COMBINATION PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

LOCAL NO. 212 IBEW

HEALTH AND WELFARE BENEFIT PLAN

Effective as of May 1, 2023

SUMMARY PLAN DESCRIPTION

for the

LOCAL UNION NO. 212, IBEW
HEALTH AND WELFARE FUND

The Local Union No. 212, IBEW Health and Welfare Fund (*Fund*) has established and continues to maintain this Group Health Plan (*Plan*) for the benefit of its *employees* and their eligible *dependents* as provided in this Summary Plan Description (SPD) and all future Summaries of Material Modifications (SMMs) and certificates of coverage as required by the Employee Retirement Income Security Act of 1974 (ERISA).

It is important that all participants understand that all benefits under this *Plan* are provided on a self-funded basis, which means that payment for benefits is ultimately the sole financial responsibility of the *Fund* and paid directly from the assets of the Trust and not an insurance company. Certain administrative *services* with respect to the *Plan*, such as claims processing, are provided under a *services* agreement.

While the *Board of Trustees* intends to continue to maintain the *Plan* indefinitely, there is no guarantee of future benefits for any participant or beneficiary. The *Board of Trustees* reserves the right to modify, merge or terminate the *Plan* as necessary. Any changes in the *Plan*, as presented in this SPD, must be properly adopted by the *Board of Trustees*, and material modifications must be timely disclosed in writing and included in or attached to this document. A verbal modification of the *Plan*, or promise having the same effect, made by any person will not be binding with respect to the *Plan*.

Services are subject to all provisions of the *Plan*, including the limitations and exclusions.

Italicized terms within the text are defined in the “Definitions” section of this SPD.

EFFECTIVE AS OF MAY 1, 2023

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IMPORTANT PLAN INFORMATION

1. Name of *Plan*: Local Union No. 212, IBEW Health and Welfare Fund

2. Purpose of the *Plan*: The *Plan* is maintained for the purpose of providing benefits in the event of sickness, accident, disability or death and is administered in accordance with the collective bargaining agreement (CBA) between the contractors in the electrical industry in Cincinnati, Ohio, including the Cincinnati Chapter of the National Electrical Contractors Association, and the Local Union No. 212, International Brotherhood of Electrical Workers. A copy of the agreement may be obtained on written request and is available for examination.

3. Board of Trustees and Named Fiduciaries:

Board of Trustees
Local Union No. 212, IBEW Health and Welfare Fund
c/o Zenith American Solutions, Inc.
5420 W. Southern Avenue, Suite 407
Indianapolis, IN 46241
(513) 861-4800

Union Appointed Trustees

Kurt Kube
IBEW Local Union 212
212 Crowne Point Place, Suite 101
Cincinnati, OH 45241

Rick Fischer
IBEW Local Union 212
212 Crowne Point Place, Suite 101
Cincinnati, OH 45241

Andy Hensley
IBEW Local Union 212
212 Crowne Point Place, Suite 101
Cincinnati, OH 45241

NECA Appointed Trustees

Daniel Miller
ESI, Inc,
4696 Devitt Dr.
Cincinnati, OH 45246

Al Mundy
Hilvert & Pope Electric
348 West Pike St
Covington, KY 41011

Howard Mayers
Mayers Electric Co., Inc.
4004 Eric Court
Cincinnati, OH 46227

Alternate Union Appointed Trustee

Tracy Thorner
IBEW Local Union 212
212 Crown Point Place, Suite 101
Cincinnati, OH 46241

4. *Employer* Identification Number: 31-0782819

5. The *Plan* number assigned for government reporting purposes is 502.

6. The *Plan* provides medical benefits for participating *employees* and their enrolled *dependents*.

7. The *Plan* Network Provider is Anthem BlueCross BlueShield.

8. The *Plan* is contract administered.

9. *Plan* benefits described in this SPD are effective May 1, 2023.

10. The *Plan year* is May 1 through April 30 of each year.

11. Service of legal process may be served upon the agent for service of legal process:
Legal Counsel
Ledbetter Parisi LLC
70B Rhoads Center Drive
Centerville, OH 45458Ledbetter
Service of legal process may also be served upon the Administrative Manager as shown above or any Trustee as named above.

12. This is a self-funded health benefit plan. The cost of the *Plan* is paid with *employer contributions* and the investment income derived from those *contributions*. *Employee* self-payments are permitted in limited situations. Benefits under the *Plan* are provided through a Taft-Hartley Trust and are used to fund payment of covered claims under the *Plan* plus administrative expenses. The amount of the *employer contributions* is stated in the current, applicable *CBA*.

13. Each *employee* of the *employer* who participates in the *Plan* receives an SPD, which is this booklet. This SPD will be provided to *employees* by the *Board of Trustees*. It contains information regarding eligibility requirements, termination provisions, exclusions and limitations, a description of the benefits provided, and other *Plan* information.

14. The *Plan* benefits and/or *contributions* may be modified or amended from time to time, or may be terminated at any time by the *Board of Trustees*. Significant changes to the *Plan*, including termination, will be communicated to Participants as required by applicable law.

15. Upon termination of the *Plan*, the rights of the participants to benefits are limited to claims incurred and payable by the *Plan* up to the date of termination. *Plan* assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by the *Plan*, except that any taxes and administration expenses may be made from the *Plan* assets.

16. The *Plan* does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the *Plan* will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.

17. Benefits and coverage can never be guaranteed by telephone conversations. Complete written documentation of the facts of a situation is needed to determine how all *Plan* provisions will apply. Final decisions will be confirmed in writing as required by federal law.

18. The Trustees are responsible for the administration of the *Plan* and have the discretionary authority to interpret the provisions of the *Plan*. This discretionary authority shall include, but

shall not be limited to, the power to construe any disputed or doubtful terms of the *Plan* as amended from time to time.

19. The *Plan* is administered and operated by the *Plan Administrator* in its sole and absolute discretion. The *Plan Administrator*, and any duly authorized delegate thereof, has the complete authority to administer, apply and interpret the *Plan* and any related documents and to decide all matters arising in connection with the operation or administration of the *Plan*. All determinations made by the *Plan Administrator* with respect to any matter arising under the *Plan* and any other *Plan* document are final and binding on all parties, subject to every participant's rights under law and under the provisions of the *Plan.*

DEFINITIONS

A

Administrative Manager means the individual or organization(s) selected by the *Board of Trustees* to handle claims and day-to-day administration on behalf of the *Fund*.

Plan Administrator means the *Board of Trustees.*

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

Alternative medicine means an approach to medical diagnosis, treatment or therapy that has been developed or practiced NOT using the generally accepted scientific methods in the United States of America.

Apprentice means an *employee* whose terms and conditions of employment are covered by an IBEW Local Union No. 212 *CBA* and whose training is supervised by the IBEW Local Union No. 212 Joint Apprenticeship Training Committee (JATC).

B

Beneficiary means *you* and *your* covered *dependent(s)*, or legal representative of either, and anyone to whom the rights of *you* or *your* covered *dependent(s)* may pass.

Bodily injury means injury due directly to an accident and independent of all other causes.

Brand name medications means a medication that is manufactured and distributed by only one pharmaceutical manufacturer, or as defined by the national pricing standard used by the Prescription Benefits Manager.

C

Calendar year/Benefit year means a period of time beginning on January 1 and ending on December 31 of the same year.

Claimant means a *covered person* (or authorized representative) who files a claim.

Collective Bargaining Agreement (CBA) means the negotiated labor agreement between the *union* and an *employer* or *employer* association requiring the *employer* or association to make *contributions* to the *Fund* on behalf of its bargaining unit *employees*.

Concurrent care decision means a decision by the *Plan* to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the *Plan* (other than by *Plan* amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the *Plan*.

Concurrent review means the process of assessing the continuing *medical necessity*, appropriateness, or utility of additional days of *hospital confinement*, outpatient care, and other health care *services*.

Confinement means being a resident patient in a *hospital* or a *qualified treatment facility* for at least 15 consecutive hours per day.

Contributions means payments made to the *Fund* by contributing *employers* on behalf of their *employees*. *Contributions* may also include, where applicable, payments made directly by *eligible employees* and their *dependents* to purchase coverage pursuant to *Plan* rules.

Copayment (prescription drug) means the amount to be paid by *you* toward the cost of each separate prescription or refill of a covered prescription drug when dispensed by a pharmacy.

Copayment (medical services) means the amount to be paid by *you* toward the cost of medical services, subject to all *Plan* provisions.

Cosmetic or reconstructive surgery means any surgical procedure performed primarily to improve physical appearance, or to change or restore bodily form without materially correcting a bodily malfunction, or to prevent or treat a mental/nervous disorder through a change in bodily form.

Covered expense means *services* incurred by *you* or *your* covered *dependents* due to *bodily injury* or *sickness* for which benefits may be available under the *Plan*. *Covered expenses* are subject to all provisions of the Plan, including the limitations and exclusions.

Covered person means the *eligible employee* or any of the *eligible employee's eligible dependents* or an *eligible retiree* or any of the *eligible retiree*'s *eligible dependents*.

Custodial care means *services* provided to assist in the activities of daily living that are not likely to improve *your* condition. Examples include, but are not limited to, assistance with dressing, bathing, toileting, transferring, eating, walking and taking medication. These *services* are considered *custodial care* regardless if a *qualified practitioner* or provider has prescribed, recommended or performed the *services*.

D

Dental injury is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. *Dental injury* does not include chewing injuries.

Dependent or eligible dependent shall mean and include all of the following:

1. An *eligible employee's* spouse (excluding the spouse of a common-law marriage unless acknowledged by the *Plan* as a *dependent* spouse prior to January 1, 1991) who is not separated;

2. Children of an *eligible employee* who are under age 26. The word "child" or "children" includes natural children, legally adopted children, children placed for adoption in the home of such *employee* or *retiree*, stepchildren, and a child for which the *employee* or *retiree* has legal guardianship. A court order may be requested regarding responsibility for a child's insurance coverage. Adopted children and children placed for adoption are subject to all terms and provisions of the *Plan*;

3. An *eligible employee's* child whose age is less than 26 and who is entitled to coverage under this *Plan* because of a *Qualified Medical Child Support Order*. You must furnish satisfactory proof, upon request, to the Administrative Manager that the above conditions continuously exist. If satisfactory proof is not submitted to the Administrative Manager, the child's coverage will not continue beyond the last date of eligibility;

4. An *eligible employee's* unmarried child who has reached age 26 but is incapable of earning his/her own living due to mental or physical handicap. The coverage of such disabled child shall continue for as long as the *employee* or *retiree* is covered under the *Plan*, provided that all of the following requirements are met:

    a. The child is mentally handicapped or permanently physically handicapped;
    b. The child is incapable of self-sustaining employment;
    c. The child meets all of the qualifications of a "dependent" as determined by the United States Internal Revenue Service;
    d. The child must remain unmarried and principally dependent upon the *employee* or *retiree* for support; and
    e. You must provide satisfactory proof to the Administrative Manager that the above conditions continuously exist on and after the date the limiting age is reached. The Administrative Manager will not request such proof more often than annually. If satisfactory proof is not submitted to the Administrative Manager, the child's coverage will not continue beyond the last date of eligibility.

5. The term *eligible dependent* shall not include a foster child.

Coverage will end on the last day of the month in which a child or spouse no longer meets the definition of *eligible dependent*.

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is needed to treat a particular condition.

Drug list means a list of *prescription* drugs, medicines, medications and supplies approved by the *Prescription Benefit Manager.* This list is subject to change.

Durable medical equipment (DME) means equipment that: 1) can withstand repeated use; 2) is *medically necessary* and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and 3) is not disposable or non-durable.

E

Eligible Dependent. Please see "*dependent*."

Eligible Employee means an individual who meets the definition of an *employee* and who has met the eligibility requirements for being eligible to receive the applicable *Plan* benefits provided for *eligible employees*.

Eligible Retiree or "Retiree" means a retired *employee* who has met the *Plan's* eligibility requirements for being eligible to receive the *retiree* benefits provided under the *Plan*.

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

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

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition.

- Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department.

- Further services that are furnished by 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).

Employee means *you*, as an *employee*, when *you* are permanently employed, paid a salary or wages and are in an *active status* and on whose behalf an *employer* makes contributions to the *Fund* under the terms of a *CBA* with the *Union* or a participation agreement with the *Trustees* of the *Plan*.

Employer or Contributing Employer means any sole proprietor, company, partnership or corporation which is signatory to a *CBA* with a *union* or a written participation agreement requiring *contributions* to be made to this *Plan* on behalf of *employees*. Participating *unions* shall be considered *employers* only to the extent they are obligated to make *contributions* to the *Fund* on behalf of their *employees*.

Expense incurred means the fee charged for *services* provided to *you*. The date a *service* is provided is the *expense incurred* date.

Experimental, investigational or for research purposes means a procedure, treatment, supply, device, equipment, facility, or drug that:

1. Does not have final approval from the appropriate regulatory body;

2. Does not have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility, or drug or health outcomes;

3. Has not been proven to improve the net health outcome;

4. Has not been determined to be as beneficial as any established alternative; or

5. Has not shown improvement outside the investigational setting.

Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same *service*; or the written informed consent used by the treating facility or by another facility studying substantially the same *service*.

"Experimental" shall also mean any medical practice, procedure, treatment, service, drug or supply that is considered experimental or investigational by or not approved by the Food and Drug Administration, the American Medical Association, the Department of Health and Human Services, or the appropriate medical society.

F

Family member means *you* or *your* spouse, or *you* or *your* spouse's child, brother, sister, parent, grandchild or grandparent.

Free-standing surgical facility means a public or private establishment licensed to perform *surgery* and which has permanent facilities that are equipped and operated primarily for the purpose of performing *surgery*. It does not provide *services* or accommodations for patients to stay overnight.

Fund means the Local Union No. 212, IBEW Health and Welfare Trust Fund.

G

Generic medication means a drug that is manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name, or as defined by the national pricing standard used by the *Prescription Benefit Manager.*

H

Hospice Care means a program of care, established and reviewed by the qualified practitioner attending the patient and the hospice care agency, that provides pain-free and alert existence for the terminally ill patient during the last months of life, either through in-patient or home care. It offers supportive care to the families of the hospice patient's medical and social needs, and a description of the care to meet those needs.

Hospice Facility means a licensed facility or part of a facility that principally provides *hospice care*, keeps medical records of each patient, has an ongoing qualify assurance program and has a physician on call at all times. A *hospice facility* provides 24-hour-a-day nursing services under the direction of an R.N. and has a full-time administrator.

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;

2. Has a physician and surgeon in regular attendance;

3. Provides continuous 24-hour a day nursing *services*;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*.

Hospital does not include an institution that is principally a rest home, skilled nursing facility, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of alcoholism, chemical dependence or *mental disorders*.

I

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

L

Legend drug means any medicinal substance the label or which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription."

Level 1 drugs means a category of generic drugs, medicines or medications on the *Prescription Benefit Manager's* drug list.

Level 2 drugs means a category of *brand name drugs*, medicines or medications on the *Prescription Benefit Manager's* drug list.

Level 3 drugs means a category of drugs that have the highest copayment for higher-cost drugs, both generic and brand names. These drugs may have generic or brand name alternatives in Levels One or Two.

M

Mail order pharmacy means a pharmaceutical vendor designated by the *Prescription Benefit Manager* who is properly licensed to dispense and deliver covered *prescriptions* through the mail.

Maintenance care means any *service* or activity which seeks to prevent *bodily injury* or *sickness*, prolong life, promote health or prevent deterioration of a *covered person* who has reached the maximum level of improvement or whose condition is resolved or stable.

Maximum allowable fee for a *service* means the lesser of:

1. The fee most often charged in the geographical area where the *service* was performed;

2. The fee most often charged by the provider;

3. The fee determined by comparing charges for similar *services* to a national database adjusted to the geographical area where the *services* or procedures were performed; or

4. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown on the Schedule of Benefits. No further benefits are payable once the *maximum benefit* is reached.

Medically necessary or medical necessity means a procedure, treatment, supply, device, equipment, facility, or drug that a medical practitioner, exercising prudent clinical judgment, would provide a

patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;

2. Clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for the illness, injury, or disease;

3. Not primarily for the convenience of the patient, physician, or health care provider;

4. Not more costly than an alternative service or sequence of services at least as likely to provide equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury, or disease.

Medicare means the Health Insurance for the Aged Program under Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Mental disorder means a mental, nervous, or emotional disease or disorder of any type as classified in the most current Diagnostic and Statistical Manual of Mental Disorders, regardless of the cause or causes of the disease or disorder.

Morbid obesity means a body mass index (BMI) of 40 kilograms per mass squared or 100 pounds or more over *your* ideal weight as determined by the Metropolitan Life Height and Weight Tables for Men and Women, as of the date of service.

N

Network Health Care Facility, in the context of non-Emergency Services, means a network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center (as defined in the Social Security Act).

Non-participating pharmacy means a *pharmacy* which has not entered into an agreement with the *Prescription Benefit Manager* or has not been designated by the *Prescription Benefit Manager* to provide services to *covered persons*.

O

Orphan drug means a drug or biological used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

1. Affects less than 200,000 persons in the United States; or

2. Affects more than 200,000 persons in the United States, however, there is no reasonable expectation that the cost of developing the drug and making it available in the United States will be recovered from the sales of that drug in the United States.

Orthotic means a custom-fitted or custom-made braces, splints, casts, supports and other devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a *qualified practitioner*.

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.

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.

P

Participating pharmacy means a *pharmacy* that has entered into an agreement with or has been designated by the *Plan Administrator* to provide *services* to *covered persons*.

Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.

Pharmacist means a person who is professional qualified to prepare and dispense medicinal drugs.

Prescription Benefit Manager means the individual or organization selected by the Board of Trustees to handle the day-to-day administration of the prescription drug benefits under this Plan.

Plan; Plan of Benefits; Benefit Plan means the *Plan* or program of welfare benefits provided by the Local Union No. 212, IBEW Health and Welfare Fund as explained in this SPD.

Plan year means the period of May 1 through April 30 of each year. This year is only for administrative purposes, as the Benefit Year is the year in which *your* benefits accrue.

Post-service claim means any claim for a benefit under a group health plan that is not a *pre-service claim*.

Preadmission testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a *hospital*. The tests must be for the same *bodily injury* or *sickness* causing the patient to be *hospital* confined. The tests must be accepted by the *hospital* in lieu of like tests made during *confinement*. *Preadmission testing* does not mean tests for a routine physical check-up.

Precertification means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-*emergency hospital* admissions, surgical procedures, outpatient care, and other health care *services*.

Predetermination of benefits means a review by the *Administrative Manager* of a *qualified practitioner's* treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of *services*.

Preferred brand name drugs (also known as "***formulary***" drugs) means certain specified drugs selected by the *Prescription Benefit Manager* because of their effectiveness and cost. This list of preferred drugs may change at any time and from time to time, at the sole discretion of the *Prescription Benefit Manager*

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The drug, medicine or medication must be obtainable only by *prescription*. The *prescription* must be given verbally, electronically or in writing by a *qualified practitioner* to a *pharmacist* for the benefit of and use by a *covered person*. The *prescription* must include:

1. Name and address of the *covered person* for whom the *prescription* is intended;

2. Type and quantity of the drug, medicine or medication prescribed, and the directions for its use;

3. Date the *prescription* was prescribed; and

4. Name, address and DEA number of the prescribing *qualified practitioner*.

Pre-service claim means a claim with respect to which the terms of the *Plan* condition receipt of a *Plan* benefit, in whole or in part, on approval of the benefit by the *Administrative Manager* in advance of obtaining medical care.

Primary Care Physician means any of the following medical professionals**:** Family Practice physician, General Practitioner, Pediatrician, Internal Medicine physician, OB/GYN, GYN, Certified Nurse Midwife or a Nurse Practitioner associated with one of the aforementioned medical professionals.

Prior authorization means the required prior approval from the *Prescription Benefit Manager* for the coverage of *prescription* drugs, medicines, medications, including the dosage, quantity and duration, as appropriate for the *covered person's* age and gender.

Protected health information means individually identifiable health information about a *covered person*, including: (a) patient records, which includes but is not limited to all health records, physician and provider notes and bills and claims with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

Q

Qualified beneficiary under COBRA law means an *employee*, *employee's* spouse or *dependent* child covered by the *Plan* on the day before a *qualifying event*.

Qualified Medical Child Support Order (QMCSO) means a court order that creates or recognizes the existence of an alternate recipient's right to receive benefits that a *participant* or beneficiary is eligible to receive under a medical plan.

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

Qualified treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

Qualifying event means an event that causes an *employee*, spouse and/or *dependent* child to become a *qualified beneficiary*. See the section entitled "Continuation of Medical Benefits (COBRA)" for more information.

Qualifying Payment Amount (QPA) generally means 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.

R

Reasonable and Customary

1. A charge for Treatment that is the lesser of the following:
   a. The usual charge made by the provider for the Treatment; or
   b. The prevailing charge made by other providers of similar professional standing
2. If the usual or prevailing charge cannot be determined, the Plan will determined what is a reasonable charge taking in account:
   a. Any usual complications of the Injury or Illness;
   b. The complexity and degree of professional skill required; and
   c. Other pertinent factors.

Reciprocity means the arrangement by which *contributions* for hours that are worked outside the jurisdiction of Local Union No. 212 can be transferred back to this *Fund*.

Recognized Amount for items and services furnished by an Out-of-Network provider or Out-of-Network emergency facility, 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)

Rehabilitation Center means a facility that provides *services* of non-acute rehabilitation. All *services* are provided under the direction of a psychiatrist, a psychologist or a medical doctor with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide *services* of a custodial nature. The facility must be *Medicare* certified licensed by the State Department of Health as a "special hospital" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

S

Self-administered injectable drug means an FDA approved medication that a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, and intended for use by *you*.

Self-payments means payments made to the *Fund* by *eligible employees*, *eligible retirees* and *eligible dependents* on their own behalf for the purposes of maintaining coverage under the *Plan* in accordance with the applicable eligibility rules.

Services means procedures, surgeries, examinations, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness means a disturbance in function or structure of *your* body that causes physical or mental signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of *your* body.

Skilled nursing facility means only an institution licensed as a *skilled nursing facility* and lawfully operated in the jurisdiction where located. It must maintain and provide:

1. Permanent and full-time bed care facilities for resident patients;

2. A physician's *services* available at all times;

3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a physician or registered nurse (R.N.);

4. A daily record for each patient;

5. Continuous skilled nursing care for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and

6. A *utilization review* plan.

A *skilled nursing facility* is not except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of *mental disorders*, chemical dependence or alcoholism.

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);

2. Has not been extensively restored;

3. Has not become extensively decayed or involved in periodontal disease; and

4. Is not more susceptible to injury than a whole natural tooth.

Specialty Care Physician means a medical professional other than a ***Primary Care Physician.***

T

Total disability *or* ***totally disabled*** means:

1. During the first twelve months of disability *you* are at all times prevented by *bodily injury* or *sickness* from performing each and every material duty of *your* respective job or occupation;

2. After the first twelve months, *total disability* or *totally disabled* means that *you* are at all times prevented by *bodily injury* or *sickness* from engaging in any job or occupation for wage or profit for which *you* are reasonably qualified by education, training or experience.

A *totally disabled* person also may not engage in any job or occupation for wage or profit.

Trustees or Board of Trustees means the individuals appointed and designated according to the terms of the Trust Agreement of the Local Union No. 212, IBEW Health and Welfare Fund to administer this *Plan* of benefits together with such individuals' successors.

U

Union means IBEW (International Brotherhood of Electrical Workers) Local Union No. 212.

Urgent care claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or

2. In the opinion of a physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
3. Generally, whether a claim is a claim involving urgent care will be determined by the *Administrative Manager*. However, any claim that a physician with knowledge of a *claimant's* medical condition determines is a "claim involving urgent care" will be treated as a "claim involving urgent care."

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital* admissions, surgical procedures, outpatient care, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

Y

You and your means *you* as the *employee* and any of *your* covered *dependents*, unless otherwise indicated.

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.

To be eligible to receive benefits under this *Plan*, *you* must work for an *employer* who is participating in the *Fund* either under a *CBA* or by way of a written participation agreement, and *you* must meet the initial and continuing eligibility rules explained below.

Credited Hours – For the purpose of gaining eligibility and continuing coverage under the *Plan*, the term "credited hours" shall be calculated by one of the following ways:

1. **Contributions made at CBA rates*** – Your credited hours shall be determined by calculating the hours *you* work for a *contributing employer* for which the appropriate *contribution* under the *CBA* has been received by the *Administrative Manager*;

2. **Contributions Less Than Inside Rate* –** If *contributions* are made on *your* behalf at an hourly rate less than the *contribution* rate specified in the *CBA* between IBEW Local 212 and NECA (known as the "inside agreement"), then *your* credited hours will be determined by dividing the amount contributed by the inside rate (the rate specified in the inside agreement);

3. **Disability, FMLA, USERRA** – Your credited hours will be those hours credited to *you* during periods of disability, Family Medical Leave, or qualifying military leave; and

4. **Transfers** – Your credited hours will be those hours gained through *reciprocity* transfers, based on the contributions rate specified in the CBA between IBEW Local 212 and the Cincinnati Chapter of NECA.

**Contributions* for hours worked are credited to the last Sunday of each month. Any hours worked during the month after that last Sunday are credited to the following month.

ELIGIBILITY PERIODS AND BENEFIT PERIODS

(1)	(2)
800 credited hours during the **ELIGIBILITY PERIOD** of:	800 credited hours during the **ELIGIBILITY PERIOD** of:
August, September, October, November, December, January	February, March, April, May, June, July
Provides coverage during the **BENEFIT PERIOD** of:	Provides coverage during the **BENEFIT PERIOD** of:
April, May, June, July, August, September	October, November, December, January, February, March

An *Employee* first becomes eligible to participate in one of two ways:

1. *You* will become initially eligible for coverage under the *Plan* on the first day of a benefit period corresponding to the eligibility period during which *you* have at least 800 credited hours. *Your employer* must make all required *contributions* to the *Fund* on *your* behalf in order for *you* to become initially eligible. *You* must also complete and submit all necessary enrollment forms to the *Administrative Manager* prior to *your* enrollment for coverage in the *Plan*. *You* will not become initially eligible for coverage under the *Plan* until the first day of the month following *your* proper completion and submission of the enrollment forms as required.

   Example: *You* start working for a contributing *employer* in September. You work at least 800 hours during September through January. *You* will be initially eligible on April 1 – the first day of the corresponding benefit period, as long as *you* have completed and submitted the required enrollment forms to the *Administrative Manager*.

   If *you* do not have at least 800 worked hours in an eligibility period but work at least 350 hours during that eligibility period, the *Administrative Manager* will bill *you* for the difference between 800 and the hours *you* worked multiplied by 75% of the current *employer* contribution rate. If you make the self-payment by the due date, *you* will become initially eligible on the first day of the corresponding benefit period.

   Example: *You* start working for a contributing *employer* in November. During the rest of that eligibility period, November, December and January, *you* work 500 hours. *You* are billed for 300 hours multiplied by 75% of the current *employer* contribution rate, and *you* make the self-payment. *You* will be initially eligible on April 1 – the first day of the corresponding benefit period.

2. If *you* are a newly organized *employee, apprentice employee*, or *employee* with a new classification, *you* and *your eligible dependents* may become covered under the *Plan* before meeting the above initial eligibility requirements to allow *you* to avoid a gap of coverage during *your* transition to continuing eligibility by accruing credited hours. Special eligibility will be effective the first day of the month following the month after which the newly organized *employee, apprentice employee*, or *employee* with a new classification completes 300 hours of work in the first 90 days of employment. The Local Union Office may validate the completed hours requirement as necessary.

   a. **Notification Requirements.** As a newly organized or apprentice *employee*, *you* may obtain coverage under the *Plan* while working to meet the initial eligibility requirements, provided the *Union* or the IBEW Local Union 212 Joint Apprenticeship Training Program (JATC) verifies in writing to the *Administrative Manager* that you are newly organized, have recently been indentured, or have recently graduated from high school.

   b. **Provisions Governing Obtaining Plan Coverage.** This opportunity to obtain special eligibility is only available to a newly organized or *apprentice employee* once per lifetime. Absent proper notice from the *Union* or the JATC, *you* will not be eligible for *Plan* coverage until you have met the regular initial eligibility requirements outlined above. *You* must fully cooperate with the *Administrative Manager* and complete all necessary paperwork to enroll. *You* and *your dependents* will not be enrolled in the *Plan* for any coverage until the first day of the month following the month that *you* fulfill all eligible requirements and properly complete and submit all required forms to the *Administrative Manager*.

c. **Coverage Date and Benefit Limitations.** Coverage for *you* and *your dependents* will begin on the same date. Weekly disability income benefits will not be available under the *Plan* until *you* satisfy the initial eligibility requirements.

d. **Effect of Delinquent Contributions.** *Your* special eligibility as a newly organized or apprentice *employee* is contingent upon receipt of *employer contributions* on *your* behalf. In the event an *employer* fails to make timely remittance of the *contributions* for the 300 hours of work required to gain accelerated coverage, the *Administrative Manager* shall retroactively terminate coverage. Such newly organized and *apprentice employees* will then be required to meet the *Plan's* initial eligibility requirements before coverage will become effective.

e. **Continued Eligibility and Termination of Special Eligibility.** Newly organized and apprentice *employees* who satisfy the special eligibility rules shall remain covered under the *Plan* for the remainder of the benefit period in which eligibility is effective and the next full benefit period. During this period, any *employee* who satisfies the *Plan's* initial eligibility requirements shall be treated the same as any other active *covered person* under the *Plan* with respect to coverage and benefits. If *you* do not satisfy the initial eligibility requirements during the special eligibility period, *you* will have *your* coverage terminated and must elect COBRA to continue coverage. No regular self-payments will be accepted. If you are terminated from the apprenticeship program or are not in good standing with the Union, your special eligibility will be terminated.

CONTINUATION OF ELIGIBILITY

Once *you* have satisfied the initial eligibility requirements, *you* and *your dependents* will maintain coverage in one of the following ways:

1. **Continuing Eligibility by Working.** *You* and *your dependents* will continue to be eligible for benefits in each following benefit period corresponding to an eligibility period during which *you* earn at least 800 credited hours by working for a *contributing employer*.

2. **Continuing Eligibility through Self-Payments.** There are two self-payment methods available to *employees*: the regular self-payment method and the COBRA coverage method. **Once you have chosen a method, the other method will not become available to *you* again until you have re-established eligibility through hours worked or disability hours credited.** In both cases, *you* will only be able to self-pay the full amount for 18 continuous months. Upon the expiration of 18 months, *you* will need to re-establish eligibility in order to continue participation in the Plan.

    a. *Regular Self-Payments.* Under this method of "regular self-payments," *you* pay only the number of hours needed to make up the difference between *your* credited hours (i.e., from work and disability) and the necessary 800 hours. *Your* payments are made at a reduced rate. These regular 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.

    b. *COBRA Coverage Self-Payments.* Regular self-payment coverage is offered when *you* initially lose coverage under the *Plan*. This is the same time that COBRA Continuation Coverage is offered. *You* can choose either regular self-payments or COBRA Continuation Coverage. If regular self-payments are chosen, COBRA

Continuation Coverage will no longer be available. Please see the section entitled "Continuation of Medical Benefits (COBRA)" in this SPD for more information.

REGULAR SELF-PAYMENT RULES

As a non-*retired employee*, *you* are allowed to make regular self-payments if *you* are in danger of losing eligibility due to a period of unemployment or underemployment, as long as the following requirements are met:

1. At the end of an eligibility period, the *Administrative Manager* will notify *you* of any shortage, bill *you* for the amount *you* must pay and tell *you* when the self-payment is due. Even if *you* feel that the bill is in error because *you* worked hours that were not credited to *you*, *you* must still pay the amount billed to *you*. Sometimes *employers* are late in reporting hours, or hours transferred for *you* under a reciprocity agreement have not yet been received by the *Administrative Manager*. *You* will be reimbursed for *your* self-payment at the rate of the late hours times the rate at which *you* made *your* self-payment, however this amount cannot exceed the self-payment *you* made. The refund will be automatic—no action is required by *you*.

2. *Your* regular self-payment rate is equal to the hours *you* are short of 800 hours times 75% of the *employer contribution* rate in effect at the end of the eligibility period (work period) during which *you* didn't earn enough credited hours for continued coverage. This amount may be changed at any time at the sole discretion of the *Trustees*.

3. *Your* regular self-payments must be received by the *Administrative Manager* within 20 days of the date on which the self-payment notice is sent to *you*. Eligibility will then begin on the 1st day of the next month. If *you* fail to make the self-payment by the due date, *your* coverage will terminate at the end of the last benefit period for which *you* were eligible.

4. Except in the case of late reported hours explained above, regular self-payments will not be refunded.

5. Except under the circumstances as stated below, *you* can continue to make regular self-payments for the full amount of coverage for only 18 continuous months without re-establishing eligibility as long as *you* continue to satisfy the self-payment rules. You may make unlimited partial self-payments.

6. *You* may use funds out of *your* Welfare Reimburse Plan account to make a self-payment. See the section "Welfare Reimbursement Plan" in this SPD for more information.

7. *You* may not make or continue to make regular self-payment in the following circumstances:

    a. If *you* become an *employer* (as defined); or

    b. If you are no longer a member in good standing of IBEW 212; or

    c. If *you* are not actively seeking employer with a contributing *employer* as shown *your* failure to register in the Local Union No. 212, IBEW referral book.

When a regular self-payment is due, the Administrative Manager will send a notice to you at your last known address. The notice will provide you with the amount of the self-payment due and information about how to make your self-payment.

It is your responsibility to keep the Administrative Manager informed of your current mailing address. Self-payment opportunities will not be extended if notice is sent to a wrong address or if you miss a

CONTINUING ELIGIBILITY DURING DISABILITY

After *you* become eligible under the Plan, *you* will be credited with 31 disability hours each week if *you* have a proven disability due to either occupational or non-occupational accidental injury or sickness. These disability hours will count as regular credited hours for use during an eligibility period to maintain *your* coverage during the corresponding benefit period.

You will qualify for continuing eligibility during disability if you qualify for Weekly Disability benefits, except your disability may be due to either occupational or non-occupational accidental injury or sickness to qualify for continuing eligibility during disability. See "Weekly Disability Income Benefits" on page 71 for more information.

Disability hours are credited only for full weeks of disability. No hours are credited for a partial week. *You* can be credited with disability hours during a disability for up to two years (104 weeks), or until retirement, whichever is earlier. Retirees are not eligible for disability hours.

If *you* are still disabled after *you* have received disability hours for two years, and if *you* do not retire, *you* can make self-payments for continued coverage under the "COBRA Coverage" rules explained in this SPD.

EMPLOYEE-OWNER ELIGIBILITY RULES

Special eligibility rules apply if an Employee is an "Employee-Owner." An Employee-Owner is an Employee who owns more than a 10% interest in a Contributing Employer, or any Employee whose spouse owns more than a 10% interest in a Contributing Employer.

An Employee-Owner will become initially eligible for coverage under the Plan on the first day of a benefit period corresponding to the eligibility period during which the Employer contributes on behalf of an Employee-Owner the greater of: (a) 1,000 hours or (b) the actual hours spent performing bargaining unit work. An Employee-Owner will continue to be eligible for benefits in each following benefit period corresponding to an eligibility period during which the Employer contributes on behalf of an Employee-Owner the greater of: (a) 1,000 hours or (b) the actual hours spent performing bargaining unit work.

If contributed hours are insufficient, an Employee-Owner may only maintain coverage through payment of the balance of hours needed to maintain coverage at the full, non-subsidized hourly rate or by electing COBRA Continuation Coverage.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on the earliest of the following dates:

1. The date the *employee* is eligible for coverage, if he has *dependents* who may be covered on that date; or

2. The date of the *employee's* marriage for any *dependent* acquired on that date; or

3. The date of birth of the *employee's* natural-born child; or

4. The date a child is placed for adoption with the *employee*, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or

5. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a Qualified Medical Child Support Order (QMCSO).

No person may be simultaneously covered as both an *employee* and a *dependent*.

DEPENDENT EFFECTIVE DATE OF COVERAGE

No *dependent's* effective date will be prior to the covered *employee's* effective date of coverage. A dependent child who becomes eligible for other group coverage through his or her own employment may still be eligible for secondary coverage under this *Plan*. If *your dependent* child becomes an *eligible employee* of the *employer,* he is no longer eligible as *your dependent* and must make application as an *eligible employee.*

COVERAGE FOR DEPENDENTS IN THE EVENT OF DIVORCE

An individual who is a child of a covered *employee* shall be enrolled for coverage under the *Plan* in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

A QMCSO is a state court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered *employee's* child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the *Plan*; and (e) is "qualified" in that it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the *Plan* for the *dependent* child of a non-custodial parent who is (or will become) a *covered person* by a domestic relations order that provides for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the *Administrative Manager*. Upon receipt of a medical child support order, the Plan will promptly notify the Participant and each Alternative Recipient named in the order that the QMCSO has been received and will provide them with a copy of the *Fund's* Procedures.

RECIPROCITY

The Local Union No. 212, IBEW Health and Welfare Fund is a party to the Electrical Industry Health and Welfare Reciprocal Agreement along with other IBEW Welfare funds. *Reciprocity* enables *you* to maintain continuity of benefit coverage when *you* are employed outside of the jurisdiction of *your* Home *Fund*. *Your* Home *Fund* is the welfare *fund* operating within the jurisdiction of Local No. 212 or the fund in which *you* have established eligibility for benefit coverage.

The Electronic Reciprocal Transfer System (ERTS) has replaced the IBEW's paper-based *reciprocity* system. If you want IBEW Local Union No. 212 to be *your* home *fund* when *you* travel outside of Local 212's jurisdiction, *you* should register with ERTS at any IBEW Local Union office. The amount of the *contribution* transferred by the non-home fund will be at the rate established within the jurisdiction of the non-home fund or at the rate of the home *fund*, if lower. If the *contribution* rate of the non-home fund is lower, the amount transferred will be prorated using the *contribution* rate specified in the inside agreement

(the CBA between IBEW Local 212 and NECA). See the Section entitled "Employee Eligibility" for more information.

If *you* are employed by a contractor outside this jurisdiction, check with the *Administrative Manager* to see if a *reciprocity* agreement exists between the fund *you* are working under and the Local Union No. 212, IBEW *Fund*. **It is *your* responsibility to ensure all paperwork has been completed to all reciprocal *contributions* to be made back to this *Plan.***

You may appeal any reciprocal transfer error within six (6) months of the date that the contributions were remitted to the Local Union No. 212 IBEW Health and Welfare Trust.

SURVIVORSHIP COVERAGE

If the *employee* or *eligible retiree* dies while covered under the *Plan*, the surviving spouse and any eligible *dependents* who were covered under the *Plan* at the time of the *employee's* or *eligible retiree's* death may continue coverage under the *Plan* for the remainder of the current benefit period plus four full benefit periods at no cost to the survivor, subsequent to the *employee's* date of death. After the conclusion of the fourth full benefit period following the *employee's* date of death, coverage is then available to the surviving spouse and any eligible *dependents* through self-payments. If *your* surviving spouse dies during the period of free coverage, coverage for any of *your* surviving *dependent* children will continue to the end of the free period. Any *dependents* acquired through the remarriage of the *employee's* surviving spouse will not be eligible for coverage under the *Plan*. The surviving spouse and/or eligible *dependents* must waive COBRA continuation rights to take advantage of the Survivorship Coverage.

SPECIAL ENROLLMENT PERIODS

If *you* initially declined enrollment for *yourself* or *your dependents* (including *your spouse*) because of other health insurance or group health plan coverage, *you* may be able to enroll *yourself* and *your dependents* in this *Plan* if *you* or *your dependents* lose eligibility for that other coverage (or if the *employer* stopped contributing towards *yours* or *your dependents'* other coverage). However, ***you* must request enrollment within 30 days** after *your* or *your dependents'* other coverage ends (or after the *employer* stops contributing toward the other coverage), and *you* must complete and submit all necessary enrollment forms to the *Administrative Manager* as required by the *Plan* during this time period.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, *you* may be able to enroll yourself and your *dependents*. However, ***you* must request enrollment within 30 days** after the marriage, birth, adoption or placement for adoption, and *you* must complete and submit all necessary enrollment forms to the *Administrative Manager* as required by the *Plan* during this time period. **Failure to request enrollment and/or complete and submit the required forms will result in the ineligibility of *your* new *dependent***.

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 the 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.

Further, two additional circumstances allow for a special enrollment opportunity as follows: 1) Where the *employee's* or *dependent's* Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility; or 2) The *employee* or *dependent* becomes eligible for a subsidy

under Medicaid or CHIP. In either of these circumstances, the *employee* or *dependent* **must request enrollment within 60 days** after the *employee* or *dependent* is terminated from, or determined to be eligible for, such assistance.

To request special enrollment or obtain more information, contact the *Administrative Manager*.

RETIREE COVERAGE

Retiree coverage in the *Plan* is not an accrued benefit and is not vested. The *Trustees* reserve the right at any time and in their sole discretion to increase the *retiree* contribution rate, to reduce *plan* benefit coverage for *retirees* and their *dependents*, and to completely terminate *plan* benefit coverage for *retirees* and their *dependents*.

Retiree coverage may include medical, prescription drug, vision, and dental benefits, depending on when you retire, but never includes loss of time benefits, accidental dismemberment benefits, and life insurance.

RETIREE ELIGIBILITY REQUIREMENTS

Eligibility for retiree benefits is not an "accrued" benefit. The right to change, reduce or eliminate any and all aspects of benefits provided for retirees and their dependents, including the right to increase the retiree self-payment rate, is a right specifically reserved for the Trustees.

If *you* retire, *you* will be considered an *eligible retiree* and entitled to retiree benefits coverage under the *Plan* if *you* meet all the eligibility requirements as follows:

1. *You* must be retired under the terms of the Local No. 212 Pension Plan or under the terms of an IBEW Pension Plan;

2. *You* have been eligible for active employee coverage under this Plan of benefits on the date you retired;

3. You must have been eligible for coverage under the Plan for 84 months out of the 120 months preceding your retirement.. The 84 months do not have to be consecutive. No more than 24 of the 120 coverage months can be due to COBRA self-payments; and of the 24 month self-payment limitation, only 12 of the months can be consecutive; and

4. *You* must make the required self-payments to the *Plan*.

5. You may not work for a non-signatory employer in "Disqualifying Employment." For purposes of determining whether employment is "Disqualifying Employment" under this Plan, it means you may not engage in electrical work for a non-signatory employer in any industry that utilizes skills you learned while working in the electrical trade prior to your retirement, including, but not limited to work in a maintenance capacity or work in a supervisory capacity for a non-signatory employer if you are supervising individuals working with tools of the electrical trade. You must cooperate with the certification requirements outlined below related to post-retirement employment as a condition of eligibility

Note: If you are a retired employee who was an *employee* of the *Administrative Manager*, you must fulfill the previous requirements and also must be at least 55 years old, unless you are receiving a disability pension from the 212 Pension Plan or from an IBEW Pension Plan.

If *you* are an employee of an employer that is party to a participation agreement with the Plan that requires contributions to be made on your behalf and you retire, *you* will be considered an *eligible retiree* and entitled to retiree benefits coverage under the *Plan* if *you* meet all the eligibility requirements as follows:

1. *You* must be receiving Social Security retirement benefits;

2. *You* have been eligible for active employee coverage under this Plan of benefits on the date you retired;

3. *You* must have been eligible for coverage under the Plan for 84 months out of the 120 months preceding your retirement. The 84 months do not have to be consecutive. No more than 24 of the 120 coverage months can be due to COBRA self-payments; and of the 24-month self-payment limitation, only 12 of the months can be consecutive; and

4. *You* must make the required self-payments to the *Plan*.

To be entitled to retiree benefits, you and any eligible dependents must waive all COBRA eligibility resulting from the retirement.

BENEFIT COVERAGE FOR RETIREES

Coverage For Retirees And Dependents Who Are Not Eligible For Medicare. If *you* are not eligible for Medicare when *you* retire, *you* and *your* eligible *dependents* who are not eligible for Medicare will be entitled to full coverage under the Comprehensive Major Medical Benefit. *You* will not be eligible for any Weekly Disability Benefits.

Coverage For Medicare-Eligible Retirees And Dependents. If *you* are eligible for Medicare when *you* retire, or if you become eligible for Medicare after *you* retire, *you* and/or *your* Medicare-eligible spouse can choose coverage under the *Plan's* Medicare Advantage program explained below. If *your* spouse or *dependents* are not eligible for Medicare at the time you become eligible for Medicare they will remain covered under the Comprehensive Major Medical Benefit while *you* are covered under the *Plan's*

Medicare Advantage program. As soon as *your dependents* or spouse becomes eligible for Medicare they will be moved to coverage under the *Plan's* Medicare Advantage Program.

Medicare Advantage Program. 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. It is generally available to all individuals over age 65 at no cost. Part B primarily covers physician services and outpatient hospital services. Part B is optional. Part D covers prescription drugs and is also optional. This Plan sponsors its own Medicare Advantage program which provides basic coverage for Medicare Parts A and B, along with extra coverage that goes beyond the basic coverage levels of Parts A and B. The Plan also sponsors its own Part D program, which is described in the Prescription Drug Benefit section of this Summary Plan Document.

If you are retired and are current with your applicable Retiree self-payments, the Plan will enroll you in the Medicare Advantage program as soon as we receive confirmation that you have obtained Medicare Parts A and B. 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, including by paying any required premiums for Part A and Part B, you will lose all coverage under this Plan and this Medicare Advantage program immediately.

For details of benefits provided under this program, refer to the Medicare Preferred (PPO) Medical plan enrollment guide and certificate of coverage.

Trustees reserve the right to terminate the Medicare Advantage Program and reinstate retiree coverage under the Plan.

MAKING RETIREE SELF-PAYMENTS

If *you* are receiving a pension benefit check from the Local Union No. 212 IBEW Pension Fund, *you* must make *your* retiree self-payments through monthly deductions from *your* pension check. To do this, *you* must fill out the authorization form provided by the *Administrative Manager*. If the amount of *your* monthly pension check is insufficient to cover the deduction for *your* self-payment, *you* will be billed with the normal billing cycle. Retirees who do not authorize automatic monthly deductions from their Pension Fund benefit will not be permitted to continue participation in the Health and Welfare Plan. If there is a change in your status or the status of a *dependent*, the following rules apply:

1. If *you* notify the *Administrative Manager* of the change in *your* status before the 15th day of a month, any adjustment in the amount of self-payment required will become effective on the first day of the next following month.

2. If *you* notify the *Administrative Manager* of the change in *your* status on or after the 16th day of that month, any adjustment in the amount of self-payment required will become effective on the first day of the second month following the month in which the *Administrative Manager* is so notified.

3. No refund or adjustment in the self-payment amount paid by a retiree will be made for the month in which the *Administrative Manager* received notification of the status change.

If *you* are receiving a *retiree* billing for your Health and Welfare Plan benefits, *you* can mail *your* self-payment for one benefit period (all 6 months of coverage) to the *Administrative Manager*. *You* must make *your* self-payments within 20 days of the date on which the self-payment notice is sent to *you*. If there is a change in *your* status or the status of a *dependent*, the following rules apply:

1. If *you* notify the *Administrative Manager* of a change in *your* status or that of *your dependent*, any adjustment in the amount of self-payment required will become effective on the first day of the next following Benefit Period.

2. No refund or adjustment in the self-payment amount paid by a retiree will be made for the month in which the *Administrative Manager* receives notification of the status change.

SURVIVING DEPENDENTS OF RETIREES

If *you* die while *you* are eligible for retiree benefits, the comprehensive Major Medical Benefits or the Medicare Advantage program, as applicable, will be continued for *your* surviving spouse and any *dependent* children as described above in the section entitled "Survivorship Coverage" as long as *your* surviving spouse and any *dependent* children were *participants* in the *Plan* at the time of *your* death.

TERMINATION OF ELIGIBILITY FOR RETIREE BENEFITS

1. **Retirees** – *You* will cease to be eligible for retiree benefits on the first to occur of the following dates:

    a. The date the *Trustees* terminate this *Plan* of benefits;

b. The date the *Trustees* terminate the *Plan* benefits for retirees;
c. At the end of the last month for which a correct and timely self-payment was made (either through a mandatory automatic deduction from your Pension Benefit if such benefit is being received or through a self-payment if a Pension Benefit is not being received);
d. The date *you* become covered under a group health plan other than this *Plan* because *you* have returned to active employment;
e. The date you return to active status under this *Plan*;
f. The date you fail to comply with any of the conditions for participation or plan rules including the rules related to Disqualifying Employment;
g. 31st day after the *Administrative Manager* sends you a notice requesting proof of termination of Medicare Part D prescription drug benefits that you may have enrolled for outside this Plan, unless you provide such proof to the *Administrative Manager*;
h. The date you fail to maintain enrollment in Medicare Part A and Part B, including by paying any required premiums for Part A and Part B, if you are eligible for Medicare; or
i. The date of *your* death.

2. **Dependents of retirees** – A *dependent* of *yours* will cease to be eligible for retiree benefits on the first to occur of the following dates:

a. The date *your* eligibility for retiree benefits terminates for reasons other than *your* death;
b. The date the *Trustees* terminate retiree benefits for *dependents* of retirees;
c. For *your* spouse, on the date of *your* divorce or legal separation;
d. For a *dependent* child, on the date the child loses *dependent* status, unless the loss of *dependent* status occurs within 18 months of *your* date of retirement and the child is entitled to COBRA coverage and an one-time election and self-payment is made by or on behalf of the child;
e. If COBRA coverage self-payments are being made by or on behalf of *your dependent*, at the end of the last day of the last month of the applicable maximum coverage period for which self-payments were made or the date of occurrence of any of the events stated in "Termination of COBRA Coverage" in this SPD, whichever occurs first;
f. The date your dependent fails to maintain enrollment in Medicare Part A and Part B, including by paying any required premiums for Part A and Part B, if your dependent is eligible for Medicare; or
g. In the event of your death, at the end of four full benefit periods following the end of the benefit period during which you die unless coverage is continued under the Survivorship Coverage provisions of the Plan.

RETIREES WHO RETURN TO WORK

If you are receiving retiree benefits and subsequently become employed in the electrical construction industry (other than in Disqualifying Employment), you must continue to make the retiree self-payments to the Fund, except as outlined below. Contributions received on your behalf will not be used to offset the normal retiree self-payment amount.

If you are an Early Retiree (defined as an individual who is age 55 or older and otherwise meets the terms of retiree coverage under this Plan) and you receive compensation from a signatory Employer during an

Eligibility Period, you will be required to pay the full cost of coverage (non-subsidized) for the following six-month Eligibility Period. This requirement does not apply if you are working for a signatory Employer who is contributing to the Fund on your behalf (i.e., you are employed through the Union referral system). The non-subsidized Early Retiree rates will be determined by the Board of Trustees in consultation with appropriate Plan professionals.

Pursuant to the Medicare Secondary Payor rules, if you are eligible for Medicare and you earn enough credited hours during an Eligibility Period to earn coverage for the corresponding Benefit Period, then you will be treated as an active participant on the first day of the new Benefit Period.
Retirees who return to work are also subject to the Coordination of Benefits (COB) provisions relating to Medicare, as set forth in this SPD under the section entitled, "Coordination of Benefits with Medicare."

CERTIFICATION REQUIREMENTS FOR RETIREES WHO RETURN TO WORK

In order to be eligible for Retiree Benefits under the Plan, you must agree to cooperate with certain substantiation requirements if you return to work after retiring. At least once each calendar year, and more frequently if deemed necessary by the Board of Trustees, you will be required to certify under oath that you are not engaged in Disqualifying Employment. As part of this certification, you may be required to submit a letter from your employer indicating you are not working in Disqualifying Employment. If you fail to provide the required certification, you will not be eligible for benefits under the Plan (until such time that the required documentation is submitted and approved by the Board of Trustees.)

TERMINATION OF COVERAGE

TERMINATION OF ELIGIBILITY FOR BENEFITS FOR ACTIVE EMPLOYEES

Employee coverage terminates on the earliest of the following:

1. The date the *Trustees* terminate this *Plan* of benefits;

2. The end of the period for which any required *contribution* was due and not paid;

3. The date *you* enter full-time military, naval or air service, subject to USERRA and federal regulations;

4. The end of the benefit period *you* fail to be in an eligible class of persons according to the eligibility requirements of the *Plan*;

5. For all *employees*, the end of the benefit period *you* retire;

6. For any benefit, the date the benefit is removed from the *Plan*;

7. If COBRA coverage self-payments are being made on your behalf, at the end of the last day of the last month of the applicable maximum coverage period for which you made self-payments or on the date of occurrence of any of the events stated in "Termination of COBRA Coverage" in this SPD, whichever occurs first;

8. The end of the benefit period *you* request termination of coverage for yourself and/or *your dependents*; or

9. The date of your death.

TERMINATION OF ELIGIBILITY FOR BENEFITS FOR DEPENDENTS

1. The date the *Trustees* terminate this *Plan* of benefits;

2. For *your dependents*, the date *your* coverage terminates for reasons other than your death;

3. For a *dependent*, the date that the *dependent* enters full-time military, naval or air service;

4. For a *dependent*, the date such *covered person* no longer meets the definition of *dependent*;

5. If COBRA coverage self-payments are being made on your behalf, at the end of the last day of the last month of the applicable maximum coverage period for which you made self-payments or on the date of occurrence of any of the events stated in "Termination of COBRA Coverage" in this SPD, whichever occurs first;

6. The end of the benefit period *the employee* requests termination of coverage to be effective for themselves and/or their *dependents;* or

7. In the event of your death, at the end of four full benefit periods following the end of the benefit period during which you die unless coverage is continued under the Survivorship Coverage provisions of the Plan.

If *you* or any of *your* covered dependents no longer meet the eligibility requirements, *you* are responsible for notifying the *Administrative Manager* of the change in status. Coverage will not continue beyond the last date of the eligibility even if notice has not been given to the *Administrative Manager*. *You* and *your* covered *dependents* will be responsible for reimbursing any improperly paid benefits.

PRECERTIFICATION

PRECERTIFICATION

Precertification is a review process where physicians, nurses and/or pharmacists work with your physician to determine whether a procedure, treatment or service is a covered benefit.

This provision will not provide benefits to cover a *confinement* or *service* which is not *medically necessary* or otherwise would not be covered under the *Plan*. *Precertification* is not a guarantee of coverage.

After *you* or *your qualified practitioner* have provided Health Link with *your* diagnosis and treatment plan, Health Link will:

1. Advise *you* by telephone, electronically, or in writing if the proposed treatment plan is *medically necessary*; and

2. Conduct *concurrent review* as necessary.

If *your* admission is *precertified,* benefits are subject to all *Plan* provisions and are payable as shown on the Schedule of Benefits.

If it is determined at any time *your* proposed treatment plan, either partially or totally, is not a *covered expense* under the terms and provisions of the *Plan*, benefits for *services* may be reduced or *services* may not be covered.

NOTIFICATION REQUIREMENTS

If *you* or *your dependents* are to receive a *service* which requires *precertification*, *you* or *your* doctor must contact Health Link within the stated time period by telephone or in writing:

Health Link
877-284-0102
800-510-2162(fax)
Phone Hours: 8:00am to 5:00pm CST

PENALTY FOR NOT OBTAINING PRECERTIFICATION

If *you* do not obtain *precertification* for *services* being rendered, *your* benefits for the *hospital* or *qualified treatment facility* may be reduced or may not be covered at all. Also, a $200 deductible will apply to the covered medical or mental health/substance use disorder expenses incurred during each hospital or qualified treatment facility confinement, or for each non-emergency outpatient surgical procedure, for which the review procedures are not followed. This deductible applies whether a participating or a Non-Participating Provider is used. This penalty does not apply to the deductible or coinsurance or out-of-pocket maximums.

Exception: This deductible does not apply to admissions for which Medicare is the primary coverage.

BENEFITS REQUIRING PRECERTIFICATION

1. **Inpatient Hospital**

   Health Link must be notified at least 7 days in advance before a scheduled non-emergency hospital admission. If the admission is on an *emergency* basis, Health Link must be notified within 48 hours or the first business day following admission. If the inpatient hospital stay is not precertified, benefits will be subject to a $200 penalty.

2. **Organ Transplants**

   Health Link must be notified prior to organ transplant *services* being rendered. If organ transplant *services* are not *precertified*, they are not covered.

3. **Home Health Care And Home Hospice Care**

   Health Link must be notified prior to *services* being rendered. If home health care *services, including home hospice* care, are not *precertified*, benefits will not be covered.

4. **Skilled Nursing Facility**

   Health Link must be notified prior to *services* being rendered.

   If a skilled nursing facility is not *precertified*, benefits will be subject to a $200 penalty.

5. **Dental Surgical Services**

   Health Link must be notified prior to *services* being rendered. If dental surgical *services* are not *precertified*, they are not covered.

6. **Replacement Artificial Limbs**

   The expense of a replacement for an artificial limb will be a covered expense if it is necessary due to wear and tear, the initial prosthesis cannot be made serviceable in any way, and Health Link *precertifies* it to be medically necessary.

7. **Inpatient Treatment For Chemical Dependency Or Mental/Nervous Disorders**

   With any admission, Health Link must be notified within 48 hours or the first business day following admission. If the admission is not *precertified*, benefits for the *hospital* or *qualified treatment facility* will be subject to a $200 penalty.

SECOND SURGICAL OPINION

A second surgical opinion may be required, as provided in the *Plan*, before the *confinement* will be *precertified*. Benefits for the second surgical opinion, including any *medically necessary* x-ray and laboratory tests performed by the second *qualified practitioner*, are payable as shown below.

Participating Provider	$35 copay; *Primary Care Physician* $50 copay; *Specialty Care Physician*
Non-Participating Provider	60% after deductible.

If the two opinions disagree, *you* may obtain a third opinion. Benefits for the third opinion are payable the same as for the second opinion. The *qualified practitioners* providing the surgical opinions MUST NOT be in the same group practice or clinic. The *qualified practitioner* providing the second or third surgical opinion may confirm the need for *surgery* or present other treatment options. The decision whether or not to have the *surgery* is always *yours*.

The Plan has partnered with a company called Included Health to offer second opinions and additional reviews of any medical diagnosis you receive. More information about Included Health can be found at www.includedhealth.com, use their dedicated phone line 855-431-5545 or contact the Administrative Manager.

SCHEDULE OF BENEFITS

COVERED AND NON-COVERED EXPENSES

Benefits are payable only if *services* are considered to be a *covered expense* and are subject to the specific conditions, limitations and applicable maximums of the *Plan.* The benefit payable for *covered expenses* will **not** exceed the *maximum allowable fee(s)*.

A *covered expense* is deemed to be incurred on the date a covered *service* is received.

One *copayment* will be taken per visit per *qualified practitioner*.

If *you* incur non-*covered expenses*, whether from a Participating Provider or a Non-Participating Provider, *you* are responsible for making the full payment to the health care provider. The fact that a *qualified practitioner* has performed or prescribed a medically appropriate procedure, treatment, or supply, or the fact that it may be the only available treatment for a *bodily injury* or *sickness*, does not mean that the procedure, treatment or supply is covered under the *Plan*.

Please refer to the "Schedule of Benefits" and the "Limitations and Exclusions" sections of this SPD for more information about *covered expenses* and non-covered expenses.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

The *covered person* has two (2) levels of benefits available – Participating Provider benefits and Non-Participating Provider benefits. *You* may select any provider to provide *your* medical care.

In most cases, if *you* receive *services* from a Participating Provider, *you* will incur lower out-of-pocket costs. *You* are responsible for any applicable deductible, coinsurance and/or *copayment*.

If *you* receive *services* from a Non-Participating Provider, *you* will pay a larger share of the costs. As Non-Participating Providers do not have contractual arrangements with the *Plan* to accept discounted or negotiated fees, they may bill *you* for charges in excess of the *maximum allowable fee*. *You* are responsible for charges in excess of the *maximum allowable fee* in addition to any applicable deductible, coinsurance and/or *copayment*. Any amount *you* pay to the provider in excess of *your* coinsurance or *copayment* will not apply to *your* out-of-pocket limit or deductible.

Some services provided by Non-Participating providers—such as Emergency Services, Air Ambulances Services, and services at Participating hospitals and facilities—may be treated differently. For more information, please refer to the Protections from Surprise Medical Bills section in this document.

PARTICIPATING PROVIDER DIRECTORY

The *Administrative Manager* will provide *you* with access to a directory of Participating Providers for *your* service area. This directory will be provided automatically at no cost to *you.* An online directory of Participating Providers is available to *you* via the *Administrative Manager's* website. Due to the possibility of Participating Providers changing status, please check the online directory prior to obtaining *services*. If *you* do not have access to the online directory, contact the *Administrative Manager* prior to *services* being rendered or to request a directory.

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

CALENDAR YEAR DEDUCTIBLES

In-Network	Individual: $500 per *covered person* per *calendar year*. Family: $1,500 per *covered family* per *calendar year*
Out-of-Network	Individual: $1,500 per *covered person* per *calendar year*. Family: $4,500 per *covered family* per *calendar year*.

The total deductible applies to each *covered person or family* each *calendar year* and is subject to the maximum shown above. Only charges which qualify as a *covered expense* may be used to satisfy the deductible. ***Copayments*** **are not applied to the deductible limits.**

COINSURANCE

The term coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and the self-insured *Plan*. *Covered expenses* are payable at the applicable percentage rate shown below after the deductible, if any, is satisfied each *calendar year*, subject to any *calendar year* maximums and the lifetime maximum of the *Plan*.

In-Network	Plan pays 80% after deductible until out-of-pocket limit (for in-network) is reached; 100% thereafter.
Out-of-Network	Plan pays 60% after deductible until out-of-pocket limit (for out-of-network) is reached; 100% thereafter.

CALENDAR YEAR MEDICAL OUT-OF-POCKET LIMITS FOR PARTICIPATING AND NON-PARTICIPATING PROVIDERS

In-Network	Individual limit: $1,400 Family limit: $4,200
Out-of-Network	Individual limit: $3,000 Family limit: $9,000

When the amount of combined *covered expenses* paid by *you* and/or all *your* covered *dependents* satisfies the separate deductible and separate out-of-pocket limits as shown above, the *Plan* will pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums of the *Plan*.

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 at Network Health Care Facilities, and Out-of-Network Air Ambulance Services.

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 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.

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 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.

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.

Waiving Surprise Medical Bill Protections

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. You may be able to waive these protections for (1) services from an Out-of-Network Provider 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 an Out-of-Network Provider in a Network facility. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; 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.

Payments to Out-of-Network Providers at Network Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities

For claims subject to the No Surprises Act from Out-of-Network Providers at Network Health Care Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities, the Plan will pay the provider or facility the Out-of-Network Rate minus any cost-sharing amounts (copayments, coinsurance, and/or amounts paid towards deductible) you paid.

Continuing Care

If you are receiving care from a network provider that becomes 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:

1. 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

2. in the case of a chronic illness or condition, a condition that

   a. is life-threatening, degenerative, potentially disabling, or congenital; and

   b. 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.

INPATIENT HOSPITAL

Precertification is required. If precertification is not received, benefits are subject to the penalty described in the "Precertification" section of this SPD. Covered expenses are payable as shown below and include charges made by a:

1. Hospital for daily semi-private, ward, intensive care or coronary care room and board charges for each day of confinement. Benefits for a private or single-bed room are limited to the maximum allowable fee charged for a semi-private room in the hospital while a registered bed patient;

2. Hospital for services furnished for your treatment during confinement.

In-Network	80% after deductible
Out-of-Network	60% after deductible
Ancillary Services	60% after deductible

OUTPATIENT HOSPITAL

Covered expenses are payable as shown below. If you receive treatment from a Non-Participating Provider, and your condition is an emergency as defined in the "Definitions" section of this SPD, benefits will be paid at the Participating Provider level. Covered expenses include charges made by a hospital for:

1. Treatment of a bodily injury, including the emergency room charge if rendered within 48 hours of an accident;

2. Treatment of a sickness following an emergency, including the emergency room charge;

3. Preadmission testing;

4. A surgical procedure;

5. Outpatient tests, laboratory tests and x-rays;

6. Outpatient physical, speech, occupational and cognitive therapy. Speech therapy will aggregate to a Benefit maximum of 50 visits per calendar year; and

7. Regularly scheduled treatment such as chemotherapy, inhalation therapy, radiation therapy as ordered by your attending physician.

In – Network (All services indicated above, except for the following): Emergency Room	80% after deductible, unless otherwise specified. $250 copayment per visit. If you are admitted to the hospital, the copayment will be waived.
Out-of-Network (All services indicated above, except for the following) Emergency Room	60% after deductible, unless other specified. $250 copay per visit. If you are admitted to the hospital, the copayment will be waived.

URGENT CARE CENTER

Facility charges made by an urgent care center are payable as shown below. Outpatient *surgery*, diagnostic x-ray, laboratory tests and any additional *services* other than the facility charge are not payable under this benefit. Please refer to the other provisions of this *Plan* for available coverage.

In-Network	$100 copayment per visit.
Out-of-Network	$100 copayment per visit.

VIRTUAL DOCTOR VISIT

Charges for virtual doctor visits to discuss non-emergency health issues through the Plan's contracted provider for online care services are payable as shown below.

Online Virtual Doctor Visits through Anthem LiveHealth Online	$0 copayment per visit

Outside of the LiveHealth Online Program, remote telehealth provider visits will be subject to the same schedule of benefits and cost-sharing as in-person provider visits.

FREE-STANDING SURGICAL FACILITY

Charges made by a *free-standing surgical facility* for surgical procedures performed and for *services* rendered in the facility are payable as shown below.

In-Network • Ancillary Services	80% after deductible. 80% after deductible.
Out-of-Network • Ancillary Services	60% after deductible. 60% after deductible.

QUALIFIED PRACTITIONER

Covered expenses are payable as shown below and include charges made by a *qualified practitioner* when incurred for:

1. Office, home, *emergency* room physician or inpatient *hospital* visits;

2. Diagnostic x-ray or laboratory tests;

3. Professional *services* of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium and radioactive isotope therapy;

4. Other covered medical *services* received from or at the direction of a *qualified practitioner*;

5. Administration of anesthesia;

6. A surgical procedure, including pre-operative and post-operative care;

   If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary surgical procedure and;

   a. 50% of the *maximum allowable fee* for the secondary procedure; and
   b. 25% of the *maximum allowable fee* for the third and any subsequent procedures.

   No benefits will be payable for incidental procedures.

7. Assistant surgeon, payable at 20% of the *maximum allowable fee* allowed for the primary surgeon;

8. Physician assistant, payable at 20% of the *maximum allowable fee* allowed for the primary surgeon;

9. Allergy testing and vials;

10. Injections, other than routine;

11. Charges made by a *qualified practitioner* for *services* in performing certain oral surgical operations due to *bodily injury* or *sickness* are covered as follows:
    a. Excision of partially or completely unerupted impacted teeth;
    b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
    c. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    d. Reduction of fractures and dislocations of the jaw;
    e. External incision and drainage of cellulitis;
    f. Incision of accessory sinuses, salivary glands or ducts;
    g. Frenectomy (the cutting of the tissue in the midline of the tongue).

PROVIDER OFFICE VISITS

In-Network (Participating Provider)	
Primary Care Physician	$35 copayment per visit.
Specialist Physician	$50 copayment per visit.
Out-of-Network (Non-Participating Provider)	60% after deductible.

ALLERGY INJECTIONS

Allergy injections and supplies are payable as shown below.

In-Network (Participating Provider)	$35 copayment per visit if injection by primary care physician; $50 copayment if injection by a specialist (Allergist); $5 copayment if injection performed at clinic without doctor visit.
Out-of-Network (Non-Participating Provider)	60% after deductible.

OUTPATIENT PHYSICAL, SPEECH, OCCUPATIONAL AND COGNITIVE THERAPY

In-Network (Participating Provider) Out-of-Network (Non-Participating Provider)	$35 copayment per visit. 60% after deductible. * Speech therapy limited to 50 visits per calendar year

HEARING SCREENINGS/EXAMNATIONS

One hearing screening/examination is covered at no cost to the member per calendar year, subject to reasonable and customary cost limitations. Only active employees and retirees ineligible for Medicare are entitled to this benefit.

ROUTINE PREVENTIVE CARE (Outpatient)

Routine Preventive Care (Outpatient)
Benefits for Preventive Care as detailed below will be paid at 100% when received from an In-Network Provider without application of the In-Network Calendar Year Deductible, co-pays or co-insurance. These benefits will be provided to all eligible non-Medicare Plan participants regardless of benefits previously paid or applied to the deductible under the Major Medical Benefit. **Preventive care services received from an Out-of-Network provider will be subject to copayment, coinsurance and deductible requirements.**

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 and the preventive services are not the primary purpose of the visit and/or the doctor bills you for the preventive services separately from the office visit, then the Plan can require you to pay a portion of the costs of the office visit.

The following list of preventive care services are currently covered under the Plan. The listing may change from time to time based upon the recommendation of the United States Preventive Services Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health and Resources and Services Administration.

- Routine Well-Child Care, including Physician's office visit, exam, screenings, immunizations tests, labs, and x-rays for covered Dependent children from birth up to 19 years of age. Benefits are limited as shown in the Schedule of Benefits.

- Routine physical exams, including Physician's office visit, exam, screenings, tests, labs, x-rays and immunizations, for covered Employees and spouses only. Benefits are limited as shown in the Schedule of Benefits.

Routine preventive care (Outpatient): Well-Child Care for children up to 19 years of age	The deductible does not apply. The Plan pays 100% of Covered Charges.
Routine preventive care (Outpatient): Well adult care for Employees and *dependents*	The deductible does not apply. The Plan pays 100% of Covered Charges.

In addition, the following preventive care benefits will be available without cost sharing:

Covered Preventive Services for Adults, age 19 years and older

Immunizations
Immunization vaccines for adults – doses, recommended ages, and recommended populations vary:

- Haemophilus influenzae type B
- Hepatitis A
- Hepatitis B
- Herpes Zoster (Shingles)
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella (Chicken Pox)

Cancer Related

- BRCA-Related Cancer: Risk Assessment, Genetic Counseling and Genetic Testing for individuals at increased risk
- Breast Cancer Mammography Screening for individuals ages 40 to 74
- Breast Cancer: Medications for Risk Reduction for individuals age 35+ at increased risk
- Cervical Cancer Screening for individuals age 21 to 65
- Colorectal Cancer screening in adults beginning at age 45 and continuing until age 75. The test methodology must be medically appropriate for the patient. The plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: a pre-procedure specialist consultation, a follow-up colonoscopy conducted after a positive non-invasive stool-based screening test, such as Cologuard, or direct visualization test (e.g., sigmoidoscopy, CT colonography), bowel preparation medications, anesthesia services, polyp removal performed during the screening procedure, and a pathology exam on a polyp biopsy. Use of the ColoGuard colon cancer screening test for those who are required to have or recommended by a treating physician will continue to satisfy the Preventive Colorectal screening opportunity provided by the Plan.
- Lung Cancer Screening for adults age 50 to 80 with who have a 20 pack-year smoking history of smoking and currently smoke or have quit within the past 15 years.
- Skin Cancer Prevention: Behavioral Counseling for children, parents of young children, adolescents and young adults (persons aged 6 months to 24 years) with fair skin type

Chronic Conditions

- Abdominal Aortic Aneurysm Screening for men age 65 to 75 who have ever smoked
- Abnormal Blood Glucose and Diabetes Mellitus (Type 2) Screening for adults aged 40 to 70 who are overweight or obese; Counseling Services for all adults with abnormal blood glucose.
- Aspirin for the Prevention of Cardiovascular Disease and Colorectal Cancer for adults aged 50 to 59 years with risk factors.
- Anxiety Screening for adolescent and adult individuals, including those who are pregnant or postpartum
- Depression Screening for all adults, including pregnant and postpartum individuals.
- Hepatitis B Screening for adults at increased risk
- Screening for Hepatitis C Virus Infection in adolescents and adults
- Hypertension (High Blood Pressure) Screening for adults
- Latent Tuberculosis Infection for asymptomatic adults 18 years and older at increased risk
- Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions for adults with body max index (BMI) of ≥30
- Osteoporosis Screening for individuals aged 65+, Postmenopausal individuals younger than 65 at increased risk
- Statin Use for Prevention of Cardiovascular Disease (CVD) for adults aged 40 to 75 without history of CVD who have 1 or more risk factors and a calculated 10-year CVD event risk of 10%+.

Health Promotion

- Alcohol Misuse Screening and Counseling for adults
- Healthful Diet and Physical Activity for Cardiovascular Disease (CVD): Behavioral Counseling for overweight or obese Interventions to promote a healthy diet and physical activity for adults with additional CVD cardiovascular disease risk factors
- Falls Prevention in Older Adults for community-dwelling adults, age 65+ at increased risk for falls
- Interpersonal, Domestic, and Intimate Partner Violence Screening and Counseling for individuals
- Screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity; Counseling services for all adults with abnormal blood glucose, including prediabetes
- Tobacco Smoking Cessation: Behavioral and Pharmacotherapy Interventions for adults
- Well-Woman Preventive Visits
- Unhealthy Drug Use Screening for adolescents age 12-17 and adults 18 and older, including pregnant and postpartum persons

Sexual Health

- Chlamydia Screening for sexually active individuals under 24 years, and older individuals at increased risk
- Contraceptive Services and Counseling for individuals with reproductive capacity; generic where available; no coverage for abortifacients
- Gonorrhea Screening for sexually active individuals under 24 years, and older individuals at increased risk
- HIV Infection Counseling and Screening for individuals
- HIV Infection Screening for adults age 15 to 65. Younger and older individuals at increased risk.
- Preexposure Prophylaxis (PrEP) for the Prevention of HIV Infection for persons at high risk of HIV.
- STI Counseling for adults at increased risk; all sexually active individuals
- STI Counseling for sexually active individuals

- Syphilis Screening for adults and adolescents at increased risk

Pregnancy Related
- Bacteriuria Screening for pregnant individuals
- Behavioral counseling interventions for healthy weight and weight gain in pregnancy for pregnant adolescents and adults
- Breastfeeding: Primary Care Interventions for pregnant and postpartum individuals
- Breastfeeding Support, Supplies, and Counseling for pregnant and postpartum individuals
- Depression Screening for adults, including pregnant and postpartum individuals.
- Folic Acid Supplements to Prevent Neural Tube Defects for individuals planning or capable of pregnancy
- Gestational Diabetes Screening for pregnant individuals
- Gestational Diabetes Screening for pregnant individuals
- Hepatitis B Screening for pregnant individuals
- HIV Infection Screening for pregnant individuals
- Maternal Depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- Preeclampsia Preventive Aspirin for pregnant individuals at increased risk
- Preeclampsia Screening for pregnant individuals
- Rh Incompatibility screening for all pregnant individuals and follow-up testing for individuals at higher risk
- Syphilis Screening for pregnant individuals
- Tobacco Smoking Cessation: Behavioral Interventions for pregnant individuals who smokepersons
- Perinatal Depression Preventive Counseling Intervention for pregnant persons at increased risk

Covered Preventive Services for Children

Immunizations

Immunization vaccines for children – doses, recommended ages, and recommended populations vary:
- Haemophilus influenzae type B
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Inactivated Polio
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavius
- Tetanus, Diphtheria, Pertussis
- Varicella (Chicken Pox)

Cancer Related
- Cervical Dysplasia Screening at 21 years
- Skin Cancer Prevention: Behavioral Counseling for children, parents of young children, adolescents and young adults (persons aged 6 months to 24 years) with fair skin type

Chronic Conditions

- Anemia Screening based on risk factors and age
- Autism Screening for children at 18 and 24 months
- Bilirubin Concentration Screening for newborns
- Blood Pressure Screening for children over 3 years, and under 3 years based on risk factors
- Blood Screening for newborns
- Critical Congenital Heart Defect Screening for newborns
- Depression Screening for adolescents beginning routinely at age 12
- Dyslipidemia Screening for all children once between 9 and 11 years and once between 17 and 21 years, and more often for children at higher risk of lipid disorders
- Hematocrit or Hemoglobin Screening for all children
- Hemoglobinopathies or Sickle Cell Screening for newborns
- Hepatitis B Screening for adolescents at high risk
- Screening for Hepatitis C Virus Infection in adolescents and adults
- Hypothyroidism Screening for newborns
- Iron Supplements for children ages 6 to 12 months at risk for anemia
- Lead Screening for children at risk of exposure and based on age
- Maternal Depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- Obesity Screening and counseling
- Phenylketonuria (PKU) Screening for newborns
- Tuberculin Testing for children at higher risk of tuberculosis and based on age

Health Promotion

- Alcohol, Tobacco, and Drug Use Assessments for adolescents
- Behavioral Assessments for children throughout childhood
- Body Mass Index (BMI) Measurements for children over 2 years
- Developmental Screening for children under age 3 and Developmental Surveillance throughout childhood
- Fluoride Chemoprevention Supplements for children without fluoride in their water source
- Fluoride Varnish for all infants and children as soon as teeth are present
- Gonorrhea Preventive Medication for the eyes of all newborns
- Head Circumference and Weight for Length Measurement for infants and young children
- Hearing Screening for children based on risk factors and age
- Height and Weight Measurements for all children
- Interpersonal and Domestic Violence Screening for adolescents
- Medical History for all children
- Oral Health Risk Assessment for children 6 months and 9 months, and later based on risk factors
- Primary Care Interventions for Prevention of Tobacco Use in children and adolescents
- Vision Screening for children 3 to 6 years, and throughout childhood based on risk factors
- Unhealthy Drug Use Screening for adolescents age 12-17 and adults 18 and older, including pregnant and postpartum persons

Sexual Health

- HIV Screening once between 15 and 18 years of age, and for adolescents at higher risk
- Sexually Transmitted Infection (STI) Prevention Counseling and Screening for adolescents at higher risk

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

CHIROPRACTIC CARE

Chiropractic care for the treatment of a *bodily injury* or *sickness* is payable as shown below. *Maintenance care* is not covered.

In-Network Providers	$35 copayment per visit.
Out of Network Providers	60% after deductible

Participating and Non-Participating Provider *covered expenses* for chiropractic care aggregate to a *maximum benefit* of $3,000 per *covered person*, per *calendar year*.

AMBULANCE SERVICE

Local professional ambulance service to the nearest *hospital* equipped to provide the necessary treatment is covered as shown below. Ambulance service must not be provided primarily for the convenience of the patient or the *qualified practitioner*. If *you* receive treatment from a Non-Participating Provider, and *your* condition is an *emergency* as defined in the "Definitions" section of this SPD, benefits will be paid at the Participating Provider level.

Participating and Non-Participating Providers	80% after deductible.

The Plan will pay reasonable and customary costs of an air ambulance service when it would take a ground ambulance 30 minutes or more to transport a participant whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the participant's illness/injury.

In addition, the air ambulance transportation must meet the following criteria:

- The participant's destination is an acute care hospital, and
- The participant's condition is such that the ground ambulance (basic or advanced life support) would endanger the member's life or health, or
- Inaccessibility to ground ambulance transport or the extended length of time required to transport the participant via ground ambulance transportation could endanger the participant, or
- Weather or traffic conditions make ground ambulance transportation impractical or impossible.

For more information on how Out-of-Network Air Ambulance claims are treated, please refer to Protections from Surprise Medical Bills section of this SPD.

PREGNANCY BENEFITS
Pregnancy is a *covered expense* for any covered *employee* or covered spouse payable as shown below.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the *Plan* or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Pregnancy benefits are subject to all terms and provisions of the *Plan*.

Participating and Non-Participating Providers	Payable the same as any *sickness.*

NEWBORN BENEFITS

Benefits for newborns are subject to the Eligibility and Effective Date of Coverage section of this SPD, as well as all terms and provisions of the *Plan*.

Covered expenses incurred during a newborn child's initial inpatient *hospital confinement* include *hospital* expenses for nursery room and board and miscellaneous *services*; *qualified practitioner's* expenses for circumcision; and *qualified practitioner's* expenses for routine examination before release from the *hospital.*

Participating Provider	80% after deductible.
Non-Participating Provider Physician *Services* *Hospital Services*	 60% after deductible. 60% after deductible.

BIRTHING CENTERS

A birthing center is a free-standing facility, licensed by the state, which provides prenatal care, delivery and immediate postpartum care, and care of the newborn child.

Expense incurred within 48 hours after *confinement* in a birthing center for *services* and supplies furnished for prenatal care and delivery of child(ren) are payable as shown below.

Participating and Non-Participating Providers	Payable the same as any other *sickness.*

SKILLED NURSING FACILITY

Precertification is required. If *precertification* is not received, benefits are subject to the penalty described in the "Precertification" section of this SPD.

Expenses incurred for daily room and board and general nursing *services* for each day of *confinement* in a skilled nursing facility are payable as shown below. The daily rate will not exceed the maximum daily rate established for licensed skilled nursing care facilities by the Department of Health and Human Services.

Covered expenses for a skilled nursing facility *confinement* are payable when the *confinement*:

1. Begins while *you* or an eligible *dependent* are covered under this *Plan*;

2. Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;

3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and

4. Occurs while *you* or an eligible *dependent* are under the regular care of a physician.

Participating Providers	80% after deductible.
Non-Participating Providers	60% after deductible.

Participating and Non-Participating Provider *covered expenses* aggregate to a maximum of 30 days per *calendar year*.

HOME HEALTH CARE

Precertification is required. If *precertification* is not received, benefits are subject to the penalty described in the "Precertification" section of this SPD.

Each visit by a home health care provider for evaluating the need for, developing a plan, or providing *services* under a home health care plan will be considered one home health care visit. Up to 4 consecutive hours of service in a 24-hour period is considered one home health care visit. A visit by a home health care provider of 4 hours or more is considered one visit for every 4 hours or part thereof. Home health care provider means an agency licensed by the proper authority as a home health agency or *Medicare*-approved as a home health agency.

Home health care will not be reimbursed unless the *Plan* determines:

1. Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;

2. Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and

3. The home health care *services* will be provided or coordinated by a state-licensed or *Medicare*-certified home health agency or certified rehabilitation agency.

The home health care plan must be reviewed and approved by the *qualified practitioner* under whose care *you* are currently receiving treatment for the *bodily injury* or *sickness* which requires the home health care.

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);

2. Physical, speech, occupational, cognitive, hearing and respiratory therapy and home health aide *services*; and

3. Medical supplies and *durable medical equipment*, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital* confined.

Expenses incurred for home health care as described below are payable as shown below. The maximum weekly benefit for such coverage may not exceed the maximum allowable weekly cost for care in a skilled nursing facility or a hospital.

LIMITATIONS ON HOME HEALTH BENEFITS

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;

2. Wage or shift differentials for home health care providers; or

3. Charges for supervision of home health care providers.

Participating Providers	80% after deductible.
Non-Participating Providers	60% after deductible.

HOSPICE CARE

Hospice *services* must be furnished in a hospice facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of six months or less. For hospice *services* only, *your* immediate family is considered to be *your* parent, spouse, and *your* children or step-children.

Covered expenses are payable as shown below for the following hospice *services*:

1. Room and board and other *services* and supplies;

2. Part-time nursing care by or supervised by a R.N. for up to 8 hours per day;

3. Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;
4. Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner,* which include the following:
   a. Assessment of social, emotional and medical needs, and the home and family situation,
   b. Identification of the community resources available, and
   c. Assistance in obtaining those resources;

5. Nutritional counseling;

6. Physical or occupational therapy;

7. Part-time home health aide service for up to 8 hours in any one day;

8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*.

LIMITATIONS ON HOSPICE CARE BENEFITS

Hospice care benefits do NOT include: (1) private duty nursing *services* when confined in a hospice facility; (2) a *confinement* not required for pain control or other acute chronic symptom management; (3) funeral arrangements; (4) financial or legal counseling, including estate planning or drafting of a will; (5) homemaker or caretaker *services*, including a sitter or companion *services*; (6) housecleaning and household maintenance; (7) *services* of a social worker other than a licensed clinical social worker; (8) *services* by volunteers or persons who do not regularly charge for their *services*; or (9) *services* by a licensed pastoral counselor to a member of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

Hospice care agency means an agency which has the primary purpose of providing hospice *services* to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meets all of these requirements: (1) has obtained any required certificate of need; (2) provides 24-hours a day, 7 day-a-week service supervised by a *qualified practitioner*; (3) has a full-time coordinator; (4) keeps written records of *services* provided to each patient; (5) has a nurse coordinator who is a R.N., who has four years of full-time clinical experience, of which at least two involved caring for terminally ill patients; and, (6) has a licensed social service coordinator.

A *hospice care* agency will establish policies for the provision of *hospice care*, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its *services* for their patients, and use volunteers trained in care of and *services* for non-medical needs.

Participating Providers	80% after deductible.
Non-Participating Providers	60% after deductible.

Participating and Non-Participating Provider *covered expenses* are limited to 21 days per lifetime.

TRANSPLANT SERVICES

Precertification must be obtained for benefits provided for Human Organ and Tissue Transplant Services. To obtain approval, contact Health Link as soon as *your Physician* suggests that *your* condition may require a transplant.

Transplant service providers are grouped into three tiers. The provider tier you select determines your portion of the cost:

- Tier 1: If you receive services at a Blue Distinction Center for Transplants (BDCT) facility, the Plan will cover 100% of eligible expenses.

- Tier 2: If you receive services at an In-Network Provider other than a Blue Distinction Center for Transplants facility, the Plan will cover 80% of eligible expenses, after deductible.
- Tier 3: If you receive services at an Out-of-Network Provider, the Plan will cover 60% of eligible expenses, after deductible.

When the recipient is the *Covered Person*, the donor's expenses will be considered expense of the recipient and will apply to the recipient's maximum benefit for the transplant provided, if applicable. Covered donor expenses will be paid up to a *maximum benefit* of $100,000 for all donor expenses during the *covered person*'s lifetime.

All direct, non-medical expenses for the *covered person* receiving the transplant and his/her *family member(s)* are limited to a combined *maximum benefit* of $10,000 per transplant.

Exclusions

The following are not covered under this section. The Plan provides no benefits for:

1. The purchase price of any bone marrow, organ or tissue that is sold rather than donated;

2. Treatment, services and supplies not orders by a Physician or surgeon;

3. Transplants involving non-human or artificial organ or tissues;

4. Human-to-human bone marrow, organ or tissues transplants other than those specifically covered under this section;

5. Treatment, services and supplies not covered by the Plan.

BEHAVIORAL HEALTH BENEFIT (MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM)

Precertification is required for inpatient treatment of chemical dependency or a mental/nervous disorder.

Covered expenses are payable as shown below, and expense incurred by you during a plan of treatment for mental disorder, chemical dependence or alcoholism is payable for:

1. Charges made by a qualified practitioner;

2. Charges made by a hospital;

3. Charges made by a qualified treatment facility;

4. Charges for x-ray and laboratory expenses.

OUTPATIENT BENEFITS

The first six (6) outpatient visits per problem with a TriHealth EAP Provider, including visits for life problems such as personal, family, financial or legal problems. (Deductibles and Maximum Benefit limitations do not apply)	Plan pays 100%.
Participating Provider Non – Participating Providers	$35 – copayment per visit 60% - after deductible

INPATIENT BENEFITS

Precertification is required through Health Link. Covered expenses while confined as a registered bed patient in a hospital or qualified treatment facility are payable as shown below:

In-network Providers	80% after deductible
• Ancillary Services	80% after deductible
Out of Network Providers	60% after deductible
• Ancillary Services	60% after deductible

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) has been developed to provide a source of professional assistance to you and your family where you can discuss, in confidence, personal problems that affect your daily life. This can be for treatment of a chemical dependence or a mental/nervous disorder, or a personal, family or other problems. **TriHealth EAP (513) 891-1627 or 1-800-642-9794**

OTHER COVERED EXPENSES

The following are other *covered expenses* payable as shown below:

1. Blood and blood plasma are payable as long as it is NOT donated or replaced, and administration of blood and blood products including blood extracts or derivatives;

2. Oxygen and rental of equipment for its administration;

3. Drugs and medicines that are provided to, or administered to *you*, while *you* are confined in a *hospital* or residential treatment center or skilled nursing facility, by a *qualified practitioner* during an office visit or from a home health care provider;

4. Initial prosthetic devices or supplies, including but not limited to, limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes as determined by the *Health Link. Covered expense* includes repair of the prosthetic device if not covered by the manufacturer;

5. Supplies, up to a 30-day supply, when prescribed by *your* attending physician;

6. Casts, trusses, crutches, *orthotics*, shoe inserts, splints and braces. *Orthotics* are considered to be *durable medical equipment (DME)* and must be custom made or custom-fitted, certified by a physician to be medically necessary, and not available over the counter. *Orthotics* are covered for *medical necessity* only and are limited to a maximum of one per lifetime;

7. Initial contact lenses or eyeglasses following cataract *surgery*;

8. The rental, up to but not to exceed the purchase price, of a wheelchair, *hospital* bed, ventilator, *hospital* type equipment or other *durable medical equipment (DME)*. The *Plan*, at its option, may authorize the purchase of *DME* in lieu of its rental, if the rental price is projected to exceed the purchase price. Repair, maintenance or duplicate *DME* rental is not considered a *covered expense*;

9. *Services* for the treatment of a *dental injury* to a *sound natural tooth*, including but not limited to extraction and initial replacement. The first treatment must be received within 6 months of the accident causing the injury. If the injury is to *your dependent* child, and it is determined that permanent treatment would best be provided when the structure of the child's jaw is more mature, payment will be made for the treatment at the later time, provided *your* child is covered under the *Plan* at that time. Benefits will be paid only for *expense incurred* for the least expensive *service* that will, in the *Administrative Manager's* opinion, produce a professionally adequate result;

10. Installation and use of an insulin infusion pump, diabetic self-management education programs and other equipment or supplies in the treatment of diabetes;

11. Surgical or non-surgical treatment including but not limited to, appliances and therapy, for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull. Surgical or non-surgical treatment of the facial muscles used in expression and mastication

functions, for symptoms including but not limited to, headaches. These expenses do not include charges for orthodontic *services*;

12. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a functional defect;

13. Reconstructive *services* following a covered mastectomy, including but not limited to:
    a. All stages of reconstruction of the breast on which the mastectomy was performed;
    b. Reconstruction of the other breast to achieve symmetry;
    c. Prosthesis; and
    d. Treatment of physical complications of all stages of the mastectomy, including lymphedemas;

14. Respiratory therapy;

15. Chemotherapy and radiation therapy;

16. Cardiac rehabilitation, limited to phases I and II, Phase II is limited to a maximum allowable period of 3 consecutive weeks after *hospital* release;

17. Osteotomies.

18. One wig per calendar year for any participant who suffers a loss of hair due to chemotherapy treatments. Coverage is limited to reasonable and customary cost restrictions.

19. Individuals at increased risk of breast cancer who are prescribed and complete an Invitae Hereditary Cancers Panel or Invitae Breast Cancer Panel through the Local 212 Activate Health and Wellness Center are eligible for reimbursement for the out-of-pocket cost of the test. To be eligible for this benefit, you must register online with Invitae and submit payment to Invitae upfront and in full for the direct-pay cost of the test. To obtain reimbursement from the Plan, you must submit proof of payment to the *Administrative Manager*.

The following *services* are considered other *covered expenses* and are payable as shown below, subject to all terms and provisions of the *Plan*, except the exclusion for *services* which are not *medically necessary*:

Participating Providers	80% after deductible, unless otherwise specified.
(All *services* indicated above, except for the following)	
Services for the Treatment of a *Dental Injury*	Payable the same as any other *sickness.*
Temporomandibular Joint Syndrome (TMJ)	Payable the same as any other *sickness.*
Diabetic Self-Management Education Programs	Payable the same as any other *sickness.*
Cardiac Rehabilitation	
Phase I	Same as Inpatient Hospital Benefit.
Phase II	80% after deductible.
Non-Participating Providers	60% after deductible.
• Osteotomies	Payable the same as any other *sickness.*

LIMITATIONS AND EXCLUSIONS

No *Plan* benefits are payable for any of the following:

1. Charges incurred by any person who is not covered under the *Plan* at the time the charges are incurred.

2. *Services* or supplies that are not recommended or approved by a *qualified medical practitioner.*

3. *Services* or supplies that are not medically necessary for treatment of a person covered under this *Plan*.

4. *Services* or supplies, including drugs, whether prescription or not, that are experimental or investigative.

5. Any charge, portion of a charge, which is in excess of a reasonable and customary charge; except claims subject to the No Surprises Act shall be payable according to federal law.

6. Charges incurred by a covered person for a particular type of care or treatment once he has already received *Plan* benefits totaling any maximum benefit stated on the Schedule of Benefits for that type of care and treatment, or which are in excess of any limitation or maximum benefit stated on the Schedule of Benefits, or which are in excess of any limitation specified in any other section of this SPD.

7. Services or supplies received from a qualified practitioner or a hospital that does not meet this *Plan*'s definition of "qualified practitioner" or "hospital."

8. *Services* or supplies which are not provided for the treatment or correction of, or in connection with, a specific injury, sickness or congenital defect unless specifically stated as covered under the *Plan*.

9. Drugs or medicines other than provided in a hospital or emergency treatment center, or that are not legally dispensed by a registered licensed pharmacist according to the written prescription of a doctor (except as may be provided under a hospice care program for which *Plan* benefits are payable).

10. Appetite suppressants or weight loss programs of any kind, regardless of intended therapeutic use.

11. Oral drugs used to treat male impotence, except as may be provided under the provisions of the Prescription Drug Program.

12. Artificial insemination or any related procedures, whether experimental or not, including but not limited to in vitro or in vivo fertilization, egg implantation, etc., or hormone therapy or any other direct attempt to induce or facilitate conception, or for treatment, therapy or counseling for infertility.

13. Surgery of any type to correct nearsightedness.

14. Treatment by or consultation with a marriage counselor.

15. Private duty nursing in a hospital.

16. Any treatment or consultation with a social worker other than under a hospice care program for which *Plan* benefits are payable, or in accordance with a referral by the EAP or that has been reviewed and approved by the EAP.

17. Any of the following items, whether prescribed by a doctor or not, regardless of intended use:
    - Air conditioners
    - Whirlpools
    - Vitamins
    - Dietary or nutrient clinics
    - Air purifiers
    - Swimming Pools
    - Nutrients
    - Diet food or diet supplements
    - Over-the-counter medicines
    - Commodes
    - Allergy-free pillows
    - Blankets or mattress covers
    - Orthopedic mattresses
    - Nautilus treatments
    - Elevators or stair lifts
    - Any type of test kit
    - Clinical thermometers
    - Wigs (unless otherwise covered under the "Other Covered Benefits" section)
    - Motorized scooters
    - Vibratory equipment, including but not limited to TENS units
    - Humidifiers or dehumidifiers
    - Lift chairs
    - Special shampoos
    - Electric heating units
    - Exercising equipment
    - Health club or spa memberships
    - Blood pressure instruments
    - Stethoscopes
    - Scales
    - Elastic bandages or stockings
    - Devices or surgical implantations for simulating nature body contour

18. Any care, treatment or surgery that is elective (not medically necessary), including plastic, beautifying, or cosmetic surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue).

    Exception: This exclusion does not apply to:

a. Cosmetic surgery for correction of defects caused by a non-occupational accidental injury;
b. Corrective surgery on body organs which function improperly;
c. Correction of congenital defects of a child;
d. Reconstructive breast surgery following a mastectomy (this includes reconstruction on the non-affected breast to achieve a symmetrical appearance);
e. Vasectomies and other sterilization procedures performed on *employees* and retirees and their eligible spouses; and
f. Medically necessary therapeutic abortions for *employees* or *retirees* and the spouses of *employees* or *retirees.*

19. Abortions or treatments *resultin*g from *abortion* unless the abortion *is perfor*med because the life of the mother would be endangered if the fetus were carried to term or if the treatment is related to a medical complication arising from an abortion.

20. Reversal or attempted reversal of vasectomies or other sterilization procedures.

21. Abortions or vasectomies or other sterilization procedures for *dependent* children, unless otherwise allowed as a Preventive Benefit;.

22. Maternity, pregnancy or a pregnancy-related condition of any person other than a *employee* or the *dependent* spouse of an *employee* or retiree.

23. Personal comfort items or other items provided in a hospital which are not medically necessary including but not limited to such items as hospital admission kits, rental of a radio or TV, a telephone, cosmetics or toiletries, slippers, guest trays, newspapers or magazines, telegrams, personal laundry, or beds or cots for guests or family members.

24. Routine physical examinations or tests for check-up purposes where not necessary for treatment of a sickness, including but not limited to:

a. Cancer prevention examinations;
b. Cancer detection center examinations;
c. Tuberculosis examinations;
d. Sickle cell anemia examinations; and
e. Any other type of physical examinations or test that is given primarily to determine whether a person has a specific sickness or disease where there have been no symptoms.

Note: This exclusion does not apply to routine physical examinations or to one (1) routine mammogram and one routine gynecological examination and Pap smear during a 12-month period for covered females. This exclusion does not apply if otherwise allowed as a Preventive Benefit.

25. Eyeglasses, contact lenses (except the first pair following cataract surgery), hearing aids, or dental *services* and supplies rendered for treatment of the teeth, the gums (other than for tumors) or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection with mouth conditions due

to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar proves or the gingival tissue, unless the *services* and supplies are stated in this SPD to be a *covered expense*.

26. *Services* of blood donors.

27. Transportation or travel (or for any room or board charge incurred in connection with such transportation or travel), except as specifically stated in this SPD to be a *covered expense*.

28. Treatment or care provided by a doctor, nurse, therapist or other individual who is a relative in any way to *you* or to the *dependent* receiving the care or treatment or who ordinarily lives in *your* home or in the home of the *dependent* receiving the care or treatment.

29. Occupational therapy other than as stated in this SPD to be a *covered expense*.

30. Orthodontics.

31. *Services*, supplies, treatments or surgical procedures provided in connection with an overweight condition or condition of obesity, unless otherwise allowed as a Preventive Benefit.

32. Corrective shoes (the initial charge for the corrective appliance, such as a bar, is covered).

33. *Services* or supplies provided in connection with smoking cessation, including but not limited to medications (prescription or non-prescription) and therapy or counseling of any type, unless otherwise allowed as a Preventive Benefit.

34. *Services* or treatments which are preventative in nature except for the *services* and treatments specifically stated in this SPD to be a *covered expense*.

35. Treatment of injury or sickness caused by suicide, attempted suicide or self-inflicted injury, unless the injury or sickness resulted from a medical condition (including both physical and mental health conditions).

36. Treatment of, or loss sustained due to, injuries sustained in the course of an attempted commission or the commission of any felony.

37. Charges incurred as a result of, or for loss sustained due to, an injury which is sustained while a person is performing any act or duty pertaining to any activity, occupation or employment for remuneration or profit, whether employed, self-employed or otherwise.

38. Charges incurred as a result of, or for loss sustained due to, injury, disease or sickness for which benefits would have been or may be or are payable in whole or in part under any workers' compensation law, employer's liability law, occupational diseases law or similar law.

39. Custodial care (care that is designed primarily to assist a person in meeting the activities of daily living), regardless of what the care is called.

40. Special education rendered to any person, regardless of the type of education, the purpose of the education, the recommendation of the attending doctor or the qualifications of the individual rendering the special education.

    Exception: The *Plan* will cover charges for nutritional counseling for a covered person following the initial diagnosis of diabetes.

41. *Services* or supplies provided to a person while he is confined in an institution which is primarily a place of rest, a place for the aged, or a nursing home (except under a *hospice care* program for which *Plan* benefits are payable).

42. Education, training or room and board while a person is confined in an institution which is primarily a school or institution of training.

43. *Services* or supplies which are furnished, paid for or otherwise provided due to past or present service of any person in the armed forces of a government unless required by law.

44. *Services* or supplies rendered while a person is confined in a hospital operated by the U.S. government or an agency of the U.S. government except that the *Plan*, to the extent required by law.

45. Charges incurred for *services* and supplies which *you* or *your dependents* would not be legally required to pay.

46. Charges that would not have been made if this *Plan* did not exist.

47. Injury or sickness caused by: war or any act or war, whether war is declared or undeclared; any act of international armed conflict; any conflict involving the armed forces of any international body; or insurrection.

48. Completing of claim forms (or forms required by the *Plan* for the processing of claims) by a doctor or other provider of medical *services* or supplies.

49. Speech therapy, including the supplies used in connection with such therapy, when provided for a mental or nervous disorder, behavioral problem, developmental speech problems or in connection with or for treatment of remedial reading, special education, self-care or self-help training.

    Exception: This exclusion does not apply to speech therapy as stated in this SPD to be a *covered expense*.

50. Charges for prescription drugs with respect to a Medicare-eligible retiree or a retiree's Medicare-eligible *dependents*, if he has enrolled in Medicare Part D *Plan*.

51. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan.

52. Any *expense incurred* for *services* received outside of the United States for non-*emergency* care *services*.

53. Vitamins, dietary supplements and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g. phenylketonuria (PKU)).

54. Medications, drugs or hormones to stimulate growth unless there is a laboratory confirmed diagnosis of growth hormone deficiency, as determined by the *Plan*.

55. Therapy and testing for treatment of allergies including, but not limited to, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
    a. The American Academy of Allergy and Immunology, or
    b. The Department of Health and Human Services or any of its offices or agencies.

56. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
    a. The *services* do not require a professional interpretation, or
    b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*.

57. *Alternative medicine*.

58. Acupuncture, unless:
    a. The treatment is *medically necessary* and appropriate and is provided within the scope of the acupuncturist's license;
    b. *You* are directed to the acupuncturist for treatment by a licensed physician; and
    c. The acupuncture is performed in lieu of generally accepted anesthesia practices.

59. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic.

60. *Services* of a midwife, unless provided by a midwife acting within the scope of his or her license or certification under applicable state law.

61. The following types of care of the feet:
    a. Shock wave therapy of the feet;
    b. The treatment of weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
    e. The cutting of toenails, except the removal of the nail matrix;
    f. The provision of heel wedges, lifts.

62. Weekend non-*emergency hospital* admissions, specifically admissions to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *qualified practitioner* when there is no cause for an *emergency* admission and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.

63. *Hospital* inpatient *services* when *you* are in observation status.

64. *Services* rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless *medically necessary*.

65. *Preadmission*/procedural testing duplicated during a *hospital confinement*.

66. Lodging accommodations or transportation, unless specifically provided under this *Plan*.

67. No benefits will be provided for:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis;
    c. Biliary lithotripsy;
    d. Home uterine activity monitoring;
    e. Sleep therapy;
    f. Light treatments for Seasonal Affective Disorder (S.A.D.);
    g. Immunotherapy for food allergy;
    h. Prolotherapy;
    i. Cranial banding;
    j. Hyperhydroosis *surgery*;
    k. Lactation therapy (unless otherwise allowed under "Preventive Benefits"); or
    l. Sensory integration therapy.

68. *Sickness* or *bodily injury* for which medical payments/personal injury protection coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the other carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverage under this *Plan* did not exist

69. Gene therapy, xenografts, cloning or non-human organ or tissue transplants; or

70. Maternity charges incurred by a covered person acting as a surrogate. This includes but is not limited to any and all charges incurred by the surrogate mother for prenatal care and delivery of the child and any charges incurred by the child born to the surrogate mother unless and until the Plan is otherwise required to provide coverage for the child because the child is a Dependent as defined by the Plan. For the purpose of this Plan, a "surrogate mother" is defined as a person who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party. 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.

NOTE: These limitations and exclusions apply even if a *qualified practitioner* has performed or prescribed a *medically necessary* procedure, treatment or supply. This does not prevent *your qualified practitioner* from providing or performing the procedure, treatment or supply, however, the procedure, treatment or supply will not be a *covered expense*.

The preceding list is not an all-inclusive listing of the *Plan's* limitations and excluded procedures, services or supplies. It is only representative of the types of services and supplies for which *Plan* benefits are not payable and of the types of situations in which charges may be incurred for which benefits are not payable.

The *Trustees* shall have the authority to authorize payment of expenses on a case-by-case basis, for a particular type of service, supply or treatment which is not stated as covered under the *Plan*, or which is stated as not covered under the *Plan*, if, in their sole discretion and upon advice of the *Health Link* or the EAP, payment of such expenses would result in less cost to the *Fund* than paying for an alternative service, supply or type of treatment that is covered under the *Plan*. Any alternative services covered under this provision shall be specific to the individual's case and shall in no event set a precedent with respect to other similar claims.

WEEKLY DISABILITY INCOME BENEFITS

Weekly benefits are payable if *you* become totally disabled while *you* are eligible for this benefit. These weekly benefits are for *eligible employees* only. Retirees and members who qualified for coverage under the accelerated eligibility rules are not eligible for weekly disability income benefits.

You are not eligible for weekly benefits if *You* become disabled while *you* are making self-payments for COBRA coverage.

WEEKLY DISABILITY INCOME BENEFIT

If you are eligible to receive a Weekly Disability Income Benefit in accordance with the provisions and conditions under the Plan, you will receive a benefit in the amount of $700.00 weekly, less applicable withholdings.

DEFINITION OF TOTALLY DISABLED

You are considered to be totally disabled if, as a result of non-occupational accidental bodily injury or sickness, *you* are completely unable to work at the electrical trade or a related occupation for which *your employer* has made *contributions* to the *Fund* on *your* behalf.

ELIGIBILITY FOR WEEKLY BENEFITS

Requirements To Be Eligible For Weekly Benefits:

1. *You* must have met the initial eligibility requirements; and

2. *You* must have worked at least 200 hours (in the 6 months preceding the disability) of the required hours in the previous eligibility period; and

3. At the time *you* are disabled:

    - *You* must be gainfully employed under the *CBA* between the Local 212 and the signatory *employers*, or
    - *You* must be employed by any member of a reciprocal agreement in which Local No. 212 is a member, or
    - *You* must be gainfully employed by an *employer* that is party to a participation agreement with the *Plan* that requires contributions to be made on your behalf; or
    - *You* must have gained eligibility in this Local Union No. 212, IBEW Health and Welfare benefit *Plan* and be employed in another local's jurisdiction, and
    - *You* must apply for benefits within 30 days of the start of *your* disability and submit the proper forms to the *Administrative Manager*. (If *you* apply for benefits more than 30 days after *your* disability starts, benefits will not begin until the first week following the date *your* claim is received.)

Exceptions:
If *you* are not employed when *your* disability starts and *you* are on the Local No. 212's referral list and *your* name reaches the No. 1 position but *you* cannot work because of the disability, *you* will be eligible for weekly benefits if *you* worked the required number of hours in the previous eligibility period.

If *you* are not employed when *your* disability starts and *you* are hospitalized due to the disability, *you* may still be eligible to receive weekly benefits during the hospital confinement if *you* are otherwise eligible for weekly benefits and *your* unemployment is due to lack of work.

If, during *your* disability, it appears that *you* are gainfully employed, even in alternative employment, and *you* are being compensated for the services, the *Trustees* will determine *your* eligibility for weekly benefits based on the facts of *your* case. As a general guideline, *you* will be eligible to receive weekly benefits if *you* are not performing *your* customary duties at the electrical or a related trade and *your* disability is certified by a doctor who is an M.D. or D.O, physician assistant, or nurse practitioner.

PROOF OF DISABILITY

A certificate indicating that *you* are unable to work, signed by a doctor who is an M.D. or D.O., physician assistant, or nurse practitioner is required before benefits will be paid. The Plan will not accept certification from a chiropractor. *You* can contact the *Administrative Manager* for the proper form. A disability will not be considered to have begun until the first day that *you* are actually examined or treated by a doctor.

The Plan requires the following information supporting any disability claim, to be supplied at your expense:

1. The date of the disability;

2. The cause of the disability;

3. The prognosis of the disability;

4. Proof that you are receiving appropriate and regular care for the condition from a licensed doctor (excluding a chiropractor), physician assistant, or nurse practitioner who is someone other than you or a member of your immediate family and whose specialty or expertise is the most appropriate for the disabling condition(s);

5. A description of the extent of the disability, including restrictions and limitations which are preventing you from performing your regular occupation; and

6. The name and address of any hospital or medical facility where you have been treated for the disability.

CONTINUING PROOF OF DISABILITY

You may be asked to provide proof that you continue to be disabled and are receiving appropriate and regular care from a doctor, physician assistant, or nurse practitioner. Requests for continuing proof of disability will be made only as often as the Board of Trustees deems reasonably necessary and must be satisfied at your expense within 30 days of the Board's request. If you fail to comply with a request for continuing proof of disability, your benefits may be delayed, suspended or terminated.

The Board may also require you to be examined as often as reasonably necessary while the weekly income disability claim continues. Such an examination will be done at the Board's expense by a board-certified doctor of the Board's selection. Further, the Board may examine any and all hospital or medical records relating to the injury or sickness underlying your short-term disability claim.

PAYMENT OF BENEFITS

When Benefits Begin: The amount of *your* weekly benefit is shown on the Schedule of Benefits. Benefits are paid only for full calendar weeks of disability, Monday through Friday. Benefits are not paid for partial calendar weeks of disability. *You* will receive one benefit check a week which may be paid via direct deposit upon request.

For example, if a disability due to injury begins on a Monday, *you* will be issued a check on Friday of that week for the full week. But if the disability begins on a Wednesday, no payment is made for that partial week. *You* will be issued a check on Friday of the next week (9 days later). If the disability is due to sickness, *you* will be issued a check for the next full week after the first full calendar week of disability.

A recurring injury will be treated as a sickness for determining when benefits start. A hernia will be considered a sickness unless *you* are hospitalized on the day of occurrence of the hernia. If *you* are a female *employee* disabled as the result of maternity or a pregnancy or a pregnancy-related condition, that disability will be considered a disability due to sickness.

Maximum Benefit Period: Weekly benefit are payable for up to 26 weeks during a 12-month period. A 12-month period starts on the day *you* report sick or injured. *You* cannot receive weekly benefits for another disability until 12 months have gone by since the beginning of the previous disability and *you* have returned to work for one eligibility period and worked at least 200 hours.

Overpayments: If you receive weekly disability income benefits when ineligible for such benefits, you must immediately notify the *Administrative Manager* and return any overpayments. The Board may choose the method of recovery for any overpayments.

RECURRENCE OF DISABILITY

The waiting week(s) will not apply to a period of total disability caused by a recurrence of a total disability for which Weekly Disability Income Benefits were paid if the subsequent period of disability meets all of the following requirements:

1. The disability recurs after less than fourteen days;

2. The second period, or any subsequent period, of disability is due to the same cause as the previous disability; and

3. *You* did not return to work during the intervening period against medical advice.

FRAUD

Any person who knowingly and with intent to defraud provides false information or omits relevant facts when filing a claim may be subject to criminal and civil penalties. These penalties include, but are not limited to, fines, denial or termination of benefits, recovery of any amounts paid, civil damages and/or criminal prosecution.

EXCLUSIONS AND LIMITATIONS (LOSSES NOT COVERED)

Weekly Benefits will not be paid for:

1. Any disability which results from a sickness or injury for which *you* are not under the direct care of a doctor, physician assistant, or nurse practitioner;

2. Any disability which starts while *you* are maintaining *your* eligibility by making self-payments for COBRA coverage;

3. Any disability for which *you* are entitled to receive benefits in whole or in part under any Workers' Compensation law, Occupational Diseases law or similar law, unless *you* have executed an appropriate subrogation agreement;

4. Any period of the disability during which you are eligible for salary continuation, sick pay, vacation or similar benefits that allow you to maintain your regular income; or

5. Any disability that results from injury sustained while performing any act or duty pertaining to any occupation or employment.

For additional exclusions and limitations that apply to the Weekly Disability Income Benefit, refer to the "Plan Conditions, Limitations and Exclusions" section in this SPD.

TAXATION OF WEEKLY BENEFITS

You must include *your* weekly Disability Income Benefits in *your* gross income and pay federal income tax on them. If *you* have a question about this, or about exclusions in the law, *you* should check with a competent tax advisor or counsel.

Weekly Income Benefits are also subject to Social Security taxes (FICA). *You* pay half of the tax and *the Plan* pays half. In accordance with federal law, the *Plan* will withhold *your* share of the FICA tax from each weekly benefit paid to *you* and will send it to the government.

WELFARE REIMBURSEMENT PLAN

The *Trustees* have established a Welfare Reimbursement Plan (WRP), also known as a Health Reimbursement Arrangement (HRA), within the Local Union No. 212, IBEW Health and Welfare Fund which establishes individual WRP accounts for *employees* and *retirees*. From this WRP account, *you* can withdraw funds to provide for eligible health care expenses for *you* and *your* eligible *dependents* that are not otherwise covered. The WRP is a self-funded benefit which the *Administrative Manager* administers.

GENERAL INFORMATION

The monies in *your* account are not attributable to any salary reduction, but are specified amounts that have been transferred to your WRP account from the IBEW 212 Supplemental Unemployment Benefit Fund. Under the provisions of the IBEW 212 Supplemental Unemployment Benefit Fund Plan Document, participants may elect to roll over funds from their Supplemental Unemployment Benefit account into their individual WRP account, subject to the limitations and conditions of the Plan.

1. *You* may not make self-payments to *your* WRP account.

2. If the *Administrative Manager* issues a WRP reimbursement check to *you* for a WRP covered expense, *your* individual WRP account balance will be reduced by that amount of reimbursement.

3. The WRP account balances can be carried forward from year to year.

4. The WRP coverage period is the Plan Year: May 1 through April 30.

5. When *you* retire, *your* WRP account balance is not forfeited.

6. *You* do not earn interest in your WRP account.

7. *You* and *your* spouse or *your* dependents are not vested in your WRP account balance.

8. The *Trustees* reserve the right to eliminate or modify this program at any time and in their sole discretion.

An individual who is eligible to participate in the WRP may elect to permanently opt-out of participation in the WRP. By permanently opting out of participation in the WRP, the Participant forfeits all amounts accumulated in his WRP Account and waives all future contributions to his WRP Account. All individuals eligible to participate in the WRP shall be given the option of permanently opting out of participation at least annually and upon termination of participation in the WRP or the IBEW Local No. 212 Health and Welfare Fund.

REQUIREMENTS FOR REIMBURSEMENT

You may only receive reimbursement from *your* individual WRP account for WRP covered expenses which meet the following requirements:

1. *You* are required to pay the covered expense;

2. The expense is not payable under the regular medical, dental or vision benefits provided under this *Plan*;

3. The expenses are not payable by any other group benefit or insurance plan;

4. The total combined reimbursement from all benefit/insurance plans, when added to the amount of the WRP account reimbursement, cannot exceed 100%;

5. The maximum dollar amount that is reimbursable from the balance in *your* account in any one coverage period shall not exceed $15,000; and

6. The WRP Plan pays benefits only after any flexible spending account or health savings account you may have available.

WRP COVERED EXPENSES

The following types of expenses are considered WRP covered expenses by the *Trustees* and Section 213(d) or the Internal Revenue Code:

1. Payments for health coverage and health insurance, including regular self-payments, COBRA continuation coverage self-payments and retiree self-payments. If *your* WRP account balance is less than the amount of the required self-payment, *you* will be responsible for paying the difference between the required self-payment amount and *your* WRP account balance to the *Administrative Manager*. The due date will not be extended. *You* may also authorize the *Administrative Manager* to make an automatic self-payment from *your* account if *you* do not have enough hours worked.

2. Comprehensive Major Medical Expense Benefit deductibles and *your* out-of-pocket copayment.

3. Medical expenses not covered by or in excess of the benefits provided under the Comprehensive Major Medical Expense Benefit.

4. Vision expenses.

5. Dental expenses.

6. Acupuncture.

7. Guide dogs for blind or deaf people.

8. Smoking cessation programs.

9. Hearing examinations and hearing aids.

10. Special telephone and television equipment for hearing-impaired persons.

11. Surgery or laser treatment to correct vision.

12. Weight-loss programs, but not food or dietary supplements.

13. Transportation expenses primarily for and essential to medical care as permitted by Internal Revenue Code §213(d)(1)(B).

14. Prescription drugs and over-the-counter drugs and products that are determined to be qualified medical expenses by the Internal Revenue Service and determined by the *Trustees* to be a Covered Medical Expense.

15. Qualified "Special Schooling for the Mentally Impaired or Physically Disabled," provided that the schooling is medically necessary and the school qualifies under the IRS regulations as such a special school.

EXPENSES THAT ARE NOT COVERED

The following types of expenses are not considered WRP covered expenses and will not be reimbursable to *you*:

- Cosmetic surgery and treatments.
- Health club memberships or expenses.
- Elder care.
- Household help.
- Maternity clothes.
- Cosmetics, toiletries and sundry products, including but not limited to acne treatments, dietary supplements, fiber supplements, herbs, lip balm, shampoos and soaps, suntan lotion, weight loss drugs and vitamins, or any other product that is not determined to be a qualifying medical expense by the IRS, or that the *Trustees* have determined not to be a WRP covered expense.
- Premiums for long-term care insurance.
- Expenses for which *you* can be reimbursed by some other source.
- Sales tax, shipping and handling or related expenses for prescription drugs, durable medical equipment, etc.

Limitation if Plan Fails to Provide Minimum Value. This WRP is intended to be "integrated" with the IBEW Local No. 212 Health and Welfare Fund, which currently meets "minimum value" standards as defined in the regulations issued pursuant to the Patient Protection and Affordable Care Act. In the event that the IBEW Local No. 212 Health and Welfare Fund is certified by the *Plan Administrator* or Plan actuary as failing to provide "minimum value" as such term is defined under the Patient Protect and Affordable Care Act, reimbursement of Medical Care expenses from the WRP shall be limited to reimbursements of co-payments, co-insurance, deductibles and premiums under non-WRP coverage, as well

as medical care expenses that are not considered essential health benefits. A Participant, Eligible Retiree, Spouse or Dependent seeking reimbursement for expenses from a health plan other than the IBEW Local No. 212 Health and Welfare Fund shall be required to submit proof sufficient to the *Administrative Manager* that the health plan related to which the individual is seeking reimbursement from the WRP provides minimum value as required under PPACA.

ELIGIBILITY

The eligibility rules applicable to the regular *Plan* of Benefits do not apply to the WRP. Any *employee* who has a balance in his WRP account is eligible to use his WRP account for the WRP covered expenses as specified above. *You* do not have to be eligible for *Plan* benefits at the time the WRP covered expense is incurred.

All persons meeting the IRS definition of "*dependent*" are eligible for benefits under the WRP.

Entitlement to reimbursement and the amount of *your* reimbursement from *your* WRP account is based on the amount of *your* WRP account balance at the time the reimbursement check is issued.

If *you* die with a balance remaining in *your* WRP account, reimbursement for covered expenses incurred by *you* prior to *your* death may be made to the representative of *your* estate. *Your* surviving spouse and *dependents* may also use the balance remaining in *your* WRP account for WRP covered expenses.

If *you* have no surviving *dependents*, *your* WRP account balance will be forfeited to the general assets of the *Plan*.

HOW TO OBTAIN REIMBURSEMENT

Reimbursement Limitations. The minimum amount *you* may request for reimbursement is $100. However, if *you* incur less than $100 in WRP covered expenses during a coverage period, *you* may submit a request for less than $100 at the end of that coverage period. 1. The maximum dollar amount that is reimbursable from the balance in your account in any one coverage period shall not exceed $15,000.

Submission of a Claim. *You* may submit WRP reimbursement requests to the *Administrative Manager* at any time, but no later than one year following the date on which the expense was incurred. When *you* or *your dependents* have unreimbursed WRP covered expenses, and a corresponding balance in *your* WRP account, *you* must submit proof of such out-of-pocket expenses on a form provided to *you* by the *Administrative Manager*. Along with the form, *you* must include:

- A copy of the itemized bill and proof of payment acceptable to the *Trustees*.
- WRP reimbursement requests for medical expenses must be accompanied by an explanation of benefits form (EOB).
- If you have secondary health plan coverage, the reimbursement request form must also include a copy of the secondary plan's EOB.
    - WRP reimbursement requests for self-payment amounts must be accompanied by a completed and signed self-payment authorization form issued by the *Administrative Manager*.

Who May Submit Requests for Reimbursement. Only an *employee* or retiree may submit reimbursement requests. *Your* spouse may submit a reimbursement request if *you* are deceased, or if the *Administrative Manager* has a written authorization on file, signed by *you*, authorizing your spouse to make reimbursement requests.

Reimbursement Payment. The *Administrative Manager* will generally send reimbursement checks to *you* and deduct the applicable amount from *your* WRP account within 30 days of receipt of a properly-submitted reimbursement form.

The amount of the reimbursement will be the amount of the WRP covered expense up to, but not to exceed, the amount in *your* WRP account at the time the check was issued.

PRESCRIPTION DRUG BENEFIT

The *Board of Trustees* have a contract with the *Prescription Benefit Manager* to provide *you* with prescription drug benefits. The *Prescription Benefit Manager* has arranged with a number of retail pharmacies in *your* area and a mail service pharmacy to fill *your* prescriptions according to the rules set out in this SPD.

The information below applies primarily to *Active Eligible Participants*. *Retired Eligible Participants* should consult the "Medicare-Eligible Retirees/Dependent Spouses of Retirees" sub-section found beginning on page 87 of the Summary Plan Description for additional information regarding their prescription drug benefits.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

You are required to pay the applicable *copayment* per *prescription* as follows:

PARTICIPATING RETAIL PHARMACY

Level 1 Drugs For a 30-day supply	$10 *copayment* per *prescription*
Level 2 Drugs For a 30-day supply	$35 *copayment* per *prescription*
Level 3 Drugs For a 30-day supply	$60 *copayment* per *prescription*
Specialty Drugs	20% *copayment* to a maximum of $120

MAIL ORDER PHARMACY

Level 1 Drugs Maximum 90-day supply	$20 *copayment* per *prescription*
Level 2 Drugs Maximum 90-day supply	$70 *copayment* per *prescription*
Level 3 Drugs Maximum 90-day supply	$120 *copayment* per *prescription*
Specialty Drugs	20% *copayment* to a maximum of $120

PRESCRIPTION OUT-OF-POCKET MAXIMUM

Individual	$5,650
Family	$10,100

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

Participating Pharmacy

When a *participating pharmacy* is used and *you* do not present *your* I.D. card at the time of purchase, *you* must pay the *pharmacy* the full retail price and submit the *pharmacy* receipt to the *Prescription Benefit Manager* at the address listed below. *You* will be reimbursed at the contracted rate after the charge has been reduced by the applicable *copayment*.

Non-Participating Pharmacy

When a *non-participating pharmacy* is used, *you* must pay the *pharmacy* the full price of the drug and submit the *pharmacy* receipt to the *Prescription Benefit Manager* at the address listed below. *You* will be responsible for 30% of the actual charge made by the dispensing *pharmacy* after this charge has been reduced by the applicable *copayment*.

Mail *pharmacy* receipts to the *Prescription Benefit Manager:*

Sav Rx
P.O. Box 8
Fremont, NE 68026

Physicians may Escribe to Sav-Rx NABP 2817926 or Fax 888-810-1394

PRIOR AUTHORIZATION

Some *prescription* drugs may be subject to *prior authorization*. To verify if a *prescription* drug requires *prior authorization*, call the toll-free customer service phone number (1-866-233-IBEW) or visit the *Prescription Benefit Manager's* website at www.savrx.com

Examples of drugs that require pre-authorization are those in the following categories or that are for the following conditions:

- Acne
- Anabolic Steroids
- Arthritis
- Attention Deficit
- Erectile Dysfunction
- Growth Hormones
- Narcolepsy

- Hyperactivity
- Injectable Specialty Drugs
- Oral Specialty Drugs
- Transplant Medications

If *your* doctor prescribes any of these categories of drugs, he should first call SavRx. Otherwise, there will be a delay at the pharmacy while the pharmacist begins the pre-authorization process.

STEP THERAPY

Sometimes there is more than one *prescription* drug that can be used to treat a health condition. For certain *prescription* drug therapies, *you* and *your* doctor will be required to use at least one lower cost brand or generic equivalent when appropriate, as a first step. If, after using the lower cost brands or generic equivalents, *you* and *your doctor* still require the higher cost treatment, coverage will be provided under the *Plan*. However, the initial *prescriptions* must be these step *prescriptions*. This program is intended to provide *you* with effective coverage, both medically and financially. Certain *prescription* drug therapies (and their related conditions) that may be subject to the *step therapy* program are:

- Antidepressants (depression)
- ACE Inhibitors (high blood pressure)
- Angiotensin II Receptor Antagonists-A2s (high blood pressure)
- Branded NSAIDS (pain/arthritis)
- Cyclooxygenase-2 Inhibitors-COX2s (pain/arthritis)
- Calcium Channel Blockers (hypertension)
- Leukotriene Pathway Inhibitors (asthma/allergies)
- Proton Pump Inhibitors-PPIs (acid reflux/ulcers)
- Selective Serotonin Reuptake Inhibitors-SSRIs (depression)
- HMG-CoA Reductase Inhibitors (cholesterol)
- Topical Immunomodulators (dermatitis, exzema)

Note that new medications and drug classes may be added to or removed from the above list. To verify if a *prescription* drug has *step therapy* requirements, call the toll-free customer service phone number (1-866-233-IBEW) or visit the *Prescription Benefit Manager's* website at www.savrx.com.

DISPENSING LIMITS

Some *prescription* drugs may be subject to *dispensing limits*. This means that there is a limit on how much medicine *you* can purchase during a period of time. These limits have been determined by the *Prescription Benefit Manager*, based upon normal medical necessity. If *your prescription* is over the limit there are two choices:

1. *You* can get the amount of medicine that is covered by the Plan, and then pay out-of-pocket for any medicine that is over this limit; or

2. If *your doctor* feels *you* need more medicine than is permitted under the *Plan*, *your doctor* may request approval of the *prescription* that is above the limit. Please note that it may take several days for these requests to be reviewed.

To verify if a *prescription* drug has *dispensing limits*, call the toll free customer service phone number (1-866-233-IBEW) or visit the *Prescription Benefit Managers'* website at www.savrx.com.

RETAIL PHARMACY

Your Plan provisions include a retail *prescription* drug benefit. *You* will receive an identification (ID) card, which includes *your* name, group number and *your* effective date.

Present *your* ID card at a *participating pharmacy* when purchasing a *prescription. Prescriptions* dispensed at a retail *pharmacy* are limited to a maximum of a 90-day (or 100 unit doses, whichever is greater) supply for maintenance medications or a maximum of a 30-day supply for self-administered injectables or non-maintenance medications per *prescription* or refill. There is a double retail copayment for prescriptions that are in excess of a 30-day supply.

MAIL ORDER PHARMACY

Your prescription drug coverage also includes *mail order pharmacy* benefits, allowing participants an easy and convenient way to obtain *prescription* drugs.

Mail order pharmacy prescriptions will only be filled with the quantity prescribed by *your* physician and are limited to a maximum of a:

- 90-day supply per *prescription* or refill for a drug received from a *mail order pharmacy*; or
- 30-day supply per *prescription* or refill for *self-administered injectable medications* or specialty office medications and injectables.

Additional *mail order pharmacy* information can be obtained by calling the toll-free customer service phone number (1-866-233-IBEW) or visit the *Prescription Drug Manager's* website at www.savrx.com.

SPECIALTY OFFICE MEDICATIONS AND INJECTABLES

Your doctor has access to specialty office medications and injectables used to treat chronic conditions. These medications can be ordered specifically for *you* for administration in his/her office setting. This allows *your* doctor a cost effective and convenient way to obtain high cost, high tech specialty medications and injectables.

SAV-RX HIGH IMPACT ADVOCACY PROGRAM

The Plan has procurement programs in place that may require participation in the High Impact Advocacy Program. This program manages the use of selected specialty medications to reduce or eliminate your out-of-pocket expense as well as reducing the cost to the Plan. In order to continue receiving *your* medication at the most affordable cost, *your prescription* will be filled at the Sav-Rx *pharmacy*. Sav-Rx will facilitate *your* enrollment into a manufacturer sponsored coupon program. Program medications may be discontinued from inclusion in the program at any time without notice.

MANDATORY GENERIC PROGRAM

The Plan has a mandatory generic rule in place for brand name drugs which have an equivalent generic available. If a brand name drug is selected when an equivalent generic available, *you* will be responsible for the *copayment* plus the difference in cost between the brand name drug and the generic equivalent. If *your physician* has determined that the brand name drug is medically necessary and the generic is not clinically appropriate, the physician may submit a Letter of Medical Necessity to the *Prescription Drug Manager*. If *your physician* submits a Letter of Medical Necessity for the brand name drug which has a generic equivalent,

the *Prescription Drug Manager* will waive the difference in cost and the applicable non-formulary brand *copayment* will apply. Letters of Medical Necessity may be faxed to Sav-RX at 888-810-1394.

PRESCRIPTION DRUG COST SHARING

Prescription drug benefits are payable for covered *prescription expenses incurred* by *you* and *your* covered *dependents*. Benefits for expenses made by a *pharmacy* are payable as shown on the Schedule of Prescription Drug Benefits.

You are responsible for payment of:

1. The drug deductible, if any;
2. The *copayment* or *coinsurance;*
3. The cost of medication not covered under the *prescription* drug benefit;
4. The cost of any quantity of medication dispensed in excess of the day supply noted on the Schedule of Prescription Drug Benefits.

If the dispensing *pharmacy's* charge is less than the *copayment*, *you* will be responsible for the lesser amount. The amount paid by the *Prescription Drug Manager* to the dispensing *pharmacy* may not reflect the ultimate cost to the *Prescription Drug Manager* for the drug. *Your copayment* is made on a per *prescription* or refill basis and will not be adjusted if the *Prescription Drug Manager* or *your employer* receives any retrospective volume discounts or *prescription* drug rebates.

PRESCRIPTION DRUG COVERAGE

Because SavRx's *drug list* is continually updated with *prescription* drugs approved or not approved for coverage, *you* must call the *Prescription Drug Manager's* toll-free customer service phone number 1-866-233-IBEW) or visit the *Prescription Drug Manager's* website at www.savrx.com to verify whether a *prescription* drug is covered or not covered under the Plan.

Covered *prescription* drugs, medicine or medications must:

1. Be prescribed by a *qualified practitioner* for the treatment of a *sickness* or *bodily injury*; and
2. Be dispensed by a *pharmacist*.

Prescription drug expenses covered under the Prescription Drug Benefit are not covered under any other provisions of the *Plan*. Any amount in excess of the maximum amount provided under the Prescription Drug Benefit is not covered under any other provision of the *Plan*.

Any *expenses incurred* under provisions of the Prescription Drug Benefit section do not apply toward *your* medical deductible or out-of-pocket limits. Any *expenses incurred* under the medical benefits do not apply toward *your prescription* drug deductible or out-of-pocket limits.

The *Administrative Manager* may decline coverage of a specific medication or, if applicable, *drug list* inclusion of any and all drugs, medicines or medications until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine or medication into the market.

PRESCRIPTION DRUG LIMITATIONS

Expense incurred will not be payable for the following:

1. Any drug, medicine, medication or supply not approved for coverage under the *Plan* (call the *Prescription Benefit Manager's* toll-free customer service phone number (1-888-233-IBEW) or visit the *Prescription Drug Manager's* website at www.savrx.com to verify whether a *prescription* drug is covered or not covered under the *Plan*);

2. *Legend drugs* which are not recommended and not deemed necessary by a *qualified practitioner*;

3. More than two fills for the same drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more retail *pharmacies*;

4. Charges for the administration or injection of any drug;

5. Drug delivery implants;

6. Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use," or experimental drug, medicine or medication, even though a charge is made to *you*;

7. Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *qualified practitioner,* excluding medications provided under the Specialty Office Medication Program;

8. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
   a. *Hospital*;
   b. Skilled nursing facility; or
   c. Hospice facility.

9. Any drug prescribed for intended use other than for:
   a. Indications approved by the FDA; or
   b. Recognized off-label indications through peer-reviewed medical literature.

10. *Prescription* refills:
   a. In excess of the number specified by the *qualified practitioner*; or
   b. Dispensed more than one year from the date of the original order.

11. Any drug for which a charge is customarily not made;

12. Therapeutic devices or appliances, including: hypodermic needles and syringes (except needles and syringes for use with insulin, and covered *self-administered injectable drugs*); support garments; test reagents; mechanical pumps for delivery of medication; and other non-medical substances, unless otherwise specified by the *Plan*;

13. Dietary supplements, nutritional products, fluoride supplements, minerals, herbs and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride), unless otherwise specified by the *Plan*;

14. Injectable drugs, including but not limited to: immunizing agents, biological sera, blood, blood plasma, or *self-administered injectable drugs* not covered under the *Plan*;

15. Any drug prescribed for a *sickness* or *bodily injury* not covered under this *Plan*;

16. Any portion of a *prescription* or refill that exceeds a 30-day supply of maintenance medications, self-administered injectables or non-maintenance medications (or a 90-day supply for a *prescription* or refill that is received from a *mail order pharmacy*);

17. Any portion of a *prescription* refill that exceeds the drug specific *dispensing limit*, is dispensed to
    a. *covered person* whose age is outside the drug specific age limits, or exceeds the duration-specific *dispensing limit*, if applicable;

18. Any drug, medicine or medication received by the *covered person*:
    a. Before becoming covered under the *Plan*; or
    b. After the date the *covered person's* coverage under the *Plan* has ended.

19. Any costs related to the mailing, sending, or delivery of *prescription* drugs;

20. Any fraudulent misuse of this benefit including *prescriptions* purchased for consumption by someone other than the *covered person*;

21. *Prescription* or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged;

22. Repackaged drugs;

23. Any drug or medicine that is:
    a. Lawfully obtainable without a *prescription* (over the counter drugs), except insulin; or
    b. Available in *prescription* strength without a *prescription*;

24. Any drug or biological that has received an "*orphan drug*" designation, unless approved by the *Administrative Manager*;

25. Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;

26. More than one *prescription* within a 23-day period for the same drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more *pharmacies*, unless received from a *mail order pharmacy*. For drugs received from a *mail order pharmacy*, more than one *prescription* within a 20-day period for a 1-30 day supply; or a 60-day period for a 61-90 day supply. (Based on the dosage schedule prescribed by the *qualified practitioner*);

27. Oral drugs used to treat male impotence unless such drugs are medically necessary for the treatment of male impotence.

28. Any drug used for cosmetic purposes, including but not limited to:
    - Tretinoin, e.g. Retin A

- Dermatologicals or hair growth stimulants; or
- Pigmenting or de-pigmenting agents, e.g. Solaquin.

29. Abortifacients (drugs used to induce abortions).

30. Any drug that does not meet the Plan's *step therapy* criteria (absent prior authorization to be exempted from the *step therapy* requirements).

MEDICARE-ELIGIBLE RETIREES/DEPENDENT SPOUSES OF RETIREES

If *you* are a Medicare-eligible retiree or Medicare-eligible *spouse, your* prescription drug benefits will be provided through an insured Medicare Part D plan. If *you* are a Medicare-eligible retiree but your eligible *dependents* are not Medicare-eligible they will remain on the Plan's traditional prescription drug policy as outlined above until they become Medicare-eligible.

The insured Medicare Part D plan has a supplemental benefit (a "wraparound" benefit) to that Part D plan which keeps *your co-payments* as outlined above with no donut hole or additional *deductible.* To receive the comprehensive Medicare Part D plan and supplemental plans' benefits *you* will need to use two prescription ID cards instead of one. UnitedHealthcare MedicareRx^{SM} for Groups (PDP) is the primary prescription drug plan and Sav-Rx is the secondary prescription drug plan.

Medicare-eligible participants are able to continue using the Sav-Rx mail-service pharmacy for maintenance medications and long-term drugs, and *your co-pay* amount should not change.

Upon *you* or *your* spouse becoming Medicare-eligible, *you* will be automatically enrolled in the Medicare Part D and supplemental plan. *You* have the option to NOT participate in the prescription drug plans. However, if *you* decline the IBEW Local 212 Health and Welfare Fund prescription drug program through UnitedHealthcare and Sav-Rx, *you* will not have any prescription coverage through the IBEW Local 212 Health and Welfare Fund. In that case, *your* self-payment for this Fund's retiree coverage will NOT be reduced, and *you* will need to obtain creditable coverage elsewhere. If *you* do not enroll in creditable coverage that starts within 60-days after *you* cancel your coverage under this Plan you may be subject to a late enrollment penalty. To dis-enroll, call the *Administrative Manager* at 513-861-4800.

If your income in a year is above a certain limit as evidenced by *your* tax return, social security will deduct an additional amount of premium from *your* social security check for *your* Medicare Part D coverage. This additional premium amount is called an income-related monthly adjustment amount.

If you are Medicare-eligible and have previously enrolled in a Medicare Part D plan, you may reinstate prescription drug coverage under this Plan only during the annual Medicare Part D open enrollment period. This option is only available once per lifetime. Prescription coverage under the IBEW Local 212 Health and Welfare Plan will resume on the first day of the month following the month in which your Medicare Part D coverage terminates. Proof of termination of Medicare Part D benefits must be provided to the Benefit Office.

Sav-Rx will be the final payer on *your* prescription drug claims and can give *you* information about *your* prescription drug costs.

Sav-Rx
820-228-3108
24 hours, 7 days a week

DENTAL BENEFIT

(Actives, Early Retirees, and Medicare-Eligible Retirees)

Your dental coverage is provided through Delta Dental of Ohio. You may visit any dentist you wish; however, when you receive care from a dentist who participates in the Delta Dental network, you may pay lower costs.

DENTAL SCHEDULE OF BENEFITS

	Plan Pays		
Calendar Year Maximum Per person total per calendar year on diagnostic & preventive, basic services, and major services.	$750		
	You Pay		
Deductible Per person total per calendar year limited to a maximum deductible of $150 per family per calendar year on all services except diagnostic and preventive services, sealants, brush biopsy, X-rays, and periodontal maintenance	$50		
	Plan Pays		
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
Diagnostic & Preventive • **Diagnostic and Preventive Services -** exams, cleanings, fluoride, and space maintainers • **Sealants -** to prevent decay of permanent teeth • **Brush Biopsy -** to detect oral cancer • **Radiographs -** X-rays • **Periodontal Maintenance -** cleanings following periodontal therapy	100%	100%	100%
Basic Services • **Emergency Palliative Treatment -** to temporarily relieve pain • **Minor Restorative Services -** fillings and crown repair • **Endodontic Services -** root canals • **Periodontic Services -** to treat gum disease • **Oral Surgery Services -** extractions and dental surgery • **Other Basic Services -** misc. services • **Relines and Repairs -** to prosthetic appliances	60%	60%	60%

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
Major Services • **Major Restorative Services -** crowns • **Prosthodontic Services -** bridges, implants, and dentures	50%	50%	50%

DELTA DENTAL NETWORK

The Delta Dental network is a network of dentists and specialists who agree to provide services at a lower negotiated rate. The Plan offers access to two Delta Dental networks—the Delta Dental PPO network and the Delta Dental Premier network.

You can use either the Delta Dental PPO network or the Delta Dental Premier network. The PPO network does not have as many participating providers; however, these dentists agree to accept deeper discounted rates for covered services. The Premier network has a larger number of participating providers; however, their discounted rates are not as low as the rates accepted by dentists who participate in the PPO network. Participating dentists and specialists in both networks agree to accept the negotiated rate as payment in full for covered dental services. This can help reduce your out-of-pocket costs. If you reach the dental benefit's Calendar Year maximum, the charges you incur for the remainder of the year are your responsibility. However, if you use an in-network provider, your cost is still based on the in-network provider's discounted rate.

When you receive services from a Nonparticipating Dentist, the lower Delta Dental negotiated rates do not apply. As a result, the coinsurance you pay for covered services is based on a higher non-negotiated rate. The percentages in the Dental Schedule of Benefits above indicates the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves. If that amount is less than what the Dentist charges or Delta Dental approves, you are responsible for the difference.

A list of dentists participating in the Delta Dental PPO or Delta Dental Premier Network is available at www.deltadentaloh.com.

EXCLUSIONS AND LIMITATIONS

Dental benefits are subject to the following exclusions and limitations:

- No pre-existing condition exclusions or limitations.
- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Posterior composite resin restorations are covered services.
- Crowns, bridges, dentures and implants are payable once per tooth per five-year period.

VISION BENEFIT

(Actives and Early Retirees)

Your vision coverage is fully insured through Anthem Vison. To learn more about your vision coverage, refer to the Anthem Vision Certificate of Coverage at1-877-635-6403 or www.anthem.com.

CONTINUATION OF MEDICAL BENEFITS (COBRA)

CONTINUATION OF BENEFITS

Federal law requires most employers sponsoring group health plans to offer Members and their families the opportunity to elect a temporary extension of health coverage (called "Continuation Coverage" or "COBRA Coverage") in certain instances where coverage under the group health plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the costs of your continuation coverage.

This section is intended to summarize your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statue requires, and this section shall be construed accordingly.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

ELIGIBILITY FOR COBRA

A *qualified beneficiary* under COBRA law means an *employee*, *employee's* spouse or *dependent* child covered by the *Plan* on the day before a *qualifying event*. A *qualified beneficiary* under COBRA law also includes a child born to the *employee* during the coverage period or a child placed for adoption with the *employee* during the coverage period.

Employee Qualifying Events: An *employee* covered by the *Plan* shall become a *qualified beneficiary* on the date his or her eligibility for benefits from the *Plan* terminates due to the occurrence of any of the following qualifying events:

1. Termination of the *employee's* employment or reduction in the hours of *employee's* employment (for reasons other than gross misconduct, as defined by *your employer*);

Spouse/Dependent Child Qualifying Events: A spouse or a *dependent* child covered by the *employee's Plan* has the right to elect continuation coverage if the group coverage is lost due to one of the following qualifying events:

1. The death of the *employee*;
2. Termination of the *employee's* employment or reduction of the *employee's* hours of employment with the *employer* (for reasons other than gross misconduct, as defined by *your employer*);
3. The loss of eligible *dependent* status as defined in this *Plan* for a dependent child
4. Divorce or legal separation
5. The *employee* becomes entitled to *Medicare* benefits.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the *employer*, and that bankruptcy results in the loss of coverage of any *retired employee* covered under the *Plan,* the *retired employee* will become a

qualified beneficiary. The *retired employee's* spouse, surviving spouse, and *dependent* children will also become qualified beneficiaries if bankruptcy results in loss of coverage under the *Plan.*

BENEFITS AVAILABLE

All benefits are available under COBRA coverage except disability benefits.

PROCEDURE FOR OBTAINING COBRA COVERAGE

1. **Notification Requirements.** The *Plan* provides that coverage terminates for a spouse or a child when they lose *dependent* status. Under the law, the *employee* or *qualified beneficiary* has the responsibility to notify the *Administrative Manager* **in writing** whenever any of the following *qualifying events* occur:

    a. Divorce from the *employee*;
    b. Legal separation from the *employee*; or
    c. Loss of status as an eligible *dependent*;
    d. Eligibility for Medicare coverage.

    The notification shall take place within 60 days after any of the *qualifying events* occur. No specific form must be used, but oral notification to a Trustee or the *Administrative Manager* is not sufficient. If a *qualifying event* listed above is not reported to the *Administrative Manager* within sixty (60) days after it occurs, COBRA coverage shall NOT be provided. Such notice should be sent or delivered to: Zenith American Solutions, Inc., Re: IBEW 212 Health and Welfare Fund 5420 W. Southern Avenue, Suite 407, Indianapolis, IN 46241.

    It is the responsibility of contributing *employers* to notify the *Administrative Manager* within forty-five (45) days of an *employee's* death, termination of employment, commencement of a proceeding in bankruptcy with respect to the *employer* or a reduction in hours which causes a loss of medical benefits under the *Plan*. However, you or another family member should also notify the *Administrative Manager* if any of these *qualifying events* occurs in order to assure timely notification of eligibility for, and processing of, your choice to receive COBRA Coverage.

2. **Election Notices and Forms.** When the *Administrative Manager* determines that a *qualifying event* has occurred, the *Administrative Manager* shall send an election notice to the *qualified beneficiary*. The election notice shall inform the *qualified beneficiary* what coverage may be continued, the cost of said coverage and what the *qualified beneficiary* must do in order to obtain the COBRA coverage. The election notice shall also contain an application form for the COBRA coverage that must be completed and returned, along with the proper payment, to the *Administrative Manager* within the time period set forth therein.

    The election notice shall be sent to the *qualified beneficiary's* last known address on file in the *Administrative Manager*. 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 and take the required action(s). The parent or guardian of a *qualified beneficiary* who is a minor child may read the election notice for said child and take action on said child's behalf.

3. **Election of COBRA Coverage.**

    a. A covered *employee* or the spouse of the covered *employee* may elect continuation coverage for all covered *dependents*, even if the covered *employee* or spouse of the covered *employee* or all covered *dependents* are covered under another group health

plan (as an employee or otherwise) prior to the election. The covered *employee*, spouse and *dependent* child each have an independent right to elect continuation coverage.

b. A spouse or *dependent* child may elect continuation coverage even if the covered *employee* does not elect it, as each *qualified beneficiary* shall be entitled to individually elect the COBRA coverage.

c. If the *qualified beneficiary*, or a parent or guardian acting on behalf of a minor *qualified beneficiary*, elects COBRA coverage, he shall make sure that a completed and signed application form is returned to the *Administrative Manager* within sixty (60) days of the date on the election notice. Each *qualified beneficiary* who elects COBRA coverage must be named on the application form or a separate application form must be submitted for any person not named therein.

d. If, for any reason, the *Administrative Manager* does not receive the completed application for any *qualified beneficiary* within the sixty (60) day period, that *qualified beneficiary's* eligibility for COBRA shall expire and his health care benefits shall terminate as of the date he first became a *qualified beneficiary*. The *Plan* shall not be liable and shall be held harmless in the event that a parent or guardian, acting on behalf of a *qualified beneficiary* who is a minor child, fails to inform the minor *qualified beneficiary* of his right to elect COBRA coverage and/or fails to elect COBRA coverage for said minor *qualified beneficiary* within the sixty (60) day period.

4. **When Coverage Begins.** Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the 60-day election period and the waiver revoked before the end of the 60-day election period, coverage will be effective on the date the election of coverage is sent to the *Administrative Manager*.

5. **COBRA Coverage Self-Payment Rules.**

a. The monthly self-payment rate for COBRA coverage shall be determined periodically by the *Board of Trustees* and shall be based upon the cost of the coverage provided by the *Plan*. The monthly self-payment rate and frequency of payment shall be stated 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 to reflect any changes in the cost of the coverage.

b. The monthly premium payment to the *Plan* for continuing coverage must be submitted directly to the *Plan*. This monthly premium may include the *employee's* share and any portion previously paid by the *employer's contributions*. The monthly premium must be a reasonable estimate of the cost of providing coverage under the *Plan* for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a 2% administration charge. However, for *qualified beneficiaries* who are receiving up to 11 months additional coverage (beyond the first 18 months) due to disability extension (and not a second qualifying event), the premium for COBRA continuation coverage may be up to 150% of the applicable premium for the additional months. *Qualified beneficiaries* who do not take the additional 11 months of special coverage will pay up to 102% of the premium cost.

c. The first self-payment shall be due on the first day of the calendar month next following the date on which the *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 next following calendar month and shall be in an amount prorated to reflect the actual number of days of coverage during the period.

d. The entire amount shown on the bill must be received within forty-five (45) days of the due date as stated on the bill. Until the bill is paid in full, COBRA coverage shall not be effective and no medical expenses incurred after the *qualifying event* shall be paid. Subsequent self-payments shall be due on the first day of each calendar month in an amount equal to the monthly self-payment rate, except that the last self-payment due shall be prorated to reflect the actual number of days of coverage up to the date COBRA coverage terminates.

e. It shall be the absolute responsibility of each *qualified beneficiary* or the person acting on behalf of a *qualified beneficiary* to ensure that the *Administrative Manager* receives correct payment on a timely basis. The *Plan* shall not be liable and shall be held harmless by the *qualified beneficiary* in the event that a parent or guardian, acting on behalf of a *qualified beneficiary* who is a minor, causes the *qualified beneficiary* to lose COBRA coverage through a failure to submit correct payment in a timely fashion.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

1. 18 months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;

2. 36 months for a spouse whose coverage ended due to the death of the *employee* or retiree, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial *qualifying event*; 36 months for a *dependent* child whose coverage ended due to the legal separation or divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial *qualifying event*, the death of the *employee*, or the child ceasing to be a *dependent* under the *Plan*;

3. For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the *Plan* filed Chapter 11 bankruptcy.

DISABILITY

An 11-month extension of coverage may be available if any *qualified beneficiaries* are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The *qualified beneficiary* must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage. Each *qualified beneficiary* who has elected continuation coverage will be entitled to the 11-month disability extension if one

of them qualifies. If a *qualified beneficiary* is determined by SSA to no longer be disabled, *you* must notify the *Plan* of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and *dependent* children who elect continuation coverage if a second *qualifying event* occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second *qualifying event* occurs is 36 months. Such second *qualifying event* may include the death of a covered *employee*, divorce or separation from the covered *employee*, the covered *employee's* becoming entitled to *Medicare* benefits (under Part A, Part B, or both), or a *dependent* child's ceasing to be eligible for coverage as a *dependent* under the *Plan*. These events can be a second *qualifying event* only if they would have caused the *qualified beneficiary* to lose coverage under the *Plan* if the first *qualifying event* had not occurred. *You* must notify the *Plan* within 60 days after the second *qualifying event* occurs if *you* want to extend *your* continuation coverage.

TERMINATION OF COBRA COVERAGE

COBRA coverage shall terminate on the first date that any of the following events occur:

1. The date on which a *qualified beneficiary* completes the maximum period of COBRA coverage for which he is eligible;

2. The date on which the *Fund* no longer provides group health coverage to any of its *participants*;

3. The date on which a self-payment for COBRA coverage is not made in a timely manner;

4. The date, after the *qualifying event*, on which a *qualified beneficiary* first becomes covered under another group health plan (as an *employee* or otherwise);

5. The individual on continuation becomes entitled to *Medicare* benefits;

6. If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;

7. The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under the *Plan*; or

8. The date the *Plan* terminates.

OTHER COVERAGE OPTIONS

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for *you* and *your* family through the Health Insurance Marketplace, Medicaid or other group health plan options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn about many of these options at www.healthcare.gov.

OTHER INFORMATION

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of the Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

If *you* or *your qualified beneficiaries* have any questions about COBRA, please contact the *Administrative Manager* at the address listed below. Also, please contact the *Administrative Manager* if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about the *Plan* benefits, eligibility, exclusions and limitations.

It is important for the *covered person* or *qualified beneficiary* to keep the *Administrative Manager* informed of any changes in marital status, dependent status or changes in address:

Zenith American Solutions, Inc.
Re: IBEW 212 Health and Welfare Fund
5420 W. Southern Avenue, Suite 407
Indianapolis, IN 46241
(513) 861-4800

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If *you* are granted a leave of absence by the *employer* as required by the Federal Family and Medical Leave Act (FMLA), *you* may continue to be covered under the Plan for the duration of the leave under the same conditions as other *employees* who are covered by the *Plan*. Coverage will continue for up to 12 weeks of unpaid full-time leave during a 12-month period for one of the following purposes, with the exception that military caregiver leave may be allowed for up to 26 weeks:

1. To care for a newborn child, or upon the placement of the child with the *employee* for adoption or foster care, so long as such leave is completed within 12 months after the birth or placement;

2. To care for a spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition;

3. For the *employee's* own serious health condition;

4. Military Care Giver Leave to care for a parent, spouse, child, or relative to whom the Employee is next of kin when the family member is a veteran who served in the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of five years before the date the veteran undergoes the medical treatment, recuperation or therapy;

5. To care for a service member whose serious injury or illness was incurred before the active duty but was aggravated by military service in the line of active duty. For veterans, a serious illness or injury is a "qualifying injury or illness" that was incurred in the line of duty on active duty in the Armed Forces and that manifested itself before or after the service member became a veteran. Only where the serious injury or illness rises to the level of a subsequent injury or illness will an employee be entitled to take leave for the same covered service member; or

6. Qualifying Exigency Leave covers members of the regular Armed Forces who are deployed to a foreign country. For members of a regular component of the Armed Forces, covered active duty means duty during deployment to a foreign country. For members of the Reserves, it means duty during deployment to a foreign country under a call or order to active duty pursuant to specified provisions of federal law. In order for an Employee to qualifying exigency leave, Employee's spouse, son, daughter or parent must be on "covered active duty." The following circumstances constitute "qualifying exigencies" under the regulation:

a. Short-notice deployment;
b. Military events and related activities;
c. Childcare and school activities;
d. Financial and legal arrangements;
e. Counseling;
f. Rest and recuperation;
g. Post-deployment activities; and
h. Additional activities not encompassed in the foregoing categories, but agreed to by the employer and employee.

For FMLA leave taken pursuant to the Families First Coronavirus Response Act between April 22, 2020, and December 31, 2020, the employer must continue to submit to the Plan regular contributions for each hour of paid leave. These contributions will be due in the same timeframe and manner as standard contributions. For all other FMLA leave, all costs of continuing coverage during FMLA leave will be treated as a charge to the Plan rather than to any particular employer.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

CONTINUATION OF BENEFITS

Federal law requires that health plans must offer to continue coverage for *employees* who are absent due to service in the uniformed services and/or their *dependents*. Coverage may continue for up to 60 months after the date the *employee* is first absent due to uniformed service. Health coverage means hospital, surgical, medical, dental or vision coverage provided under the *Plan*. Health coverage is subject to change as a result of *plan* modification. In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply. A member's USERRA rights terminate if his uniformed service ends in an undesirable conduct category of discharge.

ELIGIBILITY

An *employee* is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States of America in a time of war or national emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and for the purpose of an examination to determine fitness for duty.

An *employee's dependents* who have coverage under the *Plan* immediately prior to the date of the *employee's* covered absence are eligible to elect continuation under USERRA.

INITIAL COVERAGE AND PREMIUM PAYMENTS

Unless otherwise requested, the *employee's* coverage shall remain in place at no additional cost during the full Benefit Period in which he is deployed. At the end of the Benefit Period if continuation of *Plan* coverage is elected under USERRA, the *employee* or *dependent* is responsible for payment of the applicable cost of coverage. The cost may be up to 102% of the cost of coverage under the *Plan*, equal to that of the COBRA premium. This includes the *employee's* share and any portion previously paid by the *employer*.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will end at midnight on the earliest of:

1. The day the *Plan* is terminated;

2. The day the premium is due and unpaid;

3. The day the *employee* again becomes covered under the *Plan*;

4. The day health coverage has been continued for the period of time of 60 months, beginning the first day of absence from employment due to service in the uniformed services; or

5. The day after the *employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an *employee* and/or eligible *dependents*.

RETURNING TO WORK AFTER MILITARY SERVICE

Under the Plan, a participant who is not covered at the time of deployment will nonetheless be eligible for coverage immediately upon returning to work. The participant must provide proof of satisfactory completion of military service (Form DD 214).

The Plan Trustees have elected to credit participants' Health and Welfare accounts for military service time. The Trustees expressly reserve the right to terminate this benefit at any time. The following steps are taken to determine the hours and dollars that are to be credited to a returning participant's account following satisfactory completion of military service:

1. The average number of "USERRA" hours is calculated by averaging the number of hours worked in the 12 full months preceding deployment. The monthly USERRA hours are then multiplied by the number of months of active duty to determine the total hours to be credited.

2. The monthly USERRA hours credited are multiplied by the contribution rate in effect during each month of military duty, yielding the total dollar amount to be credited to the Health and Welfare participant.

3. The total number of hours and dollars are posted to the current eligibility period. If less than 800 hours are being credited, the *Administrative Manager* will determine the number of hours the participant had been credited during the eligibility period during which he was deployed and those hours are then added to the USERRA total to determine eligibility for the next upcoming Benefit Period.

4. Following the credit of the USERRA hours any participant with at least 800 hours in the current Eligibility Period will eligible for coverage in the following Benefit Period. Any participant who does not have the requisite hours may elect to make a short-hours payment to obtain coverage.

OTHER INFORMATION

The *employee* should contact the *Administrative Manager* with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the *Administrative Manager* of any changes in marital status, or a change of address.

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits are coordinated when *you* or *your* spouse (or any eligible *dependents*) are covered by this *Plan* as well as by another group health plan (usually *your* spouse's plan). Coordination allows benefits to be paid by two or more plans, up to but not to exceed 100% of the allowable expenses on the claim.

The weekly disability benefits are not subject to these coordination provisions. For this purpose, a plan is one which covers medical or dental expenses and provides benefits or *services* by group, franchise or blanket insurance coverage. This Coordination of Benefits (COB) provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution.

Allowable expense means any eligible expense, a portion of which is covered under one of the plans covering the person for whom claim is made. Each plan will determine allowable expenses according to their respective provisions.

EFFECT ON BENEFITS

One of the plans involved will pay benefits first. This is called the primary plan. All other plans are called secondary plans. The secondary plan will pay the difference between what the primary plan has paid and the allowable expense for any benefits covered by the secondary plan. So, when this *Plan* is the secondary plan, the sum of the benefit payable will not exceed 100% of the total allowable expenses incurred under the *Plan* and any other plans included under this provision.

ORDER OF BENEFIT PAYMENTS

In order to pay claims, it must be determined which plan is primary and which plan(s) are secondary.

Follow these guidelines to determine the order in which claims should be filed when the eligible employee or dependent is covered under more than one plan:

1. If the plan has no coordination of benefits provision, that plan will pay benefits first and this *Plan* will pay second.

2. If the other plan does have a COB provision, the plan covering the claimant (the person for whom the claim is filed) as an employee will pay first and the plan covering the person other than as an employee will pay second.

3. If *you*, the *employee*, are covered under another plan as an employee, the plan that covered the you for the longer period of time will pay first and the plan that covered the person for the shorter period time will pay second.

4. If *you* and *your* spouse are both covered as *employees* under this *Plan*, benefits will be paid for either of *you* only as the claim of an *employee*.

5. For *dependent* children:

    a. When the parents are not separated or divorced:

        i. The plan covering the parent whose birthday comes first in the year will pay first and the plan covering the parent whose birthday comes later in the year

will pay second. If both parents have the same birthday, benefits will be paid as stated in No. 8 below.

b. When the parents are separated or divorced:

i. If there is a court decree which sets financial responsibility for health care expenses for a child, the plan covering the parent who has that responsibility will pay first and the plan covering the other parent will pay second.

ii. When there is no governing court decree:

1. If the parent with custody has not remarried, the plan covering the parent who has custody of the child will pay first and the other parent's plan will pay second.
2. If the parent with custody has remarried, the plan covering the parent who has custody will pay first, the plan covering the spouse of the parent who has custody (the stepparent of the child) will pay second, and the plan covering the parent without custody will pay last.

c. If a child is covered under a group school or sports plan, this plan will pay its benefits after such other plan.

d. If *you* and *your* spouse are both covered under this *Plan* as *employees*, benefits for a *dependent* child of *yours* will be paid only as a *dependent* of one parent, subject to paragraphs a and b above.

e. If your child is covered under this *plan* as an *employee*, the child is not considered a *dependent* and the child's claim will be paid only as a claim of an *employee*.

6. If a person who has COBRA coverage is also covered under another plan as an employee, retiree or *dependent*, the COBRA coverage is secondary.

7. If a state Children's Health Insurance Program (CHIP) is involved, the Plan is primary, to the extent required by law.

8. If the above rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

COORDINATION OF BENEFITS WITH MEDICARE

Employees under age 65. If *you* a *covered person* under age 65 and eligible for *Medicare*, the benefits of the *Plan* will be payable first for as long as *you* meet the eligibility rules if any one Contributing Employer in the plan employs 100 or more persons. The benefits of *Medicare* will be payable second.

MEDICARE PART A means the Social Security program that provides *hospital* insurance benefits.

MEDICARE PART B means the Social Security program that provides medical insurance benefits.

For the purposes of determining benefits payable for any *covered person* who is eligible to enroll for *Medicare* Part B, but does not, the *Administrative Manager* assumes the amount payable under *Medicare* Part B to be the amount the *covered person* would have received if he enrolled for it. A *covered person* is considered to be eligible for *Medicare* on the earliest date coverage under *Medicare* could become effective for him.

1. **Employees continuing to work after age 65.** Under federal law, the *Plan's* actively working covered *employees* age 65 or older and their covered spouses may become eligible for *Medicare*. Under the Medicare Secondary Payer rules, the benefits of the *Plan* will be payable first and the benefits of *Medicare* will be payable second. If *you* decline coverage under the *Plan* and elect *Medicare*, *you* and *your dependents*, if any, will not be covered by the *Plan*.

2. **Retirees**. If *you* are an eligible retiree making self-payments for continued coverage and are eligible for *Medicare*, you will be covered under the Plan's Medicare Advantage program. *Co-insurance* and *deductibles* apply to any supplemental amount that the *Plan* pays. If *your* spouse is eligible for *Medicare*, he or she will also be eligible for coverage under the Medicare Advantage program. *Co-insurance* and *deductibles* apply to any supplement amount that the *Plan* pays on behalf of *your* spouse. If *you* or *your* spouse choose to not enroll in Medicare or maintain enrollment in Medicare, you will not be able to participate in the Plan's Medicare Advantage program *e*.

ENROLLMENT IN MEDICARE

You and *your* spouse are each responsible for enrolling in *Medicare* Part B. (Enrollment in Part A is automatic when you sign up for Social Security benefits.) If *you* or *your* spouse are eligible to participate in *Medicare*, contact your local Social Security office for more information about enrollment. When *you* or *your* spouse have enrolled in Part B, notify the *Administrative Manager*.

RIGHT OF RECOVERY

The *Plan* reserves the right to recover benefit payments made for an allowable expense under the *Plan* in the amount that exceeds the maximum amount the *Plan* is required to pay under these provisions. This right of recovery applies to the *Plan* against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations that according to these provisions, owe benefits due for the same allowable expense under any other plan.

The *Board of Trustees* has sole discretion in deciding against whom this right of recovery will be exercised.

REIMBURSEMENT/SUBROGATION

Subrogation and reimbursement allows the *Fund* to recoup the value of any benefits (medical, disability, etc.) paid on behalf of a person covered by this *Plan* who is injured or suffers an illness through the act or omission of another person or entity accountable for the injury or illness (hereinafter called "Accountable Person" or "Accountable Persons"). The subrogation and reimbursement process helps the overall financial stability of the *Fund* by ensuring that the *Plan* is not the only entity paying claims for illness and injuries caused by Accountable Persons.

By accepting benefits from the *Fund*, every *covered person* shall be deemed to have conclusively agreed to cooperate with the *Fund* to enforce its subrogation and reimbursement rights and to hold any recovery in trust for the benefit of the *Fund* in accordance with the terms of this *Plan*:

1. The *Plan* shall be repaid the full amount of the *covered expenses* it pays from any amount received from a Accountable Person for the *bodily injuries* or losses that necessitated such *covered expenses*. Without limitation, "amounts received from a Accountable Person" specifically includes, but is not limited to, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments, and any other settlements, judgments or insurance proceeds from any source in connection with the illness or accident. The *Plan's* rights apply to any recovery for any *covered person* regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

2. The *Plan's* right to repayment is, and shall be, prior and superior to the right of any Accountable Person, including the *covered person*, and 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 *covered person* 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 *covered person* to be "made whole" before the Plan is entitled to assert its subrogation rights.

3. The right to recover amounts from a Accountable Person for the injuries or losses that necessitate *covered expenses* is jointly owned by the *Plan* and the *covered person*. The *Plan* is subrogated to the *covered person's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the *Plan* as prescribed above; the *Plan* has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the *Plan* is subrogated are, and shall be, prior and superior to the rights of any Accountable Person, including the *covered person*. Any recovery, regardless of the source, must be held in trust by the *covered person* for the benefit of the *Plan.*

4. The *covered person* will cooperate with the *Plan* in any effort to recover from a Accountable Person for the *bodily injuries* and losses that necessitate *covered expense* payments by the *Plan*. The *covered person* will notify the *Plan* immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the *Plan*.

   Neither the *Plan* nor the *covered person* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

5. The Plan's rights of reimbursement and subrogation shall not be affected, reduced or eliminated by the make whole doctrine, comparative or contributory fault or the common fund doctrine, or any other federal or state common law defense.

6. The Plan is entitled to recover *your* debt to the Plan (such as, but not limited to, instances of overpayment) by offsetting future employer contributions.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the *Administrative Manager* and when asked, assist the *Administrative Manager* by:

1. Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;

2. Obtaining medical information and/or records from any provider as requested by the *Administrative Manager* ;

3. Providing information regarding the circumstances of *your sickness* or *bodily injury*;

4. Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits; and

5. Providing information the *Administrative Manager* requests to administer the *Plan*.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to a *bodily injury* or *sickness* for which the information is sought, until the necessary information is satisfactorily provided.

The *covered person* must sign forms assigning subrogation and reimbursement rights to the *Plan*. The *Administrative Manager* may withhold payment of any benefits due under the *Plan* until it receives the signed forms. Payment of *Plan* benefits 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 *covered person* 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*.

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with the *Administrative Manager* in order to protect the *Plan's* recovery rights. Cooperation includes promptly notifying the *Administrative Manager* that *you* may have a claim, providing the *Administrative Manager* relevant information, and signing and delivering such documents as the *Administrative Manager* reasonably request to secure the *Plan's* recovery rights. *You* agree to obtain the *Plan's* consent before releasing any Accountable Person from liability for payment of medical expenses. *You* agree to provide the *Administrative Manager* with a copy of any summons, complaint or any other process serviced in any lawsuit in which *you* seek to recover compensation for *your bodily injury* or *sickness* and its treatment.

You will do whatever is necessary to enable the *Administrative Manager* to enforce the *Plan's* recovery rights and will do nothing after loss to prejudice the *Plan's* recovery rights.

You agree that *you* will not attempt to avoid the *Plan's* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide the *Administrative Manager* such notice or cooperation, or any action by the *covered person* resulting in prejudice to the *Plan's* rights will be a material breach of this *Plan* and will result in the *covered person* being personally responsible to make repayment. In such an event, the

Plan may deduct from any pending or subsequent claim made under this *Plan* any amounts the *covered person* owes the *Plan* until such time as cooperation is provided and the prejudice ceases.

TRUSTEES' DISCRETION

Even though the subrogation rights of the *Fund* are specifically and unequivocally due from the first dollar received by the *covered person*, the *Plan* reserves the right to exercise judgment as to the facts of each case. In determining each individual case, even though the *Fund* 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 *covered person*, in the sole discretion of the *Trustees*.

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the *Plan*.

CONTESTABILITY

The *Plan* has the right to contest the validity of *your* coverage under the *Plan* at any time.

RIGHT TO REQUEST OVERPAYMENTS

The *Plan* reserves the right to recover any payments made by the *Plan* that were:

1. Made in error; or

2. Made to *you* or any party on *your* behalf where the *Plan* determines the payment to *you* or any party is greater than the amount payable under this *Plan*.

The *Plan* has the right to recover against *you* if the *Plan* has paid *you* or any other party on *your* behalf. This includes (a) offsetting the amount against any future medical claims for which you and/or your dependent(s) may be entitled to have paid for by the Plan; (b) retaining Employer Contributions to the Plan made on your behalf; and/or (c) bringing a civil action.

WORKERS' COMPENSATION NOT AFFECTED

The *Plan* is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease act or law.

WORKERS' COMPENSATION

If benefits are paid by the *Plan* and the *Plan* determines *you* received Workers' Compensation for the same incident, the *Plan* has the right to recover as described under the Reimbursement/Subrogation provision. The *Plan* will exercise its right to recover against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier;

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the *Plan*, *you* will notify the *Administrative Manager* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse the *Plan* as described above.

CONSTRUCTION OF PLAN TERMS

The *Plan* has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the *Plan*, including, without limitation, the benefits provided thereunder, the obligations of the *covered person* and the recovery rights of the *Plan*; such construction and prescription by the *Plan* shall be final and uncontestable.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If *you* have had or are going to have a mastectomy, *you* may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the covered mastectomy was performed;
- *Surgery* and reconstruction of the other breast to produce a symmetrical appearance; Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Contact *your employer* if *you* would like more information on WHCRA benefits.

FRAUD

Anyone who intentionally includes false or misleading information on any enrollment material, claims submission, or other written material pertaining to the *Plan*, in an attempt to defraud or deceive is guilty of insurance fraud or material misrepresentation. Any Participant who engages in an activity intended to defraud this Plan or who engages in material misrepresentation, as determined by the Board of Trustees, that Participant and his or her

Dependents will immediately lose heath care coverage along with all HRA credits retroactively from the date of the fraud. The Participant and/or Dependent who engages in such activity will face disciplinary action and/or prosecution. Furthermore, any Participant or Dependent who receives money from the Plan or has benefits paid on his or her behalf which he or she is not entitled to will be required to fully reimburse the Plan. If not fully reimbursed the Trustees have the right to: (a) offset the unpaid amount against any future medical claims for which the Participants and/or Dependent(s) may be entitled to have paid for by the Plan; (b) retain Employer Contributions to the Plan made on behalf of the Participant while said Participant was suspended; and/or (c) bring a civil action and/or refer the case for criminal prosecution.

PRIVACY POLICY (HIPAA)

The *Plan* is required to protect the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services ("HHS"). Protected Health Information (PHI) is defined as all individually identifiable health information transmitted or maintained by the *Plan* that relates to *your* past, present, or future health, treatment, or payment for health care services.

This Privacy Notice is provided by the *Local Union No. 212, IBEW Health and Welfare Plan.* This notice describes the *Plan's* privacy practices, legal duties, and your rights concerning *your* PHI. The *Plan* must follow the privacy practices described in this notice while it is in effect. This policy will remain in effect until the *Plan* publishes and issues a new notice.

The Local Union No. 212, IBEW Health and Welfare Plan ("*Plan*") is required by law to take reasonable steps to ensure the privacy of *your* personally identifiable health information and to inform *you* about:

1. The *Plan's* uses and disclosures of PHI;

2. *Your* privacy rights with respect to *your* PHI;

3. The *Plan's* duties with respect to your PHI;

4. *Your* right to file a complaint with the *Plan* and to the secretary of the US Department of Health and Human Services; and

5. The person or office to contact for further information about the *Plan's* privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the *Plan*, regardless of form (oral, written, electronic).

Section 1. Notice of PHI Uses and Disclosures

Upon *your* request, the *Plan* is required to give *you* access to certain PHI in order to inspect and copy it. Use and disclosure of *your* PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the *Plan's* compliance with the privacy regulations.

Pursuant to the provisions of the Genetic Non-Discrimination Act (GINA), genetic information will be treated as health information.

Uses and disclosures to carry out treatment, payment and health care operations.

Although the *Plan* and the *Administrative Manager* do not normally maintain or retain PHI, sometimes it does temporarily use such information. PHI would be maintained and used by the insurance companies/benefit service vendors retained by the *Plan*. The following categories give details about the times when the *Plan* could have access to *your* PHI. Not every use or disclosure in a category will be listed, but all of the uses and disclosures permitted by law fall within the categories.

To Help With Treatment. The *Plan* itself does not directly provide any health care treatment. However, the *Plan* may use or share *your* PHI care information to help health care providers serve or treat *you*. For

example, the *Plan* may share information about allergies to a hospital emergency department if needed to render appropriate emergency care.

To Obtain Payment of Claims. The *Plan* may use and share *your* PHI to make payment possible for covered health care that *you* receive. This includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

For example, the *Plan* may tell a doctor whether *you* are eligible for coverage or what percentage of the bill will be paid by the *Plan*.

Health care operations. These include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the *Plan* may use information about *your* claims to refer *you* to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

As Required To Comply with Laws and Government Authorities. The *Plan* will disclose *your* PHI when required by federal, state or local law, regulation, or court or government agency order. For example, as permitted or required by law, the *Plan* must reveal PHI when: required to work with public officials to prevent or manage a serious threat to public health or safety; required for government monitoring of health care, civil rights laws, or other government oversight activities; order to do so by a court or other lawful process relating to a civil lawsuit or criminal matter; and directed by law enforcement officials, coroners, medical examiners, or national security officials in the lawful pursuit of their duties. If ordered by a court or other legal process to provide PHI about *you*, the *Plan* will make an effort to tell *you* about the request.

Use and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release. Disclosure of *your* PHI to family members, other relatives and *your* close personal friends is allowed if:

1. The information is directly relevant to the family or friend's involvement with *your* care or payment for that care; and
2. *You* have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Except as otherwise indicated in this notice, uses and disclosures will be made only with *your* written authorization subject to *your* right to revoke such authorization.

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures. You may request the *Plan* to restrict uses and disclosures of *your* PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by *you* who are involved in *your* care or payment for *your* care. However, the *Plan* is not required to agree to *your* request.

The *Plan* will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or *your* personal representative will be required to complete a form to request restrictions on uses and disclosures of *your* PHI.

Such requests should be made to the Privacy Officer:

Zenith American Solutions, Inc.
5420 W. Southern Avenue, Suite 407
Indianapolis, IN 46241
(513) 861-4800

Right to Inspect and Copy PHI. *You* have the right to inspect and obtain a copy of *your* PHI for as long as the *Plan* maintains the PHI.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the *Plan* is unable to comply with the deadline.

You or *your* personal representative will be required to complete a form to request access to the PHI in *your* designated record set. Requests for access to PHI should be made to the Privacy Officer.

If access is denied, *you* or *your* personal representative will be provided with a written denial setting forth the basis for the denial, a description of how *you* may exercise those review rights and a description of how *you* may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. *You* have the right to request the *Plan* to amend *your* PHI or a record about *you* in a designated record set for as long as the PHI is maintained in the designated record set.

The *Plan* has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the *Plan* is unable to comply with the deadline. If the request is denied in whole or part, the *Plan* must provide *you* with a written denial that explains the basis for the denial. *You* or *your* personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of *your* PHI.

Requests for amendment of PHI in a designated record set should be made to the Privacy Officer. *You* or *your* personal representative will be required to complete a form to request amendment of the PHI in *your* designated record set.

The Right to Receive an Accounting of PHI Disclosures. At *your* request, the *Plan* will also provide *you* with an accounting of disclosures by the *Plan* of *your* PHI during the six years prior to the date of *your* request. However, such accounting need not include PHI disclosures made: 1) to carry out treatment, payment or health care operations; 2) to individuals about their own PHI; or 3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If *you* request more than one accounting within a 12 month period, the *Plan* will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. To obtain a paper copy of this Notice, contact the Privacy Officer.
A Note about Personal Representatives. *You* may exercise *your* rights through a personal representative. *Your* personal representative will be required to produce evidence of his/her authority to act on *your* behalf before

that person will be given access to *your* PHI or allowed to take any action for *you*. Proof of such authority may take one of the following forms:

1. A power of attorney for health care purposes, notarized by a notary public;
2. A court order of appointment of the person as the conservator or guardian of the individual; or
3. An individual who is the parent of a minor child.

The *Plan* retains discretion to deny access to *your* PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3. The Plan's Duties

The *Plan* is required by law to maintain the privacy of PHI and to provide each *covered person* and *beneficiary* with notice of its legal duties and privacy practices.

The *Plan* is required to comply with the terms of this notice. However, the *Plan* reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the *Plan* retroactively if needed. If a privacy practice is changed, a revised version of this notice will be provided (to all past and present *covered persons* and *beneficiaries*) for whom the *Plan* still maintains PHI. This notice will be delivered by first class mail to the most recent address on file with the *Administrative Manager*.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the *Plan* or other privacy practices stated in this notice.

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

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

1. Disclosures to or requests by a health care provider for treatment;
2. Uses or disclosures made to the individual;
3. Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. Uses or disclosures that are required by law; and
5. Uses or disclosures that are required for the Plan's compliance with legal regulations.

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

In addition, the *Plan* may use or disclose "summary health information" to the *Plan* sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims

history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Breach Notification Rights for Unsecured Protected Health Information

The HITECH Act requires HIPAA-covered entities to provide notification to affected individuals and to HHS following the discovery of a breach of unsecured protected health information. In addition, in some cases of breach involving more than 500 individuals, the Act requires covered entities to provide notification to the media. Finally, the Act requires the Secretary of HHS to post on an HHS Web site a list of covered entities that experience breaches of unsecured protected health information involving more than 500 individuals.

If your PHI is breached, the *Plan* will notify you without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Notice will be provided via first-class mail to your most recently known address; therefore, it is important to keep the *Plan* information of your current mailing address.

Section 5. Your Right to File a Complaint with the Plan or the HHS Secretary

If *you* believe that *your* privacy rights have been violated, *you* may complain to the *Plan* in care of the Privacy Officer. If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Privacy Officer . Note that this right to file a complaint extends specifically to, but is not limited to, the right to complain about the Plan's implementation of the breach notification process, as detailed in Section 4 above.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

The *Plan* will not retaliate against *you* for filing a complaint.

Section 6. Whom to Contact at the Plan for More Information

If *you* have any questions regarding this notice or the subjects addressed in it, *you* may contact the Privacy Officer.

PHI use and disclosure by the *Plan* is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). *You* may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

CLAIMS AND APPEALS PROCEDURES

SUBMITTING A CLAIM

This section describes what *you* as a *covered person* (or *your* authorized representative) must do to file a claim for *Plan* benefits.

1. A claim must be filed with the *Administrative Manager* in writing and delivered to the *Administrative Manager* by mail, postage prepaid or e-mail. However, a submission to obtain pre-authorization may also be filed with the *Administrative Manager* by telephone.

2. Claims must be submitted to the *Administrative Manager* at the address indicated in the documents describing the *Plan* or on *your* identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

3. Also, claims submissions must be in a format acceptable to the *Administrative Manager* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of *protected health information* and/or electronic claims standards will not be accepted by the *Plan*.

4. Claims submissions must be timely. You must file claims as soon as reasonably possible after they are incurred, and in no event later than 12 months after the date of loss, except if *you* were legally incapacitated. *Plan* benefits are only available for claims that are incurred by a *covered person* during the period that he is covered under the *Plan*.

5. Claims submissions must be complete. They must contain, at a minimum:
   a. The name of the *covered person* who incurred the *covered expense*;
   b. The name and address of the health care provider;
   c. The diagnosis of the condition;
   d. The procedure or nature of the treatment;
   e. The date of and place where the procedure or treatment has been or will be provided;
   f. The amount billed and the amount of the *covered expense* not paid through coverage other than *Plan* coverage, as appropriate;
   g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

Presentation of a *prescription* to a *pharmacy* does not constitute a claim. If *you* are required to pay the cost of a covered *prescription* drug, however, *you* may submit a claim based on that amount to the *Administrative Manager*.

A general request for an interpretation of *Plan* provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the *Plan*, should be directed to the *Administrative Manager*.

Mail medical claims and correspondence to:
Zenith American Solutions, Inc.
Re: IBEW 212 Health and Welfare Fund
5420 W. Southern Avenue, Suite 407
Indianapolis, IN 46241
(513) 861-4800

PROCEDURAL DEFECTS

If a *pre-service claim* submission is not made in accordance with the *Plan's* procedural requirements, the *Administrative Manager* will notify *you* of the procedural deficiency and how it may be cured no later than five (5) days (or within 24 hours, in the case of an *urgent care claim*) following the failure. A *post-service claim* that is not submitted in accordance with these claims procedures will be returned to *you*.

ASSIGNMENTS AND REPRESENTATIVES

The Plan reserves the right to make payments directly to you. When this occurs, you must pay the provider and the Plan is not obligated to pay additional amounts. You cannot assign your right to receive payment to anyone else nor can you authorize someone else to receive your payments for you, including your provider. We will not honor an assignment of your 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 may be liable for medical care, treatment or services.

In addition, *you* may designate an authorized representative to act on *your* behalf in pursuing a benefit claim or appeal. The designation must provide written authorization for the disclosure of *protected health information* with respect to the claim between the *Plan*, the *Administrative Manager* and the authorized representative. If the *Plan Administrator* determines that the document is not sufficient to constitute a designation of an authorized representative, then the *Plan* will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

1. Any document designating an authorized representative must be submitted to the *Administrative Manager* in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which the *Administrative Manager* may verify with the *claimant* prior to recognizing the authorized representative status.

2. In any event, a health care provider with knowledge of a *claimant's* medical condition acting in connection with an *urgent care claim* will be recognized by the *Plan* as the *claimant's* authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the *covered person*, such as whether and how to appeal a claim denial.

TYPES OF CLAIMS

There are two basic types of claims under the *Plan*: health care and disability (weekly income disability benefits) claims. The disability claims procedure is described in the section titled "Weekly Disability Income Benefits." Health care claims, which include major medical and prescription drug claims, are further divided into four types of claims:

1. **Post-Service**: A claim for health care benefits that *you* have already received the service.

2. **Pre-Service**: A claim for care or treatment where *you* are required to get preauthorization.

3. **Urgent Care**: A claim for care or treatment that would:

a. Seriously jeopardize *your* life or health if normal pre-service standards were applied; or
b. Subject *you* to severe pain that cannot be adequately managed without the care or treatment for which preauthorization is sought, in the opinion of a doctor with knowledge of *your* condition.

4. **Concurrent**: A claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits or termination of the benefits.

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

CLAIMS DECISIONS

After submission of a claim by a *claimant*, the *Administrative Manager* will notify the *claimant* within a reasonable time, as follows:

PRE-SERVICE CLAIMS

Pre-service requests for benefits are those requests that required notification or approval prior to receiving medical care. If *you* have a pre-service request for benefits, and it was submitted properly with all needed information, *you* will receive written notice of the decision from the *Administrative Manager* within 15 days of receipt of the request. However, this period may be extended by an additional 15 days, if the *Administrative Manager* determines that the extension is necessary due to matters beyond the control of the *Plan*. The *Administrative Manager* will notify *you* of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the *Administrative Manager* expects to make a decision.

If *you* filed a pre-service request for benefits improperly, the *Administrative Manager* will notify *you* of the improper filing and how to correct it within 5 days after the pre-service request for benefits was received.

If additional information is needed to process the pre-service request, the *Administrative Manager* will notify *you* of the information needed within 15 days and pend *your* request until all information is received. Once notified of the extension *you* then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the *Administrative Manager* will notify *you* of the determination within 15 days after the information is received. If *you* don't provide the needed information within the 45-day period, *your* request for benefits will be denied.

URGENT CARE CLAIMS

Urgent requests are those that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize *your* life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain.

The *Administrative Manager* will make the determination whether a claim is an *urgent care claim* on the basis of information furnished by or on behalf of *you*. In making this determination, the *Plan Administrator* will exercise its judgment, with deference to the judgment of a physician with knowledge of *your* condition. Accordingly, the *Administrative Manager* may require *you* to clarify the medical urgency and circumstances that support the *urgent care claim* for expedited decision-making.
In these situations:

1. The *Administrative Manager* will notify *you* of a favorable or adverse determination as soon as possible, taking into account the medical exigencies particular to your situation, but not later than 72 hours after receipt of the *urgent care claim* by the *Administrative Manager*.

2. If *you* filed an urgent request for benefits improperly, the *Administrative Manager* will notify *you* of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, the *Administrative Manager* will notify *you* of the information needed within 24 hours after the request was received. *You* then have 48 hours to provide the requested information.

3. *You* will be notified of a determination no later than 48 hours after:

    a. The *Administrative Manager's* receipt of the requested information; or
    b. The end of the 48-hour period within which *you* were to provide the additional information, if the information is not received within that time.

CONCURRENT CARE DECISIONS

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and *your* request to extend the treatment is an urgent request for benefits as defined above, the *Administrative Manager* will decide *your* request within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The *Administrative Manager* will make a determination on *your* request for the extended treatment within 24 hours from receipt of *your* request. If *your* request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for benefits and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and *you* request to extend treatment in a non-urgent circumstance, *your* request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

POST-SERVICE CLAIMS

Post-service claims are those claims that are filed for payment of benefits after medical care has been received. If *your* post-service claim is denied, *you* will receive a written notice from the *Administrative Manager* within 30 days of receipt of the claim, as long as all needed information was provided within the claim. The *Administrative Manager* will notify *you* within this 30-day period if additional information is needed to process the claim and may request the one-time 15-day extension and will pend *your* claim until all information is received. Once *you* are notified of the extension or missing information, *you* then have at least 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the *Administrative Manager* will notify *you* of the denial within 15 days after the information is received. If *you* don't provide the needed information within the 45-day period, *your* claim will be denied.

TIME FOR DECISIONS

The periods of time for claims decisions presented above begin when a claim is received by the *Plan*, in accordance with these claims procedures.

When an *employee's* child is subject to a medical child support order, the *Administrative Manager* will make reimbursement of eligible expenses paid by *you*, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the medical child support order.

Payment of benefits under this *Plan* will be made in accordance with an assignment of rights for *you* and *your dependents* as required under state Medicaid law.

Benefits payable on behalf of *you* or *your* covered *dependent* after death will be paid, at the *Plan's* option, to any *family member(s)* or *your* estate.

The *Administrative Manager* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the *Plan* from further liability.

Any payment made by the *Administrative Manager* in good faith will fully discharge it to the extent of such payment.

Payments due under the *Plan* will be paid upon receipt of written proof of loss.

INITIAL DENIAL NOTICES

Notice of a claim denial (including a partial denial) will be provided to *you* by mail, postage prepaid, or by e-mail, as appropriate, within the time frames noted above.

However, notices of adverse decisions involving *urgent care claims* may be provided to *you* orally within the time frames noted above for expedited *urgent care claim* decisions. If oral notice is given, written notification will be provided to *you* no later than 3 days after the oral notification. The notice will provide a description of the *Plan's* expedited review procedures applicable to such claims.

A claims denial notice will state the specific reason or reasons for the adverse determination, the specific *Plan* provisions on which the determination is based, a description of the *Plan's* appeal procedures and associated timeline, and a statement of the *claimant's* right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review. A copy of the *Plan* provision relied upon will be provided to a *claimant* free of charge upon request. The notice will also include 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.

If the adverse determination is based on *medical necessity, experimental, investigational or for research purposes,* or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

APPEALS OF ADVERSE DETERMINATIONS

An "adverse determination" means a denial, reduction, termination or failure to provide or make payment, in whole or in part, of a benefit for a filed claim. "Adverse determination" shall also include any rescission of coverage, regardless of whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

INTERNAL APPEALS PROCEDURES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

You must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). The *Plan Administrator* will make the determination on the appeal

The appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

Board of Trustees
c/o Zenith American Solutions, Inc.
5420 W. Southern Avenue, Suite 407
Indianapolis, IN 46241
(513) 861-4800

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

A *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial being appealed is based in whole, or in part, upon a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is *experimental, investigational, or for research purposes*, or not *medically necessary* or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

For internal appeals, the following additional standards apply:

1. Note that an "adverse determination" includes rescissions of coverage, pre- and post-service claim determinations, exclusions, limitations, and eligibility determinations;

2. 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;

3. Notices must be provided in a culturally and linguistically appropriate manner;

4. All claims and appeals must be handled in a way that is designed to ensure the decision-maker's impartiality; and

5. Notices to claimants must provide additional content such as identifying information on the claim, denial codes, description of available appeals processes and contact information for health insurance consumer assistance.

Time Periods for Decisions on Appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care Claims	As soon as possible, but not later than 72 hours after the *Administrative Manager* receives the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next 3 days).

Pre-Service Claims	Within a reasonable period, but not later than 30 days after the *Administrative Manager* receives the appeal request.
Post-Service Claims	Generally, no later than the next quarterly meeting after receipt of the appeal request. If the appeal request is filed within 30 days preceding the date of such meeting, the decision will be made by no later than the date of the second meeting following receipt of the appeal. If special circumstances require a further extension, a decision shall be rendered not later than the third quarterly meeting following the receipt of the appeal request. The *Administrative Manager* shall notify the claimant of the decision as soon as possible, but not later than 5 days after the decision is made.
Concurrent Care Decisions	Within the time periods specified above, depending upon the type of claim involved.

LIMITATIONS PERIOD

No action at law or equity based on an adverse determination under the Plan shall be brought after the expiration of **three (3) years** from the time of the final appeal denial.

RESTRICTION ON VENUE

A participant or Beneficiary shall only bring an action in connection with the Plan in the United States District Court for the Southern District of Ohio.

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to *you* by mail, postage prepaid, or by e-mail, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will convey the specific reason or reasons for the adverse determination and the specific *Plan* provisions on which the determination is based.

The notice will also disclose any internal *Plan* rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on *medical* necessity or *experimental, investigational, or for research purposes* or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to *your* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed claim, *you* will be entitled to receive, upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination.

2. Submitted, considered or generated in the course of making the benefit determination.

3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations.
4. That constitutes a statement of policy or guidance with respect to the *Plan* concerning the denied treatment, without regard to whether the statement was relied on.

EXHAUSTION

Upon completion of the internal appeals process under this section, *you* will have exhausted *your* administrative remedies under the *Plan*. If the *Administrative Manager* or *Plan Administrator* fails to complete a claim determination or appeal within the time limits set forth above, *you* may treat the claim or appeal as having been denied, and *you* may proceed to the next level in the review process. After exhaustion of the internal appeals process, *you* may pursue an external review. You may also pursue any other legal remedies available to *you* which may include bringing a civil action under ERISA § 502(a) for judicial review of the *Plan's* determinations, and compliance with the internal claims and appeals process requirements. Additional information may be available from a local U.S. Department of Labor Office.

EXTERNAL APPEALS PROCEDURES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

You have the right to request an "external review" of your adverse benefit determination if the denied claim involves (i) medical judgment (excluding those that involved only contractual or legal interpretation without any use of legal judgment), (ii) a rescission of coverage, or (iii) determinations regarding the surprise billing and cost-sharing protections under the No Surprises Act. The timeline for an external review is as follows:

1. Request for External Review: Must be allowed if requested within four (4) months after receipt of notice of adverse benefit determination.

2. Preliminary Review: Must be completed within five (5) business days after receipt of request and within one business day after completion of preliminary review. The Plan must issue notification in writing to the claimant. Note that for an urgent care issue, the preliminary review must be done immediately and the claimant must be notified of the decision immediately.
3. Referral to Independent Review Organization (IRO): The Plan must contract with at least three (3) IROs. Within five (5) 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 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.)
4. 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).

LEGAL ACTIONS AND LIMITATIONS

No action at law or inequity may be brought with respect to *Plan* benefits until all remedies under the *Plan* have been exhausted and then prior to the expiration of the applicable limitations period specified under the *Plan*.

DISABILITY CLAIMS PROCEDURE

The *Administrative Manager* will make a decision on the claim and notify you of the decision within 45 days. This period may be extended by the Plan for up to thirty (30) days, provided the *Administrative Manager* both determines that an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial forty-five (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 thirty (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 an additional thirty (30) days.

Calculation of Time Periods. 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 reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Adverse Determination. An adverse determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. It also includes any rescission of disability coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except if it is the result of a failure to timely pay required premiums or contributions.

Content of Notice. The *Administrative Manager* shall provide a Claimant with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the Claimant and in a culturally and linguistically appropriate manner:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the determination is based;

3. 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;

4. 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 an adverse benefit determination on review;

5. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

6. 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;

7. 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 benefit determination;

8. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    a. The views presented by health professionals treating 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, without regard to whether the advice was relied upon in making the benefit determination; and
    c. A disability determination by the Social Security Administration

Appeals Procedure

1. The Claimant shall have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

2. The Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

3. The Claimant shall be provided, 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.

4. The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

5. On appeal the Claimant shall be provided with any new or additional evidence or rationale considered or relied upon in connection with the claim automatically and free of charge; such evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the decision will be made. The Claimant shall be provided with a review that does not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual. In deciding an adverse benefit determination that is based in whole or in part on medical judgment including determinations regarding whether a treatment or drug is experimental, investigational, or not medically necessary, the Plan will consult a health care professional who has the appropriate training and experience in the medical field involved in the judgment and the medical or vocational expert will be identified. The healthcare professional engaged for consultation will not be an individual who was consulted in making the adverse benefit determination that is the subject of the appeal, nor their subordinate. The *Administrative Manager* will identify any 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.

6. The Trustees shall make a benefit determination no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within thirty (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 (2^{nd}) meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third (3^{rd}) meeting of the Trustees 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 provide the Claimant with written notice of the extension, describing the
special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The *Administrative Manager* shall notify the Claimant of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

7. 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 in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review 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.

8. The *Administrative Manager* shall provide the Claimant with a written or electronic notification of the Plan's benefit determination on review. The notification shall set forth, in a manner reasonably calculated to be understood by the Claimant and in a culturally and linguistically appropriate manner:

    a. The specific reason or reasons for the adverse determination;
    b. Reference to the specific Plan provision on which the benefit determination 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;
    d. A statement of the Claimant's right to bring an action under Section 502(a) of ERISA and a statement of the applicable contractual limitation period that applies to the Claimant's right to bring such as action, including the calendar date on which the contractual limitations period expires for the claim; and
    e. The following statement: "You and your plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.";
    f. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
    g. 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
    h. 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 benefit determination.
    i. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
        i. The views presented by health professionals treating the Claimant and vocational professionals who evaluated the Claimant;

ii. The views of medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the benefit determination; and/or
iii. A disability determination by the Social Security Administration.

Statute of Limitations. No action at law or equity shall be brought by any Participant or Beneficiary after the expiration of three (3) years from the date the Board provides written notice of a decision on appeal of an adverse benefit determination. Failure to bring an action within this three (3) year period shall forever bar such action.

De Minimis Violations. If the Plan fails to strictly adhere to all the requirements of the claims and appeals section of the Plan with respect to the claim, the Claimant is deemed to have exhausted the administrative remedies available under the Plan, except for de minimis violations explained below. As such, the claimant is entitled to pursue any 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 claims for 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, 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 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.

External Appeals Procedures under the Patient Protection and Affordable Care Act
You have the right to request an "external review" of your adverse benefit determination. The timeline for an external review is as follows:

Request for External Review: Must be allowed if requested within four (4) months after receipt of notice of adverse benefit determination.

Preliminary Review: Must be completed within five (5) business days after receipt of request and within one business day after completion of preliminary review. The Plan must issue notification in writing to the claimant.

Referral to Independent Review Organization (IRO): The Plan must contract with at least three (3) IROs. Within five (5) business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. The IRO must provide written notice of its decision within 45 days of assignment.

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).

Restriction on Venue
A participant or Beneficiary shall only bring an action in connection with the Plan in the United States District Court for the Southern District of Ohio.

STATEMENT OF ERISA RIGHTS

As a participant in Local Union No. 212, IBEW Health and Welfare Fund, *you* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all *Plan* participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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.

2. Obtain, upon written request from the Plan Administrator, copies of documents governing the operation of the *Plan*, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for copies.

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

PRUDENT ACTIONS OF PLAN FIDUCIARIES

In addition to creating rights for *Plan* participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. 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 Plan 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 domestic relations order or 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, if for example, it finds *your* claim is frivolous.

ASSISTANCE WITH 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 or visiting the U.S. Department of Labor website at http://www.dol.gov/ebsa.

END OF DOCUMENT

May 2023