full (meaning that upon settlement, the Plan shall not be responsible for any further accident-related benefit expenses).

Disavowal of "Common Fund" Doctrine

The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying Accident, Sickness or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses.

The Plan further asserts that the "Common Fund" doctrine does not apply to any proceeds recovered by an attorney the claimant or the claimant's Eligible Dependents may hire regardless of whether proceeds recovered are used to repay the benefits paid by the Plan.

The Plan specifically disavows any claims that a claimant or Eligible Dependent may make under any federal or state common law defense including, but not limited to, the make whole doctrine and/or the Common Fund doctrine.

Cooperation

The claimant and legal representatives must do whatever is necessary to enable the Plan Administrator to exercise the Plan's rights and must do nothing to prejudice the Plan's rights. The Plan Administrator may require the claimant to complete and/or execute certain documentation to assist the Plan in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment agreement.

The claimant shall assist and cooperate with representatives the Plan designates. The claimant shall do everything necessary to enable the Plan to enforce its subrogation and reimbursement rights. The claimant shall immediately notify the Plan upon receiving a judgment, settlement offer or compromise offer and shall not settle or compromise any claims without the Plan's consent.

In the event a claimant fails to reimburse the Plan the full value of its subrogated interest or otherwise fails to cooperate, the Plan shall be entitled to recover the Claimant's debt to the Plan in accordance with Plan rules for recovery and overpayments. This means that the Plan may, among other things, suspend all benefit payments due to a Claimant and deduct the amount of the subrogated interest from future benefit payments or to apply employer contributions made to the Claimant's behalf against the amount owed to the Plan. If you fail to disclose to the Plan Administrator the amount of your settlement, the Plan is entitled to deduct the amounts of its lien from any future benefit under the Plan.

Assignment of Benefits

The Plan reserves the right to make payments directly to the Participant or Eligible Dependent. When this occurs, the Participant or Eligible Dependent must pay the provider and the Plan is not obligated to pay additional amounts. The Participant or Eligible Dependent cannot assign their right to receive payment to anyone else nor can the Participant or Eligible Dependent authorize someone else to receive payments for you, including your provider. The Plan will not honor an assignment of the claim to anyone. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to initiate any court proceeding. Nothing contained in the written description of the Plan's medical coverage shall be construed to make the Plan liable to any third-party to whom a Participant or Eligible Dependent may be liable for medical care, treatment or services.

Section 10.11 - Health Care Fraud

Health care fraud is a felony that can be prosecuted. Any Participant who willfully and knowingly engages in an activity intending to defraud this Plan will face disciplinary action and/or prosecution, including retroactive loss of benefits under the Plan. Furthermore, any Participant who receives money from the Plan to which he is not entitled will be required to fully reimburse the Plan.

Section 10.12 - Right of Recovery

If the Plan makes any payment which is determined in excess of the Plan's benefits, the Plan shall have the right to recover the amount determined to be in error through any legal or equitable means. The Plan shall have the right at any time to: (a) recover that overpayment from the person or entity

to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from future claim payments made for or on behalf of the Participant and the Participant's Eligible Dependents.

Section 10.13 - Preservation of Plan Provisions

This document supersedes and replaces any previous literature furnished regarding the Plan's benefits and is intended to serve as both the Summary Plan Description and the Plan Document under ERISA. Should any provision of the Plan be held to be unlawful, or unlawful as to any person or instance, such holding will not, to the extent possible, adversely affect the other provisions contained in the Plan or the application of said provisions to any other person or instance.

Section 10.14 - Termination of Plan

The benefits provided under this Benefit Plan are **NOT** vested benefits and the Trustees have the authority to terminate any benefit, including retiree benefits, or the entire Plan, at any time.

In the event of the termination of the Plan, the Trustees shall apply the Trust Fund to pay or provide for the payment of any and all obligations of the Plan and shall distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Plan. No part of the corpus or income of the Plan shall be used for or diverted to purposes other than for the exclusive benefit of the Eligible Persons, their families, Beneficiaries, the administrative expenses of the Plan or for other payments in accordance with the provisions of the Plan. Under no circumstances shall any portion of the corpus or income of the Plan, directly or indirectly, revert to or accrue to the benefit of the Employers, as defined in this document.

Section 10.15 - HIPAA Privacy Rule

A. Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a "group health plan" within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan sponsor, the Board of Trustees, to take all actions required to be taken by the Plan in connection with the Privacy Rule (i.e., entering into Business Associate contracts; accepting certification from the Plan Sponsor). Such responsibility may be delegated by the Board to the Administrative Manager.

B. Definitions

All terms defined in the Privacy Rule shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this section:

1. "Plan" means this Plan.

2. "Plan Documents" mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this Plan Document.

3. "Plan Sponsor" means "plan sponsor" as defined at §3(16)(B) of ERISA, 29 U.S.C. §1002(16)(B). The Plan Sponsor is the Board of Trustees of this Plan.

C. The Plan's Disclosure of Protected Health Information to the Plan Sponsor - Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will: (i) disclose Protected Health Information to the Plan Sponsor or (ii) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor with respect to the Plan, *only if* the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

1. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;

2. The Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and

3. The Plan Sponsor agrees to comply with the Plan provisions as modified by this section.

D. Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor

1. The Plan (and any Business Associate acting on behalf of the Plan, or any health insurance issuer, Health Maintenance Organization ("HMO"), PPO, health care provider, etc., as applicable, servicing the Plan) will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions. Such disclosure will be consistent with the provisions of this section.

2. All disclosures of the Protected Health Information of the Plan's individuals by the Plan's Business Associate, health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to the Plan Sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

3. The Plan (and any Business Associate acting on behalf of the Plan), may not permit a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.

4. The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

5. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer, HMO, PPO, health care provider, etc., as

applicable), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

6. The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.

7. The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

E. Disclosure of Individuals' Protected Health Information - Disclosure by the Plan Sponsor

1. The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. §164.524.

2. The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. §164.526.

3. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. §164.528.

4. The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

5. The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. The Plan Sponsor will ensure that the required adequate separation, described in paragraph F below, is established and maintained.

F. Required Separation between the Plan and the Plan Sponsor

1. In accordance with the "504" provisions, this section describes the employees or classes of employees of workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer, HMO, PPO, etc, as applicable, servicing the Plan.

   a. Administrative Manager and Assistant Administrative Manager

   b. Claims Supervisors, Processors and clerical support staff

   c. Information Technology Personnel

2. This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

3. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any harmful effect of the violation or noncompliance.

Section 10.16 - HIPAA Security Rule

Under federal law, health plans (like this one) must comply with the HIPAA Security Rule ("Security Rule") concerning the security of Electronic Protected Health Information (also known as "e-PHI"). This Plan has taken the necessary steps to achieve such compliance.

The following portion of this section is intended to bring the Plan into compliance with the requirements of 45 C.F.R. 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 ("Security Rule") by establishing the Plan Sponsor's (the Board of Trustees) obligations with respect to the security of Electronic Protected Health Information.

A. Plan's Designation Of Person/Entity To Act On Its Behalf

The Plan has determined that it is a "group health plan" within the meaning of the Security Rule, and the Plan designates the Plan Sponsor, the Board of Trustees, to take all actions required to be taken by the Plan in connection with the Security Rule (i.e., entering into Business Associate contracts, etc.). Such responsibility may be delegated by the Board to the Administrative Manager.

B. Definitions

All terms defined in the Security Rule shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this section.

1. "Plan" means this Plan.

2. "Plan Documents" mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this Plan Document.

3. "Plan Sponsor" means "plan sponsor" as defined at Section 3(16)(B) of ERISA, 29 U.S.C. Section 1002(16)(B). The Plan Sponsor is the Board of Trustees of this Plan.

4. "Electronic Protected Health Information" (or "e-PHI") shall have meaning as set forth in 45 C.F.R. 160.103, as amended from time to time, and generally means protected health information ("PHI") that is transmitted or maintained in Electronic Media.

5. "Electronic Media" shall mean:

   (a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

   (b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

6. "Security Incident" shall have the meaning set forth in 45 C.F.R 164:304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

C. Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensure that the adequate separation required by Section 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

4. Report to the Plan any successful security incident of which it becomes aware within a reasonable time thereafter and report any unsuccessful security incidents quarterly or at such other times as mutually agreed upon between the Plan Sponsor and the Plan.

Section 10.17 - Protections from Surprise Medical Bills

Under a federal law called the No Surprises Act, you have protection against surprise medical bills from out-of-network providers and facilities. This law mainly applies to Out-of-Network Emergency Services, services provided by out-of-network providers with respect to visits at Network Health Care facilities, and Out-of-Network Air Ambulance Services.

A. Out-of-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 an Out-of-Network Emergency Facility. This means you will be responsible for the in-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 an out-of-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.

B. Out-of-Network Providers at Network Facilities

Unless you consent to receiving services from the out-of-network provider (as described in this section), covered services performed by out-of-network providers with respect to

visits at Network Health Care Facilities 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 an out-of-network provider with respect to a visit 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.

C. Out-of-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 an out-of-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.

D. Waiving Surprise Medical Bill Protections

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the NSA. You may be able to waive these protections for (1) services from an out-of-network provider with respect to a visit at a Network Health Care Facility or (2) services from an out-of-network emergency facility or provider after you are stabilized. This can occur if you are notified by the out-of-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 out-of-network provider, then the Plan will treat these services as out-of-network. This means you will be subject to out-of-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 out-of-network provider Network Health Care 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; diagnostic services, including radiology and laboratory services, and items and services provided by an out-of-network Provider if there is no in-network Provider who can furnish such item or service at such facility.

E. Payments to Out-of-Network Providers at Network Health Care Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities

For claims subject to the NSA from out-of-network provider at Network Health Care Facilities, out-of-network providers of Air Ambulance Services, and Out-of-Network Emergency Facility, 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.

F. Continuing Care

If you are receiving care from a network provider that becomes out-of-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

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;

2. is undergoing a course of institutional or inpatient care from the provider or facility;

3. 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;

4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

5. 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 (i) is life-threatening, degenerative, potentially disabling or congenital; and (ii) 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.

ARTICLE XI - IMPORTANT PLAN INFORMATION

Section 11.01 - Name of Plan

This Plan is known as the Electrical Workers Benefit Trust Fund.

Section 11.02 - Board of Trustees

The Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of an equal number of Employer and Union Trustees who have entered into the collective bargaining agreements that relate to this Plan. The two groups of Trustees have equal voting strength.

Union Trustees	**Employer Trustees**
Mr. Jeffrey Wheeler 1828 North Meridian Street, Suite 205 Indianapolis, IN 46202	Sam Lacher Central Indiana Chapter - NECA 200 S. Rangeline Road Suite 215 Carmel, IN 46032
Mr. Chris Grider 1828 North Meridian Street, Suite 205 Indianapolis, IN 46202	Mr. Tim Whicker 173 S County Road 525 E Avon, IN 46123
Mr. Carl Williams 1828 North Meridian Street, Suite 103 Indianapolis, IN 46202	Mr. James Tsareff P.O. Box 1507 Indianapolis, IN 46206
Mr. Blake Andrews - Alternate 1828 North Meridian Street, Suite 205 Indianapolis, IN 46202	Mr. Larry E. VanTries - Alternate Central Indiana Chapter – NECA 200 S. Rangeline Road Suite 215 Carmel, IN 46032

The Board of Trustees may be contacted at the following Benefits Office address and phone number:

Electrical Workers Benefit Trust Fund
1828 North Meridian Street, Suite 103
Indianapolis, Indiana 46202-1471
(317) 923-4577

Section 11.03 - Plan Sponsor and Plan Administrator

The Board of Trustees is the Plan Sponsor and the Plan Administrator of the Electrical Workers Benefit Trust Fund . The Trustees have hired an Administrative Manager to perform the day-to-day operations of the Plan, such as maintaining records, making Benefit payments and handling general administrative matters. The Administrative Manager is:

David M. Ray
1828 North Meridian Street, Suite 103
Indianapolis, IN 46202-1471
(317) 923-4577

Section 11.04 - Identification Numbers

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 35-0851694. The number assigned to the Plan by the Board of Trustees is 501.

Section 11.05 - Agent for Service of Legal Process

Legal Counsel
Ledbetter Partners LLC
5078 Wooster Rd, Suite 400
Cincinnati, OH 45226

Service may also be made on any Plan Trustee or the Administrative Manager.

Section 11.06 - Collective Bargaining Agreement (does not apply to Non-Bargaining Unit Employees)

This Plan is maintained pursuant to collective bargaining agreements. Plan Participants and Beneficiaries may examine these collective bargaining agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees at the address listed under Section 11.02 above.

Section 11.07 - Source of Contributions

The Plan's benefits for eligible Employees are provided through Employer contributions. The amount of the Employer contributions is determined by the provisions of the collective bargaining or other agreement.

Section 11.08 - Funding Medium for the Accumulation of Plan Assets

All contributions and investment earnings of the Plan are accumulated in a Trust Fund that is utilized to pay benefits to eligible individuals and to defray reasonable costs of administration.

Section 11.09 - Plan and Fiscal Year

The fiscal records of the Plan are kept on a January 1 to December 31 basis.

Section 11.10 - Type of Plan

This Plan is maintained for the purpose of providing death benefits, accidental death and dismemberment benefits, weekly loss of time benefit, comprehensive medical benefits, prescription drug benefits, dental and vision benefits. Most benefits are self-funded, except for the benefits provided to Medicare-eligible Retirees through the MA-PD Plan. A detailed written description of these Plan benefits appears in this booklet.

ARTICLE XII - STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish Eligibility Rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) disability.

Newborns' and Mothers' Health Protection Act
Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (i.e., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

Women's Health & Cancer Rights Act
Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to mastectomies shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

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

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan Participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. 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 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 Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

ARTICLE XIII - DEFINITIONS

THE FOLLOWING WORDS HAVE SPECIFIC MEANINGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS BOOKLET.

13.01. Allowable Charges
13.02. ACA
13.03. Accident
13.04. Air Ambulance Service
13.05. Ambulance Service
13.06. Beneficiary
13.07. Creditable Coverage
13.08. Dental Treatment
13.09. Durable Medical Equipment
13.10. Eligible Employee
13.11. Eligible Dependent
13.12. Eligible Person
13.13. Eligibility Rules
13.14. Emergency Medical Condition
13.15. Emergency Services
13.16. Employee
13.17. Employer
13.18. Experimental or Investigative
13.19. Family Unit
13.20. Fund
13.21. Hospice
13.22. Hospital
13.23. Hospital Room and Board
13.24. Incurred Date of Claim
13.25. Independent Freestanding Emergency Department
13.26. Inpatient Services
13.27. Medically Necessary
13.28. Network Health Care Facility
13.29. Nursing Care
13.30. Out-of-Network Emergency Facility
13.31. Out-of-Network Rate
13.32. Participant
13.33. Physician or Surgeon
13.34. Physician's Services
13.35. Physiotherapy
13.36. Recognized Amount
13.37. Sickness
13.38. Spouse
13.39. Surgical Expenses
13.40. Trust Agreement
13.41. Trustees
13.42. Union
13.43. Usual, Customary and Reasonable Charge (UCR)
13.44. Qualifying Payment Amount (QPA)

Section 13.01 - Allowable Charges

The term "Allowable Charges" shall mean only those charges made for services and supplies which the Trustees would consider to be reasonably priced according to the Plan's Usual, Customary And Reasonable definition, Medically Necessary in light of the Accident or Sickness being treated, and otherwise not limited or excluded by the Plan.

Section 13.02 - ACA

The term " ACA" shall mean the Patient Protection and Affordable Care Act.

Section 13.03- Accident

The term "Accident" shall mean an injury, such as a cut, break, sprain, bruise, or wound occurring from an unexpected, undesirable and unavoidable act

Section 13.04 - Air Ambulance Service

The term “Air Ambulance Service” means medical transport by helicopter or airplane for patients.

Section 13.05 - Ambulance Service

The term "Ambulance Service" shall mean charges for professional ambulance service to and from the Hospital.

Section 13.06 - Beneficiary

The term "Beneficiary" or "Beneficiaries" means any person or Estate designated by the Employee or Participant to be the recipient of any death benefit as described in Section 7.01 and/or 7.02. In the event the Employee or Participant dies without designating a beneficiary or in the event the designed Beneficiary has predeceased the Participant, the Fund will pay any applicable death benefit in the order described in Section 7.01 and Section 7.02 as applicable.

Section 13.07 - Creditable Coverage

The term "Creditable Coverage" means Creditable Coverage as defined in the Health Insurance Portability and Accountability Act ("HIPAA"). Generally, Creditable Coverage includes coverage under: 1) a group health plan (including Federal governmental and church plan); 2) hospital or medical service policy certificate or contract; 3) HMO contract; 4) Medicare; 5) Medicaid; or 6) State health benefits risk pool.

Some examples of coverage that do NOT qualify as Creditable Coverage are:

A. Coverage under accident, disability income, liability, worker's compensation, automobile medical insurance and other types of insurance which is not considered to be general health insurance; and,

B. Health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, and plans under which health benefits are secondary or incidental; or,

C. Supplemental benefits such as Medigap or MedSupp insurance, TriCare supplemental programs and similar supplemental coverage under a group health plan.

Section 13.08 - Dental Treatment

The term "Dental Treatment" shall mean treatment rendered by a dentist, Physician or Surgeon for injuries to natural teeth, including the replacement of such teeth.

Section 13.09 - Durable Medical Equipment

The term “Durable Medical Equipment” means any equipment designed for repeated use and which is medically necessary for the treatment of an illness or injury, to improve the functioning of a malformed body part, or to prevent further deterioration of the patient’s medical condition. DME shall also include wheelchairs, hospital beds, respirators and other such items as determined by the medical management vendor.

Section 13.10 - Eligible Employee

The term "Eligible Employee" means an Employee that has met the eligibility requirements for coverage as set forth in Article II.

Section 13.11 - Eligible Dependent

The term "Eligible Dependent" shall mean the eligible Employee's legal Spouse. It shall also include the eligible Employee’s biological children, step-children, legally adopted children and children placed in the home prior to adoption through the end of the month in which they turn age 26.

The term “Eligible Dependent” shall also include the following:

A. A child over the age 25 who is 1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; 2) such incapacity commenced prior to age 26 and 3) the child remains chiefly dependent upon the eligible Employee for support and maintenance. The Plan will continue coverage for the child for as long as the eligible Employee's coverage remains in force and the incapacity continues, provided that proof of the incapacity is submitted to the Benefits Office within 31 days of the date the child's coverage would otherwise terminate. The failure to submit proof of incapacity will result in termination of the child's coverage.

B. Children placed in the home by court order and enrolled in the Plan prior to January 1, 2011, shall be considered Eligible Dependents the same as biological or legally adopted children provided that they are dependent upon the eligible Employee for primary support and maintenance. Primary support and maintenance for the dependents referred to in this paragraph may be determined from the eligible Employee's latest federal tax return and by the eligible Employee's supplying an affidavit stating that the children are dependent upon the eligible Employee for primary support and maintenance. The Trustees have the authority to request supporting documentation as necessary.

C. A child for whom you or your Spouse have the permanent or temporary legal guardianship or custody as those terms are defined under the laws of the state in which you reside. A child for whom you or your Spouse have custody under a guardianship will be considered a Dependent only if the court order granting the guardianship was issued by a juvenile court as a result of the court adjudicating that the child was a “child in need of services,” as defined at Indiana Code 31-34-1-1, or similar statute if the guardianship proceeding occurred in another state. A child, including a grandchild, who is dependent not by birth or adoption, is not eligible for coverage as a Dependent unless both biological parents are deceased, or have permanently or by court order “legally relinquished all of their parental rights” in a court of

law. "Legally relinquished all of their parental rights" means that the biological parents permanently, or temporarily (as determined by a court that such temporary custody would be in the child's best interest) do not have the:

4. Authority to consent to the child's marriage or adoption or authority to enlist the child in the armed forces of the United States;

5. Right to the child's services and earnings; and

6. Power to represent the child in legal actions and make other decisions of substantial legal significance concerning the child, including the right to establish the child's primary residence.

Notwithstanding the foregoing, in extreme instances in which neither the modification of an existing custody order nor the acquisition of a guardianship order is possible, the Board of Trustees, in its sole discretion, may opt to consider a child an Eligible Dependent where the child is a Participant's grandchild and the circumstances are such that the Board reasonably believes that, but for the inability to obtain judicial intervention, said child would be eligible for coverage under the terms of this section,

In this subsection, a Dependent shall not be eligible for benefits if the Participant is awarded custody or guardianship exclusively for the purpose of obtaining health care coverage.

The Trustees have the authority to request supporting documentation as necessary. However, any child who is eligible for coverage under this Plan as an Employee is excluded from Dependent coverage.

Section 13.12 - Eligible Person

The term "Eligible Person" shall mean any person who is presently or may become eligible for benefits under this Plan in accordance with the Eligibility Rules adopted by the Trustees.

Section 13.13 - Eligibility Rules

The term "Eligibility Rules" shall mean the eligibility rules as established and adopted by the Trustees pursuant to the authority granted to them in the Trust Agreement.

Section 13.14 - Emergency Medical Condition

The term "Emergency Medical Condition" means 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.

Section 13.15 - Emergency Services

With respect to an Emergency Medical Condition, the term “Emergency Services” includes:

A. 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

B. 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

C. Further services that are furnished by an out-of-network provider or Out-of-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).

Section 13.16 - Employee

The term "Employee" shall mean all employees employed by parties to the Trust Agreement establishing this Plan, represented by the Union and working for Employers, as defined herein, and in respect of whose employment an Employer is required to make contributions into the Trust Fund. However, excluding partners or sole proprietors, the term Employee shall also mean, employees of an Employer covered by the terms of a participation agreement which requires contributions to the Plan.

Section 13.17 - Employer

The term "Employer" means all or any of the following:

A. An employer who is bound by the terms of a collective bargaining agreement with the Union providing for the establishment and maintenance of a Plan for payment of contributions to said Plan.

B. An employer who satisfies the requirements for participation as established by the Trustees. Such employer shall, by the making of a payment to the Trust Fund on behalf of an Employee, be deemed to have accepted, be bound by, and become a party to the Trust Agreement.

Section 13.18 - Experimental or Investigative

For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, facility, drug equipment, device, or supply) is considered to be "Experimental" or "Investigative" if the use is not yet generally recognized as accepted medical practice, or if the use of any such item requires federal or other governmental agency approval which has not been granted at the time the service or supply is provided, or if the service, supply or procedure is not supported by Reliable Evidence which shows that, as applied to a particular condition, it:

A. Is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty,

B. Has a definite positive effect on health outcome,

C. Over time leads to improvement in health outcomes under standard means of treatment under standard conditions of medical practice outside clinical investigatory settings (i.e., the beneficial effects outweigh the harmful effects), and

D. Is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment is not employable.

"Reliable Evidence" includes only the following:

1. Published reports and articles in authoritative medical and scientific literature,

2. The written investigational or research protocols and/or written informed consent used by the treating facility or another facility which is studying the same service, supply or procedure, and

3. Compilations, conclusions, and other information which is available and may be drawn or inferred from 1 or 2 above.

Consideration may be given to any or all of the following factors:

- If the drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished, and

- If Reliable Evidence shows that the treatment is the subject of ongoing Phase I, II or III clinical trials to determine its maximum tolerated dosage, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis, or

- If Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis.

- Final determination of whether the use of a treatment is Experimental or Investigative shall rest solely in the discretion of the Trustees.

Section 13.19 - Family Unit

The term "Family Unit" shall mean the eligible Employee and all of the eligible Employees' Eligible Dependents.

For the purpose of the Plan, the term "Family Unit" shall also include an Eligible Person without dependents.

Section 13.20 - Fund

The term "Fund" or "Trust Fund" shall mean the Electrical Workers Benefit Trust Fund.

Section 13.21 - Hospice

The term "Hospice" shall mean a licensed agency that provides counseling and medical services to the terminally ill and which meets **all** of the following tests:

A. Has obtained any required state or governmental Certificate of Need approval; and

B. Provides services on a 24 hour, seven day a week basis; and

C. Is under the direct supervision of a Physician; and

D. Has a nurse coordinator who is a Registered Nurse (RN); and

E. Has a social service coordinator who is licensed; and

F. Is an agency that has as its primary purpose the provision of Hospice services; and

G. Has a full time administrator; and

H. Maintains written records of services provided to the patient; and

I. Is licensed in the jurisdiction in which it is located, if licensing is required.

Section 13.22 - Hospital

The term "Hospital" shall mean any institution that meets ALL of the following requirements:

A. Maintains permanent and full-time facilities for bed care of five or more resident patients;

B. Has a legally qualified Physician in regular attendance;

C. Continuously provides 24-hour-a-day nursing service by a Registered Nurse;

D. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics or a place for drug addicts; and,

E. Is operating lawfully in the jurisdiction where it is located.

Hospitalization is referred to as a "Hospital stay" or "Hospital confinement."

Section 13.23- Hospital Room And Board

The term "Hospital Room and Board" shall mean charges for the average semi-private Hospital room rate. With regard to the Intensive Care, Coronary Care or Constant Care Units of the Hospital, the term "Hospital Room and Board" shall mean the average daily charge for those units.

Section 13.24- Incurred Date Of Claim

The term "Incurred Date of Claim" shall mean the first date on which an Eligible Person is under the care of a Physician or Surgeon and/or has incurred a Covered Charge which is payable by the Plan.

Section 13.25 - Independent Freestanding Emergency Department

The term “Independent Freestanding Emergency Department” mean health care facility that:

A. Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and
B. Provides any Emergency Services

Section 13.26 - Inpatient Services

The term “Inpatient Services” shall mean those services are those which are provided by a facility in the PPO Network in an acute hospital, rehabilitation unit or skilled nursing facility for short-term, active progressive service that cannot be provided in an outpatient or home setting.

Section 13.27 - Medically Necessary

The term "Medically Necessary" means only those services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based upon the opinion of a qualified medical professional, to identify or treat an Eligible Person's Accident or Sickness and which:

A. Are consistent with the symptoms or diagnosis and treatment of the eligible individual's condition, disease, ailment, or injury,

B. Are appropriate according to standards of good medical practice,

C. Are not solely for the convenience of the Eligible Person, Physician or Hospital,

D. Are the most appropriate which can be safely provided to the Eligible Person,

E. Are not deemed to be Experimental or Investigative, and

F. Are not furnished in connection with medical or other research. However, the Plan will cover Approved Clinical Trials, as described in Section 3.04.

Section 13.28 - Network Health Care Facility

In the context of non-Emergency Services, the term “Network Health Care Facility” means a network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center (as defined in the Social Security Act).

Section 13.29 - Nursing Care

The term "Nursing Care" shall mean services of a Registered or Graduate Nurse other than a person who ordinarily resides in the treated individual's home, or who is a member of the treated

individual's immediate family. The "immediate family" is considered for these purposes to be the Spouse, children, brothers, sisters and parents of such persons or their spouses.

Section 13.30 - Out-of-Network Emergency Facility

The term “Out-of-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.

Section 13.31 - Out-of-Network Rate

The “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.

Section 13.32 - Participant

The term "Participant" shall mean any Employee covered by the eligibility rules described in Article Two, or a retiree that is covered by the Retiree Program described in Article Two.

Section 13.33 - Physician Or Surgeon

The term "Physician" or "Surgeon" shall mean a licensed medical doctor (MD) who performs a service which is payable under the Plan. Where law requires, “Physician” or “Surgeon” also includes any other provider who is a licensed practitioner acting within the lawful scope of his or her license, and performs a service which would be payable under the Plan if the service were performed by an MD. A provider does not include a person who lives with, or is part of, the covered Participant’s family.

Section 13.34 - Physician's Services

The term "Physician's Services" shall mean home, office and/or Hospital visits and other medical care and treatment rendered by a legally qualified Physician or Surgeon.

Section 13.35- Physiotherapy

The term "Physiotherapy" shall mean treatment by a licensed or registered physiotherapist other than a person who ordinarily resides in the treated individual's home, or who is a member of the treated individual's immediate family. The "immediate family" is considered for these purposes to be the Spouse, children, brothers, sisters and parents of such persons or their spouses.

Section 13.36 - Recognized Amount

For items and services furnished by an Out-of-Network provider or Out-of-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)

Section 13.37 - Sickness

The term “sickness” means any abnormal physical or mental condition, including physical sickness, mental illness, or functional nervous disorder, which affects the person's ability to function normally. A recurrent sickness will be considered to be one sickness. Concurrent sicknesses will be considered one sickness unless the concurrent sicknesses are totally unrelated. The term "Sickness," as used in this Plan document, shall also include pregnancy, childbirth, or resulting complications.. The term "Sickness" shall also include an illness not caused by an Accident.

Section 13.38 - Spouse

The term "Spouse" shall mean the eligible Employee's legal spouse for federal tax purposes. The term "Spouse" shall **NOT** include the divorced spouse of an eligible Employee.

Section 13.39 - Surgical Expenses

The term "Surgical Expenses" shall mean the fees charged by a legally qualified Physician or Surgeon for a surgical procedure, including the usual pre-operative and post-operative care. The surgical procedure may be performed in the patient's home, in the Hospital, in the doctor's office or elsewhere. Surgical Expenses are Covered Charges; to the extent the Surgical Expense meets the criteria for Covered Charges.

Section 13.40 - Trust Agreement

The term "Trust Agreement" shall mean the amended Agreement and Declaration of Trust establishing the Electrical Benefit Trust Fund effective May 3, 1949.

Section 13.41- Trustees

The term "Trustees" shall mean the Employer Trustees and Union Trustees, collectively, as appointed pursuant to the terms of the Trust Agreement, as amended.

Section 13.42 - Union

The term "Union" shall mean the International Brotherhood of Electrical Workers ("IBEW") Local No. 481, affiliated with the American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO").

Section 13.43- Usual, Customary And Reasonable Charge (UCR)

With regard to an In-Network PPO Provider Facility, UCR means the Allowed Charge as determined by the contract between the In-network PPO Provider or Facility and the network organization designed by the Fund. For an Out-of-Network Provider or Facility, the UCR will be determined by the network organization.

Section 13.44- Qualifying Payment Amount (QPA)

Generally, the term "Qualifying Payment Amount" (or "QPA") mean 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.

APPENDIX ONE – ABBREVIATIONS

This appendix contains a list of abbreviations that may be found in this document:

ACA – Patient Protection and Affordable Care Act

AD&D – Accidental Death and Dismemberment

CARES Act – Coronavirus Aid, Relief, and Economic Security Act

CBA – Collective Bargaining Agreement

CDC – Centers for Disease Control and Prevention

CHIP – Children's Health Insurance Program

COBRA - Consolidated Omnibus Budget Reconciliation Act

DME – Durable Medical Equipment

e-PHI – Electronic Protected Health Information

ERISA – Employee Retirement Security Act

ERTS – Electronic Reciprocal Transfer System

EWBTF – Electrical Workers' Benefit Trust Fund

FDA – U.S Food and Drug Administration

FMLA – Family and Medical Leave Act

HDHP – High Deductible Healthcare Plan

HIA – High Impact Advocacy Program

HIPAA – Health Insurance Portability and Accountability Act

HMO – Health Maintenance Organization

HRA – Health Reimbursement Account

HSA – Health Savings Account

IRO – Independent Review Organization

IRS – Internal Revenue Service

MAPD or MA-PD – Medicare Advantage and Prescription Drug

NECA – National Electrical Contractors Association

NSA – No Surprises Act

PBM – Pharmacy Benefits Manager

PCB - Preventative Care Benefit

PHI – Protected Health Information

PPO – Preferred Provider Organization

SPD – Summary Plan Description

UCR – Usual, Customary and Reasonable

UHC – UnitedHealthcare

URAC - Utilization Review Accreditation Commission

USERRA – Uniformed Services Employment and Reemployment Rights Act

USPSTF – United States Preventative Services Task Force

Every effort has been made to assure that the information contained in this Combined Plan Document and Summary Plan Description (Booklet) is accurate and up to date as of the time of its printing. You will be notified, in writing, of any changes in the Plan that may affect your benefits or rights under the Plan.