Electrical Insurance Trustees Health and Welfare Plan

For Construction Workers

Summary Plan Description

April 1, 2025

About This Summary Plan Description ("SPD")

This SPD is intended to give you an accurate summary of the benefits and provisions of the Electrical Insurance Trustees Health and Welfare Plan for Construction Workers (the "Plan"). This SPD and the Trust Agreement contain a detailed description of the rules, regulations, benefits, and provisions of the Plan. This SPD (and any future amendments to it) also serves as the official Plan document.

Only the Board of Trustees is authorized to interpret the Plan described in this SPD. The Board of Trustees' interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. Benefits will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decides, in their sole and unrestricted discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan. If a decision of the Board of Trustees is challenged in court, it is the intention of the parties that such decision will be upheld unless it is determined to be arbitrary or capricious. No agent, representative, officer, or other person from the Union or an employer has the authority to speak for the Board of Trustees or to act contrary to the written terms of the governing Plan documents.

This SPD describes benefits that are provided under the Plan. Your eligibility for each benefit is based on whether you meet the eligibility requirements for a particular benefit. **You may not assume you are covered by a benefit because it is described in this SPD.** You may call the Fund Office if you have questions about your eligibility and benefits.

If you have questions about your eligibility under the Plan or a claim for benefits, only the Executive Director or her authorized representatives are authorized to answer your questions for the Board of Trustees.

The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change any and all provisions of the Plan at any time and from time to time. The Plan is maintained for the exclusive benefit of its participants and beneficiaries.

Keep the Fund Office informed of any changes in the address or contact information for you and your Dependents. It is your responsibility to ensure that the Fund Office has an accurate address and contact information for you and your Dependents. You should also keep a copy, for your records of any notices you send to or receive from the Plan.

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Important Contact Information

Electrical Insurance Trustees Fund Office ("Fund Office")		
6195 West 115th Street Alsip, IL 60803	(312) 782-5442	

Health and Wellness Center – Premise Health		
6195 West 115th Street, Suite A Alsip, IL 60803	(312) 262-7002	
4179 Dundee Road, Suite A106 Northbrook, IL 60062	(847) 402-2300	

Vision Center – VSP		
6195 West 115th Street, Suite B Alsip, IL 60803	(312) 795-5841	

Medical, Dental & Behavioral Health & Substance Abuse Benefits

Blue Cross Blue Shield of Illinois

P.O. Box 80517 Chicago, IL 60680	Customer Service	(800) 862-3386	
	TTY Only Customer Service	(800) 526-0844	
	Voice Assisted Customer Service	(800) 526-0857	
	PPO Provider Finder	(800) 810-2583	
	Pre-Authorization/Pre-Certification	(800) 635-1928	
	24/7 Nurse Help Line	(800) 299-0274	
	Dental & Orthodontia	(800) 862-3386	
	Behavioral Health/Substance Abuse Customer Service	(800) 851-7498	

Prescription Drug Benefits			
CVS Caremark			
P.O. Box 94467 Palatine, IL 60094	Customer Service	(800) 566-5693	
	Pharmacist Help Line	(800) 345-5413	
	Mail Order Prescription Services	(800) 566-5693	
	Specialty Customer Care	(800) 237-2767	www.CVSspecialty.com
	Specialty Prescription Fax	(800) 323-2445	
Member Assistance Program (MAP)			
Employee Resource Systems, Inc. (ERS)			
No claim forms required	24/7 Assistance Program	(800) 292-2780	
Vision Benefits			
Vision Service Plan (VSP)			
Online claim forms	Customer Service	(800) 877-7195	
Life Insurance and AD&D Benefits			
Voya Financial			
Kocher Group	Customer Service	(888) 212-7882	
Health Reimbursement Arrangement (HRA)			
WageWorks/HealthEquity			
P.O. Box 14053, Lexington, KY, 40512	Customer Service	(877) 924-3967	
	Card Activation	(866) 363-4128	

Section 1: Health & Wellness Centers and Vision Clinic

If you are an Active Employee or Retiree and you and your eligible Dependents are eligible for health benefits under the Plan, you may access services provided by the Health & Wellness Centers and the Vision Clinic.

1.01 Health & Wellness Centers

The Health & Wellness Center, operated by Premise Health, provides a comprehensive range of healthcare services, including primary care, care management, lab services, vaccinations, physical therapy, chiropractic and mental health services at **no cost to you or your eligible Dependents.**

The Health & Wellness Centers are staffed by experienced Physicians, nurse practitioners, physical therapists, chiropractors and behavioral health specialists. The Health & Wellness Centers are open Monday through Friday and located at the following addresses:

EIT Health & Wellness Center
6195 W. 115th Street, Suite A
Alsip, Illinois 60803
(312) 262-7002
Mon, Tue, Wed, Fri 8 a.m. – 5 p.m.
Thu 10 a.m. – 7 p.m.

Premise Health Wellness Center – Northbrook
4179 Dundee Road, Suite A106
Northbrook IL 60062
(847) 402-2300
Mon, Tue, Thu, Fri 8 a.m. – 5 p.m.
Wed 9 a.m. – 6 p.m.

Please contact the Health and Wellness Centers to schedule an appointment, or you can download the My Premise Health app and schedule an appointment.

1.02 Vision Center

The Vision Center in Alsip, operated by VSP, is staffed by a skilled optometrist and knowledgeable opticians who are dedicated to provide you with a first-class experience. While the Plan's copayments and coinsurance do apply at the Vision Center, the Vision Center offers a large selection of frames that are within the vision benefit allowance and a personalized experience to be shared only by other Plan Participants and their eligible Dependents.

Some of the services provided at the Vision Center include the following:

- **WellTech Exam**: Delivers more accurate eye health exam and vision Rx.
- **WellTech Fit:** One photo provides precise measurements to customize your prescription to fit your frame.
- **Free Retinal Imaging**: Assess eye health and provide an eye health history. It can also help in identifying other underlying health issues such as diabetes and high blood pressure.
- **Kids' Worry-Free Glasses:** Guaranteed for one year including breaks, damage and loss.
- **Free Adjustments:** Custom fit or realign any eyewear, regardless of where it was purchased.

- **90-Day Guarantee:** If you need to change frames, lenses, or both during the first 90 days, the clinic will assist you and make the changes at **no charge.**

- **Large selection** of glasses and safety glasses for you and your eligible Dependents.

EIT Vision Center
6195 W. 115th Street, Suite B
Alsip, Illinois 60803
(312) 795-5841
Monday, Tuesday, Wednesday, Friday 8 a.m. – 5 p.m.
Thursday 10 a.m. – 7 p.m.

Section 2: Schedule of Benefits

In general, the level of coverage the Plan provides differs depending on whether treatment is provided by Network Providers versus Non-Network Providers, as shown in the schedule below. Network Providers are providers who participate in a Preferred Provider Organization (PPO) by agreeing to accept certain negotiated rates for services provided. The Plan contracts with a PPO to provide Participants with access to Network Providers. Non-Network Providers do not participate in a PPO network and do not have an agreement to accept negotiated rates. This means that if you visit a Non-Network Provider, it may cost more, and you may be responsible for amounts above what the Plan allows for a service.

The Plan pays a percentage of the Eligible Charges, as shown in the chart below, for covered medical expenses. The Eligible Charge differs depending on if the service is being performed by a Network Provider or Non-Network Provider.

You are responsible for paying for the following: Deductibles, Copayments, your share of Eligible Charges (including charges that are more than the Eligible Charges when you use a Non-Network Provider), any amount over a maximum benefit, and any expenses that are not covered by the Plan. Please refer to each section for further details about specific service coverage and limitations or contact the Fund Office or the appropriate healthcare provider.

Medical Benefits: What You Pay	Network	Non-Network
Calendar Year Deductible – Does not apply to Network Preventive Services; Emergency Services; Chiropractic Services; Physical, Speech and Occupational Therapy Services; and Hearing Aid Benefit	$600 per person $1,200 per family	
Medical Out-of-Pocket Maximum – Includes Deductibles, Office Visit Copays, and Coinsurance Payments, but excludes Prescription Drug Copayments	$3,000 per person/family	$5,000 per person/family
Medical Benefits: What the Plan Pays	**Network**	**Non-Network**
Office Visits		
Physician Office Visits	100% after $25 copay	80%
Specialist Office Visits	100% after $60 copay	80%
Chiropractor and Naprapathy Services – 30 visit limit per person, per calendar year	90%	80%
Acupuncture Services – 30 visit limit per person, per calendar year	90%	80%
Routine Physical Examination – One exam per person, per calendar year	100%	80%
Routine Coronary Artery Scan – One exam per person, per calendar year	90%	80%

Routine Immunizations – Dependent Children under age 19	100%	80%
Routine Immunizations – Participants and Dependents over age 19	100%	80%
Other Preventive Services *(as required by federal law)*	100%	80%
Urgent and Emergency Care		
Urgent Care Center	90%	80%
Emergency Services	90%	90% of the lesser of the amount billed or the QPA
Emergency Medical Transportation	80% of Billed Charges	
Hospitalization		
Facility	90%	80%
Physician/Surgeon	90%	80%
Prior Authorization Review is required for Inpatient admissions, for more information see Section 7.07.		
Outpatient Services		
Outpatient Surgery	90%	80%
Physical Therapy – 30 visit limit per person, per diagnosis, per calendar year	90%	80%
Speech Therapy – 30 visit limit per person, per diagnosis, per calendar year	90%	80%
Occupational Therapy – 30 visit limit per person, per diagnosis, per calendar year	90%	80%
Mental and Substance Abuse Disorder Services		
Inpatient Care	90%	80%
Outpatient Care	100% after $15 copay	80%
Structured Intensive Outpatient Substance Abuse Program	100% after $15 copay	80%
Prior Authorization Review is required for Inpatient admissions, for more information see Section 7.07.		
Laboratory and Imaging Services		
Laboratory Services – Such as x-rays and blood work	90%	80%
Diagnostic Imaging – Such as CT scans, PET scans and MRIs	90%	80%
Home Healthcare and Hospice Services		
Skilled Nursing Facility	90%	80%
Home Healthcare	90%	80%
Hospice Care	90%	80%

Pregnancy and Delivery		
Prenatal and Postnatal Office Visits – Does not include laboratory and imaging	100% after $25 copay	80%
Delivery and Inpatient Services	90%	80%
Fertility Treatment – $15,000 combined lifetime maximum for Participants and Dependent spouse only	90%	80%
Hearing Aid Benefits		
Exam – One exam per person, per calendar year	$75	
Instrument – Per person, per ear once every 60 months, maximum two (2) hearing aids	80% up to $2,500 per hearing aid	
Limits **do not apply** to **bone anchored hearing aids** for eligible **Dependent Children under the age of 19**.		
Other Care and Expenses		
Prosthetic Devices, Casts and Splints	90%	80%
Durable Medical Equipment	90%	80%
All Other Covered Expenses	90%	80%

Prescription Drug Benefits: What You Pay	**Network Pharmacy**
Prescription Drug Out-of-Pocket Maximum Includes prescription drug copayments; excludes all medical expenses. **Subject to change each Calendar Year**	$6,200 per person/family
Fertility Treatment	$15,000 lifetime combined maximum for Participant and Dependent spouse only
Retail Pharmacy – 30-day supply; two (2) fill limit on maintenance/long-term prescriptions	
Generic	$10 copay
Preferred Brand	25% of cost ($30 minimum copay; $50 maximum copay)
Non-Preferred Brand	30% of cost ($50 minimum copay; $100 maximum copay)
Maintenance Choice Mail-Order or CVS Pharmacy – 90-day supply; no fill limit	
Generic	$20 copay
Preferred Brand	25% of cost ($60 minimum copay; $100 maximum copay)
Non-Preferred Brand	30% of cost ($100 minimum copay; $200 maximum copay)
Prescription drugs purchased at a **Non-Network Pharmacy** are **not covered** under the Plan. Specialty Drugs **must be purchased** through the Specialty Pharmacy Program. The copay amount for specialty drugs are the preferred brand or non-preferred brand copays, as shown above.	

Dental Benefits: What the Plan Pays	Network	Non-Network *(based on U&C Charges)*
Maximum Benefit per person, per calendar year (excludes orthodontia)	$3,000	
The calendar year **dental benefit maximum does not apply** to **diagnostic and preventive services** for **Dependent Children under age 19**.		
Dental Services		
Diagnostic and Preventive Services	100%	100%
Basic and Major Services	80%	80%
Orthodontia Services – $4,000 per person lifetime maximum	80%	80%
Surgical Removal of Complete Bony Impacted Teeth – $3,500 per person lifetime maximum	80%	80%
The lifetime orthodontia maximum **does not apply** to **Medically Necessary expenses** for eligible **Dependent Children under the age of 19**.		

Vision Benefits: What the Plan Pays	Network	Non-Network *(based on Billed Charges)*
Exams		
Adults – One exam per calendar year	100% after $30 copay	100% up to $45 maximum after $30 copay
Dependent Children under aged 19 – One exam per calendar year	100%	100% after $30 copay
Lenses		
Adults	100% after $20 copay	100% up to specified maximums • $37 single vision • $60 lined bifocal • $75 lined trifocal & progressive after $20 copay
Dependent Children under aged 19	100% after $20 copay	80% after $20 copay

Frames		
Adults	100% after $30 copay up to specified maximums: • $225 featured frame brands allowance; or • $175 standard frame allowance; or • $175 frame allowance at Walmart • or Sam's Club; or • $95 frame allowance at Costco Plus 20% savings on the amount over allowance	100% up to $60 maximum after $30 copay
Dependent Children under aged 19	100% after $20 copay	80% after $20 copay
Contact Lenses		
Adults	100% up to $200 maximum	80% up to $200
Dependent Children under aged 19	100%	80%

Participant Annual Limit: Two pairs of framed lenses or two sets of contact lenses or one of each per calendar year limit.

Dependent Annual Limit: One pair of framed lenses or one pair of contact lenses per calendar year limit.

Maternity Leave Benefits: What the Plan Pays

Weekly Benefit	$800 per week up to a maximum of 26 consecutive weeks

Participants are **credited with 5 hours per day**, up to a **maximum of 25 hours per week** for each week of Maternity eligibility to maintain coverage under the Plan.

Short-Term Disability Benefit: What the Plan Pays

Weekly Benefit	$750 per week up to a maximum of 13 consecutive weeks

Participants are **credited with 5 hours per day**, up to a **maximum of 25 hours per week** for each week of Short-Term Disability eligibility to maintain coverage under the Plan.

Long-Term Disability Benefit: What the Plan Pays	
Monthly Benefit	60% of average monthly pay for the previous 12 months ($2,000 minimum; $3,000 maximum)
Benefit will be reduced by any disability benefits paid or payable by Social Security. Participants are **credited with 5 hours per day**, up to a **maximum of 25 hours per week** for each week of Long-Term Disability eligibility to maintain coverage.	

Life Insurance and Accidental Death & Dismemberment Benefit: What the Plan Pays	
Life Insurance	$20,000
Accidental Death	$10,000
Accidental Dismemberment	$10,000
Covered Loss	
• Loss of both hands, both feet, or the sight of both eyes • Loss of one hand and one foot • Loss of hearing in both ears and speech • Loss of one hand, or one foot and the sight of one eye • Quadriplegia (paralysis of both upper and both lower limbs)	$10,000
• Loss of one hand or one foot or sight of one eye • Paraplegia (paralysis of both lower body limbs) • Hemiplegia (paralysis of the one arm and one leg on the same side of the body)	$5,000
• Loss of speech • Loss of hearing in both ears • Loss of a thumb and index finger on the same hand	$2,500

Member Assistance Program: What the Plan Pays	
Telephonic Counseling Sessions	Unlimited
Face-to-Face Counseling Sessions	3 sessions per problem, situation or issue

Section 3: Eligibility for Coverage – Active Employees

3.01 Initial Eligibility Requirements

You will become eligible for coverage under the Plan on the first day of the month following a period of six consecutive months during which you accumulate at least 600 Contributed Hours. Hours earned at the Apprentice School are counted as Contributed Hours for purposes of meeting this eligibility requirement.

Your initial eligibility will continue for the remainder of the applicable Coverage Quarter, and then you must satisfy the Continued Eligibility Requirements to maintain eligibility for coverage under the Plan.

For Example – Initial Eligibility			
Work Period	**Contributed Hours**	**Cumulative Contributed Hours**	**Coverage Period Date**
May	75	75	Not Eligible
June	120	195	Not Eligible
July	100	295	Not Eligible
August	130	425	Not Eligible
September	105	530	Not Eligible
October	130	**660**	***Eligible November 1st through December 31st**

*Note: Contributed Hours for October are not reported to the Fund Office until November 15th.

If you do not accumulate 600 Contributed Hours during the initial period of six consecutive months, the Fund Office will roll the work period forward by one month. The work period will continue to roll forward one month at a time until you accumulate 600 Contributed Hours.

For Example – Initial Eligibility			
Work Period	**Contributed Hours**	**Cumulative Contributed Hours**	**Coverage Period Date**
May – October	500	500	Not Eligible
June – November	80	580	Not Eligible
July – December	120	**700**	***Eligible January 1st through March 31st**

*Note: Contributed Hours for December are not reported to the Fund Office until January 15th.

3.02 Continued Eligibility Requirements

Generally, once you meet the Initial Eligibility Requirements, you will remain eligible for subsequent Coverage Quarters as long as you accumulate at least 300 Contributed Hours during the most recent Review Quarter. If you do not accumulate 300 Contributed Hours during the most recent Review Quarter, you may be eligible to continue your coverage under the 1,200 Hour Rule or by making self-payments as explained below.

300 Hour Rule

Once you meet the Initial Eligibility Requirements, you will remain eligible for subsequent Coverage Quarters if you accumulate at least 300 Contributed Hours during the Review Quarter that corresponds to the Coverage Quarter as follows:

Review Quarter	Coverage Quarter
January, February, March	July, August, September
April, May, June	October, November, December
July, August, September	January, February, March
October, November, December	April, May, June

1,200 Hour Rule

If you do not meet the 300 Hour Rule explained above, you will remain eligible for subsequent Coverage Quarters if you accumulate at least 1,200 Contributed Hours during the four Review Quarters that corresponds to the Coverage Quarter as follows:

Four Review Quarters	Coverage Quarter
April 1st – March 31st	July, August, September
July 1st – June 30th	October, November, December
October 1st - September 30th	January, February, March
January 1st – December 31st	April, May, June

The Fund Office reviews your work history four (4) times a year to determine if you have met the 300 Hour Rule or the 1,200 Hour Rule to continue your coverage.

Month of Review	Coverage Quarter	Review Quarter	Four Review Quarters	Coverage Through Month *(If hour requirement met)*	Cancellation Month *(If hour requirement not met)*
November	January, February, March	July, August, September	October 1st – September 30th	March 31st	December 31st
February	April, May, June	October, November, December	January 1st – December 31st	June 30th	March 31st
May	July, August, September	January, February, March	April 1st – March 31st	September 30th	June 30th
August	October, November, December	April, May, June	July 1st – June 30th	December 31st	September 30th

Self-Payments

If you do not meet the Continued Eligibility Rules as described above, you may be eligible to continue your coverage under the Plan by making self-payments. The Fund Office will notify you if you are eligible to continue coverage through self-payments.

To qualify for self-payment, you must meet the following requirements:

- Your Covered Employment was terminated involuntarily due to lack of work or reduction in work force. You will not be eligible if such a reduction or lack of work is due to a voluntary quit or a discharge due to misconduct.

- You are registered with the Union Referral Hall or Apprentice School as available for work during the Review Quarter and are compliant with Referral Hall procedures.

- You have not exceeded three (3) consecutive Coverage Quarters of self-payment.

Submitting Self-Payment
All self-payments are due by the date indicated in the self-payment notice from the Fund Office. All payments are due by the date indicated, and no payment will be accepted after the due date. The Fund Office will accept checks or money orders as a form of payment. Cash, credit card or debit card payments will not be accepted; partial or installment payments will also not be accepted.

If eligible, the amount of your self-payment is equal to the number of hours you have fallen short of the 300 Hour Rule or the 1,200 Hour Rule, whichever is less, multiplied by the current Principal or Residential Agreement's health and welfare contribution rate.

All self-payments must be postmarked no later than the 15th day of the month prior to termination. You will be notified by mail. If you fail to make a timely self-payment or are no longer eligible to make a self-payment, your eligibility will terminate at the end of the applicable Coverage Quarter.

Disability Related Hour Credits

If you are unable to work because of a certified disability, you may be eligible to receive disability-related hour credit(s) that count toward the eligibility requirements for the Plan for each week of disability. For more information, including requirements to earn disability-related hour credits, please see Section 12.01.

3.03 Reciprocity

If you work partly in another IBEW jurisdiction under a reciprocity agreement and you wish to maintain your eligibility under the Plan, your employer's health and welfare contributions on your behalf to the other fund (the "traveling fund") must be transferred to the Plan.

To do this, you must register your reciprocity authorization with the Electronic Reciprocal Transfer System (ERTS) in the jurisdiction where the work is to be performed. You should register *before* you begin work in another jurisdiction, as only the health and welfare contributions made based on the number of hours worked after the date you register on ERTS are transferred to the Fund Office.

It generally takes a minimum of six (6) -to eight (8) weeks before health and welfare contributions from another jurisdiction are submitted to the Fund Office. **Please remember that it is your responsibility to keep track of your reciprocated hours**. If there is a discrepancy between the number of hours worked and the number of hours reciprocated to the Fund Office, you must contact the traveling fund (or local union) where the work was performed to resolve any issues. When you are working in another jurisdiction, you are subject to that jurisdiction's collective bargaining agreement.

If you do not arrange to have your employer's health and welfare contributions transferred to the Plan, hours worked in another jurisdiction will not be eligible for credit in determining whether you meet the Continued Eligibility Requirements for coverage under the Plan.

To be eligible for hour for hour credit while working for other jurisdictions, you must have worked a minimum of 1,040 contributed hours under the Principal Agreement, Residential Agreement or a similar agreement negotiated in the following IBEW collar county Local Unions: Locals 9, 117, 127, 150, 176, 196, 364, 430, 461, 531, 697, and 701 during the 36 months immediately preceding the work month health and welfare contributions are made,

If you do not meet the minimum hour requirement in the 36 months immediately preceding the work month contributions are made, then your hours will be **prorated** to reflect the difference in the health and welfare contribution rates between the locals. This means your contributed health and welfare hours will be calculated by dividing the other local's health and welfare contribution rate by the Local 134 health and welfare contribution rate under the Principal or Residential Agreements.

The Board of Trustees has the authority to add and/or remove additional locals to which the exception applies on a temporary or permanent basis.

For Example – Reciprocity:

Local 134 Principal/Residential Health and Welfare Contribution Rate:	$17.06
Local 58 Health and Welfare Contribution Rate:	$9.75
Hours worked in Local 58 for June:	100
Total hours reported in Local 134 and/or prorated Locals in last 36 months:	980
Total hours reported in Local 58 in the last 36 months:	2,010
Prorated Reciprocated Hours for June:	**57**

Assume you have been traveling in Local 58 for the last four (4) years and have worked 100 reciprocated hours. Your reciprocated hours are prorated because you have not earned the minimum of 1,040 hours in Local 134 and/or a similar agreement negotiated in the collar county area in the prior 36 months. You will be credited with 57 reciprocated hours toward continuing your coverage under the Plan. This amount is calculated by dividing Local 58's current health and welfare contribution rate of $9.75 by Local 134's current health and welfare contribution rate of $17.06 and multiplying the result by the 100 hours worked in Local 58.

$9.75 ÷ $17.06 =.57 x 100 worked hours = 57 prorated reciprocated hours

If your reciprocated health and welfare hours are prorated and you have insufficient Contributed Hours to maintain your eligibility under the Plan solely because of such proration, you can make self-payments for the number of hours you are short due to proration of your reciprocated health and welfare hours to continue coverage under the Plan. These self-payments will be required at Local 134's health and welfare contribution rate in effect at the time of such self-payment and will extend your coverage for you and your Eligible Dependents for the coverage quarter. You must be Registered with the Union Referral Hall or Apprentice School and be Available for Work during the Review Quarter and are compliant with Referral Hall procedures.

If you fail to make your self-payment timely, your coverage under the Plan will terminate, and you will be offered COBRA Continuation coverage.

In the event the contribution rate of the traveling fund is lower than Local 134's contribution rate and it is difficult for you to continue your eligibility under the Plan because of these proration rules, you can request a temporary or permanent cessation of transfer of health and welfare contributions through the ERTS system. By making this request, health and welfare contributions earned under the traveling fund will no longer be transferred back to the Plan. While you run out your eligibility under the Plan, you can begin earning hours under the traveling fund and work toward establishing eligibility under the traveling fund. Once you stop transferring contributions back to the Plan, the traveling fund is obligated to keep your health and welfare contributions so you can work to gain eligibility under the traveling fund.

If you later decide that you want to return to the Plan, you would be able to take the same actions and work to gain eligibility under the Plan while you run out your eligibility under the traveling fund.

Additionally, your HRA contributions may be impacted when you work for reciprocal locals who have a health and welfare contribution rate that is equal to or less than the Local 134 health and welfare contribution rate. See Section 11.05 for further details on how this is determined.

3.04 When Coverage Ends

Your coverage under the Plan as an Active Employee ends when the first of the following occurs:

- You fail to meet the Continued Eligibility Requirements; or
- Your employer fails to make the required contributions to the Plan on your behalf; or
- You retire (unless you are running out your Active Employee Benefits); or
- You die; or
- You become eligible under another welfare plan administered by the Board of Trustees; or
- The Board of Trustees terminates the Plan for any reason.

Insufficient Contributed Hours
It is your responsibility to know when your coverage will end due to insufficient Contributed Hours. Advance notice of loss of coverage from the Fund Office is not an obligation of the Fund, its Trustees or the Fund Office.

Coverage termination will be prospective unless you (or a person seeking coverage under the Plan as an Eligible Dependent) perform an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

3.05 Reinstatement of Eligibility

If you lose coverage under the Plan, you may reinstate your eligibility on the first day of the month following a period of three-consecutive months during which you accumulate 300 Contributed Hours **after the date you lost your coverage**. Once you reinstate your eligibility, your coverage will continue for the remainder of the corresponding Coverage Quarter. To continue to maintain eligibility thereafter, you must meet the Continued Eligibility Requirements.

For Example – Reinstatement of Eligibility: Assume you failed to meet the Continued Eligibility Requirements and your coverage under the Plan ended September 30th. From October 1st through December 31st, you accumulated 400 Contributed Hours. You are therefore eligible for coverage under the Plan from January 1st through March 31st (remainder of the Coverage Quarter). You have also met the Continued Eligibility Requirements based on the 300 Hour Rule (Review Quarter: October - December), so you will continue to be eligible from April 1st through June 30th. Eligibility for coverage after June 30th will depend on whether the Continued Eligibility Requirements are met.
If you do not qualify for reinstatement within 52 weeks of the date your eligibility under the Plan ended, you must meet the Initial Eligibility Requirements under the Plan.

3.06 Coverage under the Family and Medical Leave Act

Under the Family and Medical Leave Act of 1993 ("FMLA"), you may qualify to take up to 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- Birth and care of a newborn child; or
- Placement of a child with you for adoption or foster care; or
- Care of your spouse, child or parent with a serious health condition; or
- A serious health condition that prevents you from performing your job; or
- A qualifying exigency because your spouse, parent or child is on covered active duty or called to covered active-duty status as a member of the National Guard, Reserves, or Regular Armed Forces.

In addition, you may also qualify to take up to 26 weeks of unpaid leave during any 12-month period to care for a spouse, child, parent or next of kin who is a covered service member suffering from a serious injury or illness incurred while on covered active military duty.

Your eligibility for FMLA leave will be determined by your employer. You are generally eligible for leave under FMLA if your employer approves and you meet the following criteria:

- You worked at least 12 months for a participating employer; and
- You have at least 1,250 hours of contributions within the last 12 months from the leave starting date.

If you would like to take an FMLA leave of absence, you must notify your employer and the Fund Office. Should your employer grant your request for leave under FMLA, you will receive five (5) hours of credit for each day you are on FMLA leave. For more information about FMLA or if you have any questions, please contact the Fund Office.

3.07 Coverage During Military Service

If you are on a military leave of absence under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), your coverage and your Dependents' coverage will continue under the Plan.

You must provide the Fund Office with a copy of your military orders that gives both a report date and a discharge date. You will receive five (5) hours of credit for each day you are on military leave. For additional information about coverage during a military leave of absence, contact the Fund Office.

3.08 Suspension of Benefits Due to Delinquent Employers

If your employer has not submitted contributions for the hours you worked, coverage for you and your covered Dependents will be suspended under the Plan if you continue working for that employer while the employer is delinquent.

Your coverage under the Plan will be retroactively reinstated once your employer is in compliance with the Collective Bargaining Agreement or if you stop working for that employer. You must stop working for that employer and sign the out-of-work list at the Referral Hall within seven (7) days after being notified of your suspension of benefits.

Suspension of benefits is not a Qualifying Event as defined under COBRA. This means you and your covered Dependents are not entitled to COBRA coverage solely because your coverage under the Plan is suspended. For more information on COBRA coverage, see Section 6.

Section 4: Eligibility for Coverage – Dependents

4.01 Initial Eligibility Requirements

Generally, your Dependent(s) become eligible for coverage on the date you become eligible, or, if later, on the date he or she meets the definition of Dependent under the Plan. For Dependent eligibility for Retiree Health Benefits, see Section 5.02.

4.02 Enrolling Dependents for Coverage

Once you are eligible for coverage under the Plan, you may choose to add your eligible Dependents. To add an eligible Dependent to the Plan, you must submit the following supporting documentation:

Eligible Dependents	Required Documentation
Spouse	✓ Copy of the court certified marriage certificate ✓ Copy of court certified birth certificate ✓ Copy of Social Security card ✓ Health insurance information, if spouse is covered under another plan for purposes of coordination of benefits.
Children (under age 26)	**For All Children:** ✓ Copy of court certified birth certificate or legal paternity test ✓ Copy of Social Security card **Stepchildren:** ✓ Copy of court certified marriage certificate ✓ Copy of court certified birth certificate, which must contain name of the child's parent listed on marriage license **Adopted Children (or children placed in your home for adoption):** ✓ Copy of final adoption papers or interim court order **Qualified Medical Child Support Order (QMCSO)** ✓ Copy of court decree verifying obligation to provide medical benefits for a dependent child **Note:** Newborns will be covered for the first 30 days following birth without a birth certificate. After 30 days, coverage will be suspended without the required documentation listed above. Once all documents have been received, benefits will be retroactively reinstated to the date of suspension.
Disabled Children (age 26 and older)	**In addition to the required documents listed above for Children under age 26:** ✓ Proof of disability, including diagnosis and treatment by a Physician ✓ Proof of financial dependency, including tax filing documents **Note:** You may be requested to periodically provide proof of continued disability.

Please note that Federal law requires **all** Active Employees and eligible Dependents to provide a Social Security number for tax reporting purposes. Your coverage will be suspended if Social Security numbers are not received by the Fund Office within 90 days of the coverage effective date and will be retroactively reinstated if such information is received within 12 months. If such information is received more than 12 months from the coverage effective date, coverage will be reinstated no earlier than 12 months prior to the date the information is received.

4.03 When Dependent Coverage Ends

Your Dependent's coverage will end on the earliest of the following to occur:

- The date your eligibility under the Plan ends for a reason other than death; or
- The date he or she no longer meets the definition of a Dependent under the Plan; or
- The date you become eligible under another plan administered by the Board of Trustees; or
- The date the Board of Trustees terminates Dependent benefits under the Plan for any reason.

4.04 Dependent Coverage in the Event of Your Death

After the date of your death, your surviving Dependent(s) will remain eligible for coverage under the Plan for 36 months beginning with the month following the date of your death. Dependents are not subject to the Retiree Self-Pay. Once that period passes, your Dependent(s) may elect COBRA coverage.

4.05 Dependent Coverage under a Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order issued under a state domestic relations law by a court or an administrator that requires a parent to provide medical support to a child.

The Fund will honor the terms of a QMCSO regarding communication with the custodial parent of a Dependent and with regard to which plan is primary when a Dependent is covered by more than one group health plan for the purposes of the Plan's coordination of benefits rules.

The Fund Office will notify you if a QMCSO is received. You may request a copy of the Fund's QMSCO procedures, free of charge, if you need additional information.

4.06 Dependent Coverage of a Disabled Child

If your Child is age 26 or older and disabled, his or her coverage may be continued under the Plan. To continue coverage, the Child must have been diagnosed with a severe physical or mental disability and the disability is expected to last for a continuous period of 12 or more months or more, provided:

- Such incapacity began before the end of the month the Child attains age 19; and
- The Child was covered by the Plan on the day prior to his or her 19th birthday; and
- The Child is dependent on you for more than 50% of his or her financial support and maintenance for the calendar year; and

- The Child resides in your home; and
- The Child's disability is not solely due to alcoholism or drug addiction; and
- You (the Participant) remain eligible for coverage under the Plan.

You must provide proof of the mental or physical disability within 30 days prior to the date coverage would end because the Child attains age 26.

The Fund may also require you to provide proof of the disability periodically. Contact the Fund Office for more information on how to continue coverage for a Child with a serious disability.

Section 5: Retiree Health Benefits

5.01 Eligibility Requirements

You are eligible for Retiree Health Benefits under the Plan if (1) you retire on a disability pension or you attain age 62, and (2) you meet the following requirements under the 15-Year Rule, 20-Year Rule, 25-Year Combined Service Rule, or the 30-Year Rule as follows. Note that the effective date of your retirement benefit under Pension Plan No. 2 is your "Retirement Date."

The 15-Year Rule

You are eligible for Retiree Health Benefits under the 15-Year Rule if you meet all the following criteria:

- You are receiving a retirement benefit from and have at least 15 years of Credited Service earned after December 31, 1976, under Pension Plan No. 2;
- You began earning Credited Service under Pension Plan No. 2 before January 1, 2023, which Credited Service was not cancelled by a permanent break in service;
- You have been covered as an Active Employee under the Plan throughout the two (2) years before your Pension Plan 2 Retirement Date; and
- You continuously pay the applicable retiree self-pay contributions as required under the Plan.

The 20-Year Rule

You are eligible for Retiree Health Benefits under the 20-Year Rule if you meet all the following criteria:

- You are receiving a retirement benefit from Pension Plan No. 2 and have at least 20 years of Credited Service earned under Pension Plan No. 2;
- You began earning Credited Service under Pension Plan No. 2 on or after January 1, 2023;
- You have been covered as an Active Employee under the Plan throughout the two (2) years before your Pension Plan 2 Retirement Date; and
- You continuously pay the applicable retiree self-pay contributions as required under the Plan.

The 25-Year Combined Service Rule

You are eligible for Retiree Health Benefits under the 25-Year Combined Service Rule if you meet all the following criteria:

- You are receiving a retirement benefit from and have a combined total of at least 25 years of Credited Service under Pension Plan No. 2 and Pension Plan No. 4 (with a minimum of at least 10 of those years of Credited Service earned under Pension Plan No. 2);
- You have been covered as an Active Employee under the Plan throughout the two (2) years before your Pension Plan 2 Retirement Date; and
- You continuously pay the applicable Retiree Self-Pay Contribution as required under the Plan.

25-Year Combined Service Rule C-Card & F-Card Service
Generally, Credited Service is only earned under Pension Plan 2 (formerly Pension Plan 4) by **Communication Participants** between 1995 & 1996 and is based on 400 – 1,800 Contributed Hours per calendar year. **For Building, Hotel, Sign and Maintenance Participants**, Credited Service may be earned under Pension Plan 2 (formerly Pension Plan 4) beginning January 1978 and is based on a 400 – 1,800 Contributed Hours per calendar year. Contact the Fund Office for further information.

The 30-Year Rule

You are eligible for Retiree Health Benefits under the 30-Year Rule if you meet all the following criteria:

- You are receiving a retirement benefit from and have a combined total of at least 30 years of (i) Credited Service under Pension Plan No. 2; and/or (ii) eligibility service earned under Pension Plan No. 2 solely from employment as a Union business representative, Apprentice School teacher or Apprentice School administrator; and
- You continuously pay the applicable Retiree Self-Pay Contribution as required under the Plan.

If you do not satisfy the requirements for Retiree Health Benefits before your Retirement Date and you commence your Pension Plan 2 benefits, you will not be able to return to work and qualify. Additional credit earned after your Retirement Date will not affect your eligibility for Retiree Health Benefits. Your initial Retirement Date will always be used for determining your eligibility for Retiree Health Benefits.

5.02 Dependent Eligibility

If you are eligible for Retiree Health Benefits, you may enroll any individual that qualifies as your Dependent as of your Retirement Date. **You may not add any individual that first qualifies as a Dependent after your Retirement Date.**

5.03 Retiree Interim Coverage

If you stop working at age 60, elect COBRA coverage for 18 months and meet the eligibility requirements for Retiree Health Benefits listed above (except for the age requirement), you may request Retiree Interim Coverage under the Plan for up to six (6) additional months. The payment and monthly cost of Retiree Interim Coverage is the same as the monthly cost of COBRA coverage, and you must pay the full cost of coverage. Retiree Interim Coverage is intended to provide you with continuous coverage under the Plan until you reach age 62, at which time you would be eligible for Retiree Health Benefits under the Plan. **You MUST contact the Fund Office to request Retiree Interim Coverage before the expiration of your COBRA coverage. It is your responsibility to request, in writing, Retiree Interim Coverage.** Receiving Retiree Interim Coverage is no guarantee that you are eligible for Retiree Health Benefits.

For Example – Retiree Interim Coverage: Your birthday is March 15, 1965. You stop working and lose coverage as of March 31, 2025 at the age of 60. You elect COBRA coverage for the maximum period (18 months), so you have COBRA coverage from April 1, 2025 through September 30, 2026. As of September 30, 2026, you are age 61. Assume you meet the service requirements for Retiree Health Benefits. You request in writing to the Fund Office to receive Retiree Interim Coverage for up to six (6) additional months, from October 1, 2026 through March 31, 2027. When the Retiree Interim Coverage ends as of March 31, 2027, you retire at age 62 and can begin Retiree Health Benefits (since this example assumes you met the service requirement for Retiree Health Benefits).

5.04 Retiree Self-Pay Contributions

A Retiree Self-Pay Contribution is required to maintain your eligibility for Retiree Health Benefits. The monthly Retiree Self-Pay Contribution applies to you and each of your eligible Dependents. The Retiree Self-Pay Contribution does not apply to (1) surviving spouses or (2) if your birth date is on or before January 1, 1938.

Amount of Retiree Self-Pay Contribution

The amount of the required Retiree Self-Pay Contribution is determined by the Board of Trustees and may be subject to change prospectively from time to time. The current Retiree Self-Pay Contribution amount is $100 per covered person, per month.

The amount of the monthly Retiree Self-Pay Contribution for you and your eligible Dependents will decrease by fifty percent (50%) starting with the month following your 80th birthday.

Automatic Deduction of Retiree Self-Pay Contribution

The amount of the required Retiree Self-Pay Contribution for you and your eligible Dependent(s) is automatically deducted from the monthly pension benefit payment, provided you authorize such automatic deduction in writing on a form provided by the Fund Office. This authorization is continuing and for an indefinite duration until and unless the Fund Office receives your revocation of such authorization.

If the amount of your Retiree Self-Pay Contribution for you and your eligible Dependent(s) exceeds your monthly pension benefit payment, then the amount of your required Retiree Self-Pay Contribution for you and your eligible Dependent(s) is deemed to be the amount of your monthly pension benefit.

If you do not contribute the required monthly Retiree Self-Pay Contribution for you and your eligible Dependent(s) (e.g., if you have not authorized the deduction from your monthly pension benefit payment), Retiree Health Benefits for you and your eligible Dependent(s) will be suspended until payment is received. Once the Fund Office receives payment of all outstanding monthly Retiree Self-Pay Contributions, Retiree Health Benefits for you and your eligible Dependent(s) will be retroactively reinstated.

5.05 Retiree Benefit Opt-Out

If you and/or your Dependents are covered under another group health plan, you may affirmatively elect to opt-out of Retiree Health Benefits under the Plan by submitting the necessary documentation to the Fund Office. Your Dependent will also be required to complete a form indicating that he or she understands that he or she will no longer have coverage under the Plan. This form must be notarized. If you or your Dependent choose to opt-out of Retiree Health Benefits, coverage under the Plan will terminate and you or your Dependent will not be allowed to opt back into the Plan at any later date, except as provided below.

You and/or your eligible Dependents may opt back into the Plan at a later date provided the following conditions are met:

- There is no gap in coverage between the other group health plan and the Plan (a Certificate of Creditable Coverage or other proof of prior coverage is required);
- The other group health plan coverage is lost by reason of termination of employment, termination of the plan, death or divorce (not including failure to pay premiums or otherwise opting out of coverage); and
- The application to opt back into the Plan is made within 60 days of the termination of the other group health plan coverage.

5.06 When Retiree Health Benefits End

Retiree Health Benefits under the Plan are not vested and will not vest at any time. Accordingly, your coverage for Retiree Health Benefits ends when the first of the following occurs:

- You fail to meet the eligibility requirements for Retiree Health Benefits;
- You die;
- The Board of Trustees discontinues Retiree Benefits under the Plan for any reason; or
- The Board of Trustees terminates the Plan for any reason.

Section 6: Continuation of Health Coverage under COBRA

6.01 COBRA Coverage at a Glance

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), requires that participants and their eligible Dependents have an opportunity to continue certain coverage for benefits under the Plan when they would otherwise lose coverage under the Plan due to a Qualifying Event.

6.02 Eligibility for COBRA Coverage

After a Qualifying Event, COBRA coverage must be offered to each person who is a "qualified beneficiary." Qualified beneficiaries include you, your spouse, and your Dependent Children who were covered by the Plan on the day before the Qualifying Event.

If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while you are covered under COBRA, you may add the child to your COBRA coverage immediately. Your new child is considered a "qualified beneficiary."

A child born to, adopted by or placed for adoption with you during the period of COBRA coverage would also be a qualified beneficiary with a right to COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. If you have any questions about your eligibility for COBRA, please contact the Fund Office.

6.03 Types of COBRA Coverage

The Plan provides two (2) options for COBRA coverage for you and your covered Dependents (or former Dependents): (1) medical, prescription drug, dental, orthodontic, and vision coverage; or (2) medical and prescription drug coverage only. You receive the same benefits available to Active Employees for the option you choose.

COBRA *does not extend* to other benefits under the Plan, such as Short-Term Disability, Long-Term Disability, Maternity Leave Benefits, Life Insurance or AD&D.

6.04 Qualifying Events

Qualifying Events are certain circumstances that cause you and/or your covered Dependents to lose coverage under the Plan.

If you are an Active Employee, COBRA coverage for you and your covered Dependents continues for up to 18 months if you become eligible for COBRA because your hours are reduced below the number required for coverage or your employment is terminated for any reason (other than gross misconduct).

The following constitute Qualifying Events for your eligible Dependents enabling them to enroll in COBRA coverage for up to 36 months:

- Your death;
- Failure to meet the definition of "Dependent" under the terms of the Plan;
- Your divorce or legal separation; or

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- You become entitled to Medicare.

6.05 Duration of COBRA Coverage

COBRA coverage can continue for up to 18, 29 or 36 months depending on the Qualifying Event. If more than one Qualifying Event applies, the maximum coverage period is 36 months total. The following chart shows when you and your Dependents may qualify for continued coverage under COBRA and how long your COBRA coverage may continue.

Maximum Period Coverage Can Continue			
COBRA Qualifying Event	**You**	**Spouse**	**Dependent Child**
You lose coverage because: Your hours are reduced Your employment ends for any reason (except gross misconduct)	18 months	18 months	18 months
You or your qualified Dependent are disabled (as defined by Social Security) when you lose coverage or within 60 days of the date you lose coverage	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your spouse divorce or become legally separated	N/A	36 months	36 months*
You become entitled to Medicare**	N/A	36 months	36 months
Your Child no longer qualifies as an eligible Dependent under the Plan	N/A	N/A	36 months

* Only if the dependent child loses coverage as a result of divorce or legal separation (i.e., stepchildren).

** If you become entitled to Medicare *before* your coverage ends, your spouse and any Dependent Children are entitled to elect COBRA coverage for up to the greater of 36 months from the date of Medicare entitlement, or 18 months from the date your coverage ends.

Extended COBRA Period for Disability

The 18-month COBRA coverage period may be extended by up to 11 months for a total of 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled at any time within 60 days of the start of the COBRA period. This 11-month extension is available to all COBRA qualified beneficiaries in your family. To be granted this extension, you must notify the Fund Office in writing within 60 days of the disability determination by the Social Security Administration and within the 18-month COBRA coverage period. You must also provide a copy of the determination of disability notification from the Social Security Administration.

The disabled individual must also notify the Fund Office within 30 days of any final determination that such individual is no longer disabled.

Multiple Qualifying Events

The 18-month COBRA period may be extended for up to a maximum of 36 months for your spouse and Dependent children who are qualified beneficiaries if a second Qualifying Event (death, divorce, legal separation or a Dependent child ceasing to be a Dependent under the terms of the Plan) occurs during the 18-month COBRA coverage period. However, this extension will only be allowed if the second event would have caused the spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. To be granted an extension, the qualified beneficiary must notify the Fund Office within 60 days of the second Qualifying Event.

Please note your Medicare entitlement (Part A, Part B or both) is considered a second Qualifying Event for your spouse and Dependent children under the Plan.

6.06 Cost of COBRA Coverage

You are responsible for the cost of COBRA coverage. When you and/or your Dependents become eligible for this coverage, the Fund Office will notify you of the COBRA premium amount.

Your COBRA premium may be as much as 102% of the regular contribution rate or the cost of coverage for Participants and Dependents (100% of the premium plus a 2% administration fee). If you are eligible for the 11-month extension due to a determination of disability by the Social Security Administration, your COBRA payment may be as high as 150% of the Plan's cost for the additional 11 months. The COBRA premiums are determined by the Board of Trustees and adjusted from time to time.

6.07 Payment for COBRA Coverage

You and/or your Dependents who are electing COBRA coverage must make the initial payment for coverage no later than 45 days after the date of your election for COBRA coverage. You are responsible for making sure that the amount of your first payment is enough to cover the entire period, and you may contact the Fund Office to confirm the correct amount of your first payment. Any claims filed will not be paid until the Plan receives your payment.

After your initial premium payment, payments are due monthly and must be continuous. The due date for each following monthly payment is the first day of the month for which payment is due. Payment will be considered on time if it is received within 30 days of the due date. If you do not make a timely payment, your COBRA coverage will end, and it cannot be reinstated.

6.08 Notification Responsibilities

Your employer is required to notify the Fund Office of your death, termination of employment, reduction in hours or Medicare entitlement within 30 days after such event occurs. However, because your employer may not be aware of these events, you or your Dependents should notify the Fund Office of any Qualifying Event as soon as it occurs.

For other Qualifying Events (your divorce or legal separation, or ineligibility of a Dependent Child), you or your Dependent must notify the Fund Office within 60 days of the date coverage terminates. If you do not provide the notice to the Fund Office within 60 days of the loss of coverage, the Dependent will not be eligible for COBRA coverage.

When the Fund Office is notified of a Qualifying Event, the Fund Office will send a COBRA election notice and COBRA election form to you and any Dependents who would lose coverage due to the Qualifying

Event. The Fund Office will send the notice within 14 days of the time it receives notice of a Qualifying Event. The election notice tells you about your right to elect COBRA coverage, the due dates for returning the election from, the cost of COBRA coverage and the deadlines for payments.

To protect your family's rights, you should notify the Fund Office of any changes in your address or the addresses of your Dependents.

6.09 Electing COBRA Coverage

COBRA coverage is administered by the Fund Office. If you are eligible for COBRA coverage, you will receive an election form from the Fund Office. You and your Dependents must complete the election form and send it back to the Fund Office to elect COBRA coverage. The following rules apply to the election of COBRA coverage:

- Each qualified beneficiary has a separate right to elect COBRA coverage. For example, your spouse may elect COBRA coverage even if you do not.
- You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their Dependent Children. However, your Dependents have the right to revoke that election before the end of the election period.
- If you do not elect COBRA coverage for your Dependents when they are entitled to COBRA coverage, your Dependents have an independent right to elect COBRA coverage for themselves.
- You or your affected Dependent must elect COBRA coverage within 60 days after the Fund Office mails your election form or 60 days after your coverage would terminate, whichever is later. An election of COBRA coverage is considered to be made on the date the COBRA election form is postmarked.
- If you do not elect COBRA coverage within the 60-day period described above, you and/or your Dependents will be considered to have waived your rights to COBRA coverage.

6.10 Termination of COBRA Coverage

COBRA coverage may terminate before the end of the maximum coverage period for any of the following reasons:

- Any required premiums are not paid in full by the due date.
- A qualified beneficiary becomes covered under another group health plan after electing COBRA coverage.
- A qualified beneficiary becomes eligible for Medicare after electing COBRA coverage (this only affects the person with Medicare coverage).
- A qualified beneficiary recovers from a disability during the 11-month extension period.
- The Plan ceases to provide group health coverage to any individual.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage for a participant not receiving COBRA coverage (such as gross misconduct). **If your COBRA coverage terminates for any reason, it cannot be reinstated.**

6.11 Health Coverage Alternatives

You and your Dependents may be eligible for coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA coverage does not limit your eligibility for coverage for a tax credit through the Health Insurance Marketplace.

Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You should review your options under the Health Insurance Marketplace and other possible group health plans and compare them with the Plan's COBRA coverage to determine which option is best for you and your family. If you have any questions about your rights to COBRA coverage, you should contact the Fund Office. For information on the Health Insurance Marketplace, please visit www.healthcare.gov.

Section 7: Medical Benefits

The Plan provides you and your eligible Dependents medical benefits to help you pay for covered Medical Care and protect you from the financial impact of catastrophic expenses.

I.D. Cards
If you've lost or misplaced your I.D. card, contact Blue Cross Blue Shield of Illinois at 1-800-862-3386 for a replacement I.D. card or you may call the Fund Office.

7.01 Calendar Year Deductible

The Deductible is the amount of covered medical expenses that you and your eligible Dependents pay each calendar year before the Plan begins to pay benefits. The amounts of the individual and the family Deductibles are listed in the *Schedule of Benefits* at the front of this booklet.

The family Deductible may be satisfied through any combination of individual Deductibles. Once you meet the family Deductible, no further Deductible will be applied to any eligible member of your family during the remainder of the calendar year.

7.02 Copayments and Coinsurance

Once you satisfy the calendar year Deductible, the Plan will pay, up to any Plan maximums, the percentage of your covered medical expenses listed in the *Schedule of Benefits* up to the Eligible Charge.

Any Copayments and Coinsurance payments made by you will count towards your annual medical out-of-pocket maximum.

7.03 Out-of-Pocket Maximum

The Plan limits the amount you must pay for covered medical expenses in any calendar year. These out-of-pocket maximums are listed in the *Schedule of Benefits*. Once you reach the applicable out-of-pocket maximum, which differs depending on whether the provider is Network or Non-Network, the Plan pays 100% of all additional covered medical expenses, up to any specific Plan maximums, for the remainder of the calendar year.

The family out-of-pocket maximum may be satisfied through any combination of individual out-of-pocket maximums. Once you meet the family out-of-pocket maximum, no further individual out of-pocket maximum will be applied to any eligible member of your family during the remainder of the calendar year.

The amounts excluded from the out-of-pocket maximums are provided in the *Schedule of Benefits*.

7.04 Preferred Provider Organization (PPO)

General Information

The Fund has contracted with a preferred provider organization (PPO) to help control medical costs. A PPO is a medical organization that allows you to choose from a list of participating providers. The providers agree to provide services at discounted fees that are generally lower as a result of the Plan's participation in the PPO.

To minimize your out-of-pocket costs, contact Blue Cross Blue Shield of Illinois, the Claims Administrator, for information about which Hospitals and providers are in the Plan's Network. You are not required to use Network Providers and Hospitals, but when you use Network Providers and Hospitals rather than Non-Network Providers and Hospitals, you can generally reduce costs for both you and the Plan.

If your Network Provider refers you to a specialist, the referral is typically to another Network Provider. However, it is your responsibility to confirm that the specialist is a Network Provider.

For a directory of Network Providers, visit www.bcbsil.com or call BCBS at 1-800-810-2583. You may also contact your Physician directly to confirm whether he or she participates in the BCBS PPO network.

Continuing Care

If you are a continuing care patient, and the contract with your Network provider or facility terminates, or the Plan changed benefits because the provider or facility left the Network, then you may qualify for transitional care from the Provider or facility for up to ninety (90) days at Network cost sharing. You are a "continuing care patient" if you are receiving treatment for a serious and complex condition, are undergoing a course of institutional or inpatient care, are scheduled for non-elective surgery, are pregnant and undergoing a course of treatment for pregnancy or are determined to be terminally ill and receiving treatment for such illness. This provision does not apply to contracts with Network Providers or facilities that terminate for-cause (provider fails to meet quality standards or commits fraud). You will be notified by the Claims Administrator if this provision may apply to you.

7.05 Non-Network Benefits

Because Non-Network Providers have not agreed to accept discounted and negotiated rates, they may charge any amount for services or supplies – which can cost you more. This means that if you use a Non-Network Provider, you may have larger out-of-pocket expenses, a lower percentage paid by the Fund, and the Non-Network Provider may charge you the difference between the Eligible Charge and the total billed amount, a practice known as Balance Billing for which you are responsible. To determine the Eligible Charge for a Non-Network Provider, the Plan uses Usual and Customary Rates ("U&C") or 100% of the current Medicare Reimbursement Rate, as indicated in the *Schedule of Benefits*.

Charges by Non-Network Providers above the Eligible Charge do not count toward the Deductible or out-of-pocket maximum. Additionally, if you use a Non-Network Provider, you may have to pay the Non-Network Provider first, file claim forms and then wait for reimbursement from the Plan.

7.06 Out-of-Area Benefits

If there are no Network Providers within 10 miles of your home (as defined below), you may be eligible to receive out-of-area benefits from the Plan as shown in the *Schedule of Benefits*. If you receive out-of-area benefits, any amount you pay above the Non-Network charges does not apply to your Deductible or out-of-pocket maximum.

For purposes of out-of-area benefits, "home" means the address that the Fund Office has on file for you at the time of treatment.

7.07 Prior Authorization, Case Management and Utilization Review

For certain services, your provider will need to verify treatment and services prior to those treatments and services being performed. Failure to request prior approval of benefits may result in treatment and service being denied after they have already been performed. If services aren't approved ahead of time, you may be responsible for charges.

Prior-Authorization

Prior Authorization is the process of obtaining approval from the Plan before you have certain procedures performed.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield's contractual agreement with the Provider, and you will be held harmless for the Provider sanction.

If you fail to contact the Claims Administrator or to comply with the determinations of the Claims Administrator, as described in this section, then your benefits may be reduced. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles, and out-of-pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from the failure to contact Blue Cross Blue Shield or to comply with the determinations of Blue Cross Blue Shield. We encourage you to call ahead to verify if prior authorization is necessary. **The prior-authorization toll-free telephone number is on the back of your Identification Card.**

To receive maximum benefits under the Plan, you must obtain Prior Authorization from the Claims Administrator before you receive treatment or are admitted for the following types of services. Providers may obtain Prior Authorization for you, by contacting the Claims Administrator when required, however, it is your responsibility to ensure Prior Authorization requirements are satisfied.

- **Pre-admission Review**
  - **Non-Emergency/Non-Maternity Inpatient Hospital –** at least one (1) day prior to admission.
  - **Emergency** – no later than two (2) business days or as soon as reasonably possible after the admission has occurred.
  - **Pregnancy/Maternity** – no later than two (2) business days after the admission has occurred. Even though you are not required to call the Claims Administrator prior to your maternity admission, if you call the medical pre-authorization number as soon as you find out you are pregnant, the Claims Administrator will provide you with information on support programs to assist you during pregnancy.
  - **Skilled Nursing Facility –** no later than one (1) business day prior to the scheduling of the admission.
  - **Coordinated Home Care Program –** at least one (1) day prior to admission.
  - **Private Duty Nursing Service –** at least one (1) day prior to receiving services.
  - **Certain Outpatient Procedures**, including but not limited to private duty nursing, transplant evaluations and hospice care. You or someone on your behalf must notify the Claims Administrator no later than two (2) business days prior to receiving these services.
  - **Durable Medical Equipment.**

- **Length of Stay/Service –** upon completion of the Inpatient or emergency admission review, the Claim Administrator will send a letter to you, your Physician, Provider of services, behavioral health practitioner and/or the Hospital or facility with a determination on the approved length of stay.

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. If the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

  A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to the Plan for continued services. If you, your Provider, or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an ongoing course of treatment, the Plan will make a determination on the request/appeal as soon as possible but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

- **Behavioral Health**

  - **Inpatient Hospital –** at least one (1) day prior to admission.

  - **Emergency Mental Health or Substance Use Disorder –** no later than two (2) business days or as soon as reasonably possible after the admission has occurred.

  - **Residential Treatment Center –** at least one (1) day prior to scheduling admission.

  - **Partial Hospitalization Treatment Program –** no later than 48 hours after the admission for the treatment of mental illness or substance use disorder.

Please remember that prior authorization **does not** verify eligibility for benefits or guarantee benefit payments under the Plan. **Prior authorization also does not constitute a guarantee or warranty of the quality of treatment you receive**.

For Non-Network Providers Only: If you fail to obtain prior authorization, all Eligible Charges incurred may be subject to an additional **$200 penalty** before any payment is made by the Plan. If assessed, the penalty does not apply toward your out-of-pocket maximum. Additionally, room and board expenses may be covered at **50% of the Eligible Charge** for not pre-certifying a Hospital admission and for any admission reviewed but not approved.

Case Management and Utilization Review

Case management is a collaborative process that assists you with the coordination of complex care services. A Blue Cross Blue Shield case manager is available to you, at no cost, as an advocate for cost-effective interventions. Case managers are also available to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as Blue Cross Blue Shield determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Plan.

Blue Distinction® and Blue Distinction Specialty Care Program

Blue Distinction® ("Blue Distinction") is a national designation awarded by Blue Cross and Blue Shield Plans to health care Providers. The Blue Distinction Specialty Care program includes two levels of designation: Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+). The Blue Distinction Specialty Care program focuses on BDC and BDC+ providers.

Blue Distinction Centers

The Blue Distinction designation uses nationally consistent criteria to designate high-performing providers based on objective, evidence-based selection criteria. The Blue Distinction Specialty Care program's purpose is to assist you in finding BDC and BDC+ providers that have met overall quality measures for patient safety and outcomes, fewer medical complications, lower readmission rates, and higher survival rates in the administration of specialty care. Blue Distinction Centers provide care in the following specialty care areas:

- Cardiac care
- Cellular immunotherapy (CAR-T)
- Substance use treatment and recovery
- Gene therapy
- Spine Surgery
- Bariatric Surgery
- Knee and hip replacement Surgery
- Maternity care
- Transplants

While you are free to choose to receive treatment at a non-BDC and/or non-BDC+ provider; you may notice higher costs for services or that you may be balance billed since many are out-of-network.

For additional information regarding Blue Distinction Centers for specialty care, please contact a Customer Service Representative at the toll-free telephone number shown on your Identification Card or visit the following website: https://www.bcbsil.com/find-care/blue-distinction-specialty-care/blue-distinction.

7.08 No Surprises Act

To the extent required by law, the Plan will comply with the No Surprises Act and the regulations promulgated thereunder. The No Surprises Act generally protects you from "balance billing" for Non-Network Emergency Services, Non-Network air ambulance services, and certain non-emergency services performed by a Non-Network Provider or facility.

Emergency Services

If you have an Emergency Medical Condition and receive Emergency Services from a Non-Network Provider or facility, the most the Provider or facility may bill you is the Plan's Network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these Emergency Services. This includes services you may get after you are in stable condition, unless you provide written consent and give up your protection not to be balanced billed for these post-stabilization services. Note that this does not apply to ground ambulance services.

Non-Emergency Services from a Non-Network Provider at a Network Facility

If you receive services from a Network Hospital or ambulatory surgical center, certain providers may be considered Non-Network providers. Under the No Surprises Act, the most these providers may bill you is the Plan's Network cost-sharing amount (such as copayments and coinsurance). This applies to emergency medicine, anesthesia, pathology, laboratory, neonatology, assistant surgeon, hospitalist or intensivists services. These providers cannot balance bill you and may not ask you to give up your protection not to be balance billed.

If you receive other services at these Network facilities, the Non-Network providers cannot balance bill you, unless you provide written consent and give up your protections. You are never required to give up your protections from balance billing.

Non-Network Air Ambulance Services

If you receive air ambulance services from a Non-Network provider, the most the provider may bill you is Plan's Network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these services.

Complaint Process

If you believe you have been wrongly billed or otherwise have a complaint under the No Surprises Act, you may contact the Fund Office, or the No Surprises Help Desk at 1-800-985-3059.

7.09 Covered Medical Expenses

The Plan covers the Eligible Charge for the following services and supplies provided or ordered by a Physician (except as specifically provided otherwise) that you receive for the treatment of a non-occupational accident or sickness when Medically Necessary, subject to the Plan maximums and limitations provided in the *Schedule of Benefits*.

Hospital Covered Services

Inpatient Hospital Care

The following are Covered Services when you receive them as an Inpatient in a Hospital.

- **Inpatient Covered Services**
  - Bed, board and general nursing care when you are in: (a) a semi-private room; (b) a private room; or (c) an intensive care unit.
  - Ancillary services (such as operating rooms, drugs, surgical dressings and lab work).

- **Preadmission Testing**
  Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery. These tests are considered part of your Inpatient Hospital surgical stay.

- **Partial Hospitalization Treatment**
  Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claims Administrator.

- **Coordinated Home Care**
  Benefits will be provided for services under a Coordinated Home Care Program. There is no limit on visits under the Coordinated Home Care Program per calendar year.

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 and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not more than 48 hours (or 96 hours as applicable).

Outpatient Hospital Care

The following are Covered Services when you receive them from a Hospital as an Outpatient.

- Surgery and any related Diagnostic Service received on the same day as the Surgery.

- Radiation therapy treatments.

- Chemotherapy.

- Electroconvulsive therapy.

- Renal dialysis treatments – if received in a Hospital, a dialysis facility, or in your home under the supervision of a Hospital or dialysis facility.

- Diagnostic services – when you are an Outpatient, and these services are related to Surgery or medical care.

- Emergency accident care.

- Emergency Services.

- Bone mass measurement and osteoporosis – benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Hospice Care Program

Your Hospital coverage also includes benefits for Hospice Care Program Service. Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider.

However, for benefits to be available, you must have a terminal illness with a life expectancy of six (6) months or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is provided in the home.

The following services are covered under the Hospice Care Program:

- Coordinated Home Care
- Medical supplies and dressings
- Medication
- Nursing Services - skilled and non-skilled
- Occupational therapy
- Pain management services
- Physical therapy
- Physician visits
- Social and spiritual services
- Respite care service

Physician Covered Services

- **A1C Testing**
  This plan provides benefits for A1C testing for prediabetes, type I diabetes, and type II diabetes mellitus.
- **Allergy Injections and Allergy Testing**
- **Amino Acid-Based Elemental Formulas**
  Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary.
- **Autism Spectrum Disorder treatment**
  Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed or ordered by an individual with an Autism Spectrum Disorder: (a) by a Physician or Psychologist who has determined that such care is Medically Necessary; or (b) by a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorders, including but not limited to, a health care professional who is eligible as a Qualified ABA Provider by state regulation and when such care is determined to be Medically Necessary and ordered by a Physician or Psychologist:
    - Psychiatric care, including diagnosis services

- Psychological assessments and treatments
- Habilitative or rehabilitative treatments
- Therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas:
    - ✓ Self-care and feeding
    - ✓ Pragmatic, receptive and expressive language
    - ✓ Cognitive functioning
    - ✓ Applied behavior analysis (ABA)
    - ✓ Intervention and modification
    - ✓ Motor planning
    - ✓ Sensory processing

- **Biomarker Testing**
  This Plan provides benefits for Medically Necessary biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition.
- **Blood Glucose Monitors for Treatment of Diabetes**
  This plan provides benefits for Medically Necessary blood glucose monitors (including non-invasive monitors and monitors for the blind), if a Physician has provided a written order.
- **Bone Mass Measurement and Osteoporosis**
  Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.
- **Clinical Breast Examinations**
  Benefits will be provided for clinical breast examinations when performed by a Physician, advanced practice nurse or a physician assistant working under the direct supervision of a Physician.
- **Chemotherapy**
- **Chiropractic and Osteopathic Manipulation**
  Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 30 visits per person, per calendar year, unless additional visits are determined to be Medically Necessary.
- **Comprehensive Cancer Testing**
  This Plan provides benefits for Medically Necessary comprehensive cancer testing, including, but not limited to, whole-exome genome testing, whole-genome sequencing, RNA sequencing, tumor mutation burden, and targeted cancer gene panels.

- **Consultations**
  Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or maternity service during the same admission.

- **Diabetes Self-Management Training and Education**
  Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1c level within the ranges identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management, operating within the scope of his/her license. Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

- **Diagnostic Services**
  Benefits will be provided for those services related to covered Surgery or medical care.

- **Durable Medical Equipment**
  Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

- **Emergency Services**

- **Electroconvulsive Therapy**

- **Fertility Treatment**
  Benefits will be provided for Medically Necessary infertility treatment for Participants and their Dependent spouses. Infertility means a disease, condition, or status characterized by the inability to conceive a child or to carry a pregnancy to live birth after one (1) year of regular unprotected sexual intercourse or due to an impairment of a person's capacity to reproduce either as an individual or with her/his partner. However, earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12 month or 6-month term for determining infertility).

  Infertility may be due to:

  - Female factors (e.g. pelvic adhesions, ovarian dysfunction, endometriosis, prior tubal ligation, and absent or nonfunctioning uterus);

  - Male factors (e.g. abnormalities in sperm production, function, or transport, or prior vasectomy);

  - A combination of both male and female factors; or

  - Unknown causes.

  If determined to be Medically Necessary, the covered infertility services included, but are not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, intracytoplasmic sperm injection, oocyte and sperm retrieval.

  The Plan will not provide coverage for the following:

  - Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.

  - Expenses incurred for cryo-preservation or storage of sperm, eggs, or embryos, except for those procedures which use a cryo-preserved substance.

  - Non-medical costs of an egg or sperm donor.

  - Infertility treatments which are deemed experimental, investigational or unproven, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

  - Expenses for services that, in the judgment of the Claims Administrator, are not Medically Necessary.

  - Infertility treatment for Dependent Children.

  Though this benefit does not require precertification, the Fund recommends you contact the Claims Administrator prior to obtaining treatment to ensure it meets the guidelines for coverage.

- **Hearing Examinations and Hearing Aids**

- **Medical Care**
  Benefits are available for medical care visits when:

  - You are an Inpatient in a Hospital, a Skilled Nursing Facility, or substance use disorder treatment facility or a Residential Treatment Center; or

  - You are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program; or

  - You visit your Physician’s office, or your Physician comes to your home.

- **Naprapathy**

- **Occupational Therapy**
  Benefits will be provided for occupational therapy when these services are rendered by a registered occupational therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of 30 visits per person, per diagnosis, per calendar year, unless additional visits are determined to be Medically Necessary. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any occupational therapy visit maximums indicated in the *Schedule of Benefits* section of this benefit booklet.

- **Orthotic Devices**
  Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. Your benefits for foot orthotics will be limited to two (2) foot orthotic devices or one pair of foot orthotic devices per calendar year.

- **Outpatient Contraceptive Services**
  Benefits will be provided for prescription contraceptive devices, injections, implants and outpatient contraceptive services. Outpatient contraceptive services mean consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

- **Pancreatic Cancer Screening**

- **Physical Therapy**
  Benefits will be provided for physical therapy when rendered by a licensed professional physical therapist; provided, however, when the therapy is beyond the scope of the physical therapist's license, the physical therapist must be under the supervision of a Physician, and the therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for outpatient physical therapy will be limited to a maximum of 30 visits per person, per diagnosis, per calendar year, unless additional visits are determined to be Medically Necessary. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any physical therapy visits maximum indicated in the *Schedule of Benefits* section of this benefit booklet.

- **Prosthetic Appliances**
  Benefits will be provided for prosthetic devices, special appliances and surgical implants when:
  - They are required to replace all or part of an organ or tissue of the human body; or
  - They are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances and replacement of cataract lenses when a prescription change is not required).

- **Pulmonary Rehabilitation Therapy**
  Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

- **Radiation Therapy Treatments**

- **Routine Pediatric Hearing Examination**

- **Speech Therapy**
  Benefits will be provided for speech therapy when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient speech therapy benefits will be provided only if speech therapy is not the only reason for admission. Outpatient speech therapy benefits will be limited to a maximum of 30 visits per person, per diagnosis, per calendar year, unless determined to be Medically Necessary. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech therapy visits maximum indicated in the *Schedule of Benefits* section of this benefit booklet.

- **Surgery**
  Benefits are available for Surgery performed by a Physician, Dentist or podiatrist. However, for services performed by a Dentist or podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them, and which would be payable to the Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

  - Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth

    Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth

  - Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

  The following services are also part of your surgical benefits:

  - **Anesthesia Services –** if administered at the same time as a covered surgical procedure in a Hospital or surgical facility or by a Physician other than the operating surgeon or by a certified registered nurse anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or ambulatory surgical facility.

    In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or ambulatory surgical facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon's office, Hospital or ambulatory surgical facility if you are under age 19 and have been diagnosed with an Autism Spectrum Disorder or a developmental disability.

  - **Assist at Surgery –** when performed by a Physician, Dentist or podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or ambulatory surgical facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an advanced practice nurse. Benefits will also be provided for assist at Surgery performed by a physician assistant under the direct supervision of a Physician, Dentist or podiatrist.
  - Sterilization Procedures (even if they are voluntary rather than Medically Necessary).

- **Vitamin D Testing**
  This Plan provides benefits for vitamin D testing in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention.

7.10 Other Covered Medical Expenses

- The processing, transporting, storing, handling and administration of **blood and blood components**.

- **Ambulance Transportation –** benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

- **Dental Accident Care –** dental services rendered by a Dentist or Physician which are required as the result of an accidental injury. The following services and supplies are covered only if needed because of accidental injury to sound, natural teeth:

  - Oral Surgery
  - Full or partial dentures
  - Fixed bridge work
  - Prompt repair to natural teeth
  - Crowns

  A natural tooth is a virgin or unrestored tooth, or a tooth that has no decay, no filing on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

  An accidental injury occurs when dental damage is severe enough that initial contact with a Physician or Dentist occurred within 72 hours of the accident. Services must be provided and completed within six (6) months of an injury and approved in advance by the Claims Administrator. Accidental injury coverage does not include damage resulting from biting or chewing.

- **Medical and surgical dressings, supplies, casts and splints**.

- Medical and surgical benefits for **mastectomies** as required by federal law under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), including the following, when requested by the patient in consultation with her Physician:
    - Reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses and physical complications of all stages of mastectomy including lymphedemas

- **Oxygen and its administration.**

- **Preventive Services** in accordance with federal law. The list of Preventive Services changes from time to time, so please visit www.healthcare.gov/preventive-care-benefits for a comprehensive list.

- Charges for "routine patient costs" incurred by a "qualified individual" who is participating in an "**approved clinical trial**." For the purposes of this benefit, the following applies:
    - A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.
    - "Routine patient costs" generally include all items and services that typically would be covered under the Plan for an individual not enrolled in a clinical trial. Routine patient costs do not include the actual device, item or service that is being studied. Also excluded are items and services that are given only to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or a service that is clearly consistent with widely accepted and established standards or care for a particular diagnosis.
    - An "approved clinical trial" means a Phase I, II, III, or IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

- Treatment of **Mental or Nervous Disorders**.

- Treatment of **Chemical Dependency/Substance Abuse**.

- Treatment or Surgery for the occurrence of **Morbid Obesity**.

7.11 Medical Expenses not Covered by the Plan

The following is a list of procedures, services, supplies and types of treatment for which Plan benefits are not payable or for which the benefits are limited as indicated below. The following list is not an all-inclusive or an exhaustive list; rather, it is only representative of the types of services and supplies for which charges may be incurred but which are not payable by the Plan.

Please keep in mind, the fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as medically necessary, does not make the hospitalization, services or supplies medically necessary and does not mean that the Claims Administrator will pay the cost of the hospitalization, services or supplies.

- Hospitalization, services and supplies which are not Medically Necessary.
- Expenses for services; supplies, treatments or procedures:
  - which are not rendered for the treatment or correction of, or in connection with, a specific non-occupational accident or sickness, unless specifically identified as being covered under the Plan. In excess of any maximum benefit or limitation specified in the Plan
  - not specifically listed as a Covered Medical Expense under the Medical Benefit
  - received by a person, facility or organization acting outside the scope of the applicable license.
  - from more than one provider on the same day(s) to the extent benefits are duplicated.
  - not provided in accord with generally accepted professional medical standards
  - that in the judgment of the Claims Administrator are not Medically Necessary; or
  - For drug therapy programs not available in the United States or available in the United States only under special license by the federal government for practitioners engaged in research.
- A pregnancy or pregnancy related conditions other than for a Participant or Dependent spouse, except as required by the Affordable Care Act.
- Infertility related conditions other than for a Participant or Dependent spouse.
- Abortion procedures unless the life of the Participant or Dependent spouse is endangered or there is a medical complication. For the avoidance of doubt, the Plan does not cover abortion procedures for a Dependent Child.
- Charges for marriage counseling and premarital exams.
- Any losses, expenses or charges for Cosmetic Surgical procedures and related expenses, except for the following:
  - To correct the effects of an injury if the Surgery is performed in the year of the injury or the next year
  - To improve a congenital deformity
  - To improve a deformity resulting from disease or Medically Necessary Surgery

- Any type of rest cure or custodial care (care that is designed primarily to assist a person in meeting the activities of daily living (e.g., milieu therapy)), regardless of what the care is called. This also includes, without limitation, food, housing and supportive items such as air conditioners, handrails, ramps and telephones.

- Long term care services.

- Some Hospice related services, including not limited to:

    - Durable Medical Equipment

    - Home delivered meals

    - Homemaker services

    - Traditional medical services provided for the direct care of the terminal illness, disease or condition

    - Transportation, including, but not limited to, Ambulance Transportation

- Inpatient private duty nursing services.

- Charges for psychological evaluations if they relate to fitness to act as a custodial parent or diagnosis of a learning disability.

- Maintenance care.

- Habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

- Broken appointments.

- Over-the-counter medications or baby formulas.

- Massage therapy.

- Weight loss programs.

- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in the Plan.

- Dental braces and over-the-counter orthotics.

- Charges for services or supplies which constitute personal comfort or convenience items. Examples of items that are not covered include, but are not limited to, the following: personal hygiene items, hair appointments, magazines, cosmetics, guest trays, televisions, or telephone services.

- Dietary or nutritional counseling and supplements, except as required under federal law.

- Therapeutic devices and appliances, support garments or other non-medical items, regardless of their intended use.

- Services or supplies which are not recognized as payable (in whole or in part) by Medicare, including services and supplies that are more than the maximum number of such services/supplies allowed by Medicare where the covered individual is eligible for Medicare.

- Expenses covered under the Plan's Dental Benefit, Vision Benefit or Prescription Drug Benefit.

- Charges for any of the circumstances listed under the *General Plan Limitations and Exclusions* section of the Plan.

Section 8: Prescription Drug Benefits

The Prescription Drug Benefit is administered by a prescription drug benefit manager ("PBM") and is subject to the contractual agreements between the Plan and PBM. The Prescription Drug Benefit includes a Network Pharmacy Program, Mail Order or Maintenance Choice Program and Specialty Pharmacy Program to provide coverage for your short-term and long-term prescription needs. **Prescriptions purchased at a Non-Network Pharmacy are not covered under the Plan.**

8.01 Eligibility Requirements

The Prescription Drug Benefit applies to you and your Dependents if you are an Active Employee or Retiree, and you are eligible for medical benefits under the Plan.

8.02 Formulary, Generic, Preferred and Non-Preferred Drugs

A drug formulary is a list of generic and brand-name prescription medications covered by the Plan. The Plan's formulary is divided into tiers based on the type of drug. If your prescription medication is included in a lower tier, it will cost less. The formulary list is designed to help you get the medication you need at the lowest possible cost. While it does not include every available medication, it includes options to treat most health conditions. If the prescription medications you take are not included in the Plan's formulary, you may be responsible for paying them out-of-pocket.

The amount of your prescription drug copayment will depend on whether the drug is generic, preferred or non-preferred. The applicable copayments are listed in the *Schedule of Benefits*.

Generic drugs are chemically and therapeutically equivalent to their corresponding brand name counterpart. Preferred drugs are typically brand name drugs which are included in the list of medications that are preferred by the Plan and are determined by a committee of pharmacists and doctors to be the safest, most effective and most economical.

Non-preferred drugs are not included in the preferred list of drugs and are generally more expensive, brand name drugs. Drugs may change from preferred and non-preferred (and vice versa) from time to time.

For more information about which drugs are considered generic, preferred or non-preferred, please contact the PBM.

8.03 Out-of-Pocket Maximum

The maximum amount you pay for expenses under the Prescription Drug Benefit each calendar year is the out-of-pocket maximum listed in the *Schedule of Benefits*. This is subject to change annually based on the federal out-of-pocket-maximums. Once you reach the applicable out-of-pocket maximum, the Plan pays 100% of all covered Prescription Drug Benefit expenses, up to any specific Plan maximums, for the remainder of the calendar year.

The family out-of-pocket maximum may be satisfied through any combination of individual out-of-pocket maximums. Once you meet the family out-of-pocket maximum, no further individual out-of-pocket maximum will be applied to any eligible member of your family during the remainder of the calendar year.

The out-of-pocket maximum for the Prescription Drug Benefit is separate from your out-of-pocket maximum for the Medical Benefit, so your prescription drug copayments do not count towards your Deductible or out-of-pocket maximum under the Medical Benefit and vice versa.

8.04 Prior Authorization

Prior authorization (PA) is an extra layer of review that is needed for some medications. If your physician prescribes a medication that is on the drug formulary and it is denied, prior authorization may be necessary. This process ensures certain criteria is met before the Plan will cover your prescription. There are a few reasons why prior authorization might be required. The medication may be unsafe when combined with other medications you are taking, used only for certain health conditions, have the potential for misuse or abuse, or an effective alternative might be available. If your medication does require a prior authorization, you should speak with your physician to determine if an alternative is available. If not, then you or your pharmacist can ask your physician to start a prior authorization. The PBM will then work with your physician to get additional information that will help them determine if the medication should be covered. The process can take several days and depends on how complete and quickly information is provided and reviewed. If approved, you can fill your prescription. If denied, you will receive a letter from the PBM and then you can ask your physician if there is another medication covered by the Plan that may also work for you. You could also choose to pay for the medication yourself at a Network Pharmacy, or you or your physician could submit an appeal under the Plan.

8.05 Quantity Limits

A quantity limit is the highest amount of medication covered by the Plan for a period of time (e.g., 90 tablets per 90 days). The Plan will cover your medication up to the limit. Once the quantity limit is reached, you will have to pay the full cost of the medication. Quantity limits are sometimes used to help make sure a medication is not overused or to help save money for you and the Plan.

8.06 Mandatory Generic Drug Program

The Mandatory Generic Drug Program requires your pharmacist to fill your brand name prescriptions with a generic equivalent whenever one is available, unless your Physician indicates that it is Medically Necessary for you to have the brand name prescription. If your Physician indicates it is Medically Necessary for you to have the brand name drug, you will be responsible for paying the appropriate brand name drug copay with no penalty. If your Physician does not indicate it is Medically Necessary for you to have the brand name drug and you choose to purchase the brand name drug when a generic equivalent is available, you will be responsible for the difference in cost between the generic drug and the brand name drug, plus the generic copayment.

8.07 Network Pharmacy Program

Important Note!

Always ask your pharmacy if it is a member of the CVS/Caremark network before filling a prescription. Prescriptions purchased at a Non-Network pharmacy are *not* covered under the Plan.

The Plan has contracted with CVS/Caremark and its network of pharmacies ("Network Pharmacies") to fill prescriptions for you and your covered Dependents. Before filling a prescription, ask the pharmacy if it is a member of the CVS/Caremark network. **Prescriptions purchased at a Non-Network Pharmacy are not covered under the Plan.**

You must present your prescription drug identification card and pay the applicable copayment to receive benefits for drugs bought at a pharmacy. For your covered Dependents' prescriptions, you will also need to provide a date of birth.

If you do not present your prescription drug identification card when you visit a Network Pharmacy, you will be reimbursed for any covered prescription drugs, provided you:

- Pay the full price of the prescription at the time of purchase;
- Have your pharmacist fill out a claim form; and
- Submit the claim form to the PBM for reimbursement.

Please be aware that your reimbursement may be less than if you had presented your prescription drug identification card at the time of service. You will pay the copayment and any amounts above the Network Pharmacy discount to the pharmacy.

Helpful Tip

FORGOT OR LOST YOUR PRESCRIPTION DRUG CARD? You can access your CVS Caremark ID card by downloading the CVS Caremark app on your mobile device or by visiting www.cvscaremark.com and accessing your member portal.

8.08 CVS Mail Order and Maintenance Choice Program

If you take prescribed maintenance drugs (medications you fill each month for longer than 2 months), you have the choice to receive up to a 90-day supply of your maintenance medication from a CVS/Caremark pharmacy or through the CVS Mail Order Program.

The Plan allows you to obtain two (2) initial 30-day supply prescription fills of a maintenance medication from a Network Pharmacy. After the two (2) initial fills, the Plan will cover your maintenance medications for 90-day prescriptions and only if you have those medications are filled through either the CVS Mail Order Program or at a CVS/Caremark pharmacy.

The first time you have a prescription filled through the CVS Mail Order Program, you will need to submit a copy of your 90-day prescription, and the appropriate copayment along with an order form. New prescriptions generally take 2 to 3 days to process and fill. Refills take 1 to 2 days to process and fill. Shipping is free of charge and typically takes 10-14 days for standard delivery. You can choose 2-day or next-day shipping at an additional cost; however, it will still take 1 to 3 days for your order to be processed before it is shipped. If delivery is delayed for any reason, your order will not be reprocessed until 15 days from the original shipping date.

For further information, contact CVS/Caremark at the number listed in the *Important Contact Information* section.

8.09 Specialty Pharmacy Program

Specialty drugs are prescriptions used to treat complex and chronic health conditions. To receive coverage for specialty drugs, you must have your prescription filled through the Specialty Pharmacy Program, which is a mail-order pharmacy that will ship your specialty medications directly to you or, if you prefer, to a CVS/Caremark Pharmacy. When you are prescribed a specialty medication, contact CVS/Caremark to enroll in the program. Once you enroll in the program, your medications will be sent directly to your home, work or a CVS/Caremark pharmacy via safe, temperature controlled and tested packaging at no additional cost. The amount of your copayment for specialty drugs are the preferred or non-preferred copayments, as appropriate, and are listed in the *Schedule of Benefits*.

If you do not purchase your specialty drugs through the Specialty Pharmacy Program, the cost of your prescription specialty drugs will not be covered by the Plan.

Specialty Step Therapy Program

The specialty step therapy program encourages the use of preferred drugs over non-preferred drugs. Under the program, you may be asked to try a lower-cost preferred drug before the non-preferred drug will be dispensed. If you are asked to try a lower-cost preferred drug and it is determined to be Medically Necessary for you to continue to use a non-preferred specialty drug, you will be responsible for paying the non-preferred copayment. **However, if the preferred drug is an option for you, but you continue to use the non-preferred drug, you will be responsible for paying the full cost of the non-preferred specialty drug.**

For further information, contact CVS/Caremark at the number listed in the *Important Contact Information* section.

8.10 Covered Prescription Drug Expenses

Unless otherwise excluded under the Plan, the Prescription Drug Benefit covers Medically Necessary prescriptions prescribed by a Physician. For a complete list of covered prescription drugs, you may contact CVS/Caremark. The following are examples of covered prescription drugs:

- All federal legend drugs
- State restricted drugs
- Contraceptives as required under federal law
- Injectable insulin
- Syringes and hypodermic needles in quantities compatible with the number of doses of insulin prescribed (**Note:** You must fill the insulin order first for the syringes to be covered by the Plan).

8.11 Non-Covered Prescription Drug Expenses

The following expenses are not covered under the Plan:

- Drugs you can purchase without a prescription, except as required by the Affordable Care Act.
- Over-the-counter medication or medical supplies other than diabetic supplies or as required by the Affordable Care Act.
- Experimental or Investigational drugs.
- Charges for the administration of prescription drugs or injectable insulin.
- Drugs taken by or administered to an individual in whole or in part while an inpatient in a hospital or other health care facility licensed for dispensing pharmaceuticals (such drugs may be covered under the medical benefit).
- Prescription drugs that may be properly received without charge under local, state or federal programs, including Workers' Compensation.
- Renova (Tretinoin).
- Imcivree (Setmelanotide).

- Gene therapy drugs (including but not limited to Luxturna (voretigene neparvovec-rzyl), Yescarta (Axicabtagene ciloleucel)).
- Lifestyle drugs such as drugs treating weight loss (except for weight loss drugs when approved as medically necessary by the Claims Administrator) and/or hair loss.
- Drugs prescribed for erectile dysfunction (ED) more than six (6) doses per month.
- Compound drugs.
- Opioids beyond the Morphine Milligram Equivalent (MME) quantity limit.
- 501K pathway devices, including, but not limited to, bandages, infusion pumps, pacemakers, wound care and durable medical equipment.
- Vision enhancement agents.
- Prescription digital therapeutics.
- Expenses for drugs obtained through another medical or prescription drug plan (no coordination of benefits).
- Drugs for which a required prior authorization has not been approved.
- Charges for more than the number specified by the prescriber for a 30-day supply (90-day supply for maintenance drugs).
- Any refill of a prescription drug dispensed more than one (1) year after the date of the prescription.
- Prescriptions purchased at a Non-Network Pharmacy.
- Any drug that is not approved by the Federal Drug Administration (FDA) or that is used for a non-FDA approved purpose.

Section 9: Dental Benefits

9.01 Eligibility Requirements

The Dental Benefit applies to you and your Dependents if you are an Active Employee or Retiree, and you are eligible for medical benefits under the Plan.

9.02 Network and Non-Network Providers

The Blue Cross Blue Shield BlueCare® Dental Preferred Provider Organization (“Dental PPO”) network allows you and/or your eligible Dependent(s) the freedom to choose any Dentist when you need dental care. You will maximize your dental benefits when you visit a general or specialty Dentist through the Dental PPO network because Network Providers have agreed to accept a negotiated rate for their services. Advantages of using Dentists in the Dental PPO network include the following:

- Reduced out-of-pocket costs due to discounted fees
- No Balance Billing
- No referral needed for specialty Dentists
- Network Provider will submit claims for you

Your annual maximum for dental benefits remains the same regardless of whether you select a Dentist from within or outside the network. If you choose to receive services from a Non-Network Provider, the Plan will pay a percentage of the charges for Covered Services, based on Eligible Charges, up to the maximum annual benefit, depending on the services received. The Eligible Charges are the Usual and Customary Rates. You may also be balance billed by Non-Network Providers for Covered Services.

9.03 Payment of Dental Benefits

Covered dental expenses are considered to have been incurred on the day the service is provided. When the complete service is not performed in one day, only the expense for that portion of the completed service will be considered incurred.

You will be responsible for the applicable percentage of covered expenses as listed in the *Schedule of Benefit*s, up to the maximum annual benefit limit. You will be responsible for the full cost of any services incurred after the limit has been met. If you choose a Non-Network Provider, you may be responsible for any amount above the Eligible Charges.

9.04 Dental Expenses Covered by the Plan

Benefits are based on a calendar year, beginning in January and ending in December. The Plan covers the following types of dental services:

Preventive and Diagnostic Services

- Application of dental sealants for Dependent Children up to age 16

- Dental x-rays (bitewings limited to two (2) per calendar year; full mouth limited to once every 36 months)
- Fluoride applications for Dependent Children up to age 19
- Oral examination, limited to two (2) times in a calendar year
- Teeth cleaning, scaling and polishing, limited to two (2) times in a calendar year
- Additional cleanings (up to four (4) per year) to treat periodontal disease with a letter of Medical Necessity for Dependent Children up to age 19

Basic and Major Services

- Addition of teeth to an existing removable partial or full denture or fixed bridgework, or its total replacement, if made necessary by drifting of anchor teeth.
- Artificial tooth implants
- Crowns and initial installation of fixed bridgework
- Extractions and oral surgery
- Surgical removal of complete bony impacted teeth
- Fillings and inlays
- General anesthesia for dental procedures when Medically Necessary
- Initial installation of removable or partial or full dentures
- Orthodontia (as described below under "Orthodontia Services")
- Repair or recementing of crowns, inlays, bridgework or dentures
- Treatment for tooth damage that results from the grinding or biting of teeth (occlusal services.
- Treatment of diseases of the gums and tissue of the mouth.

9.05 Dental Expenses Not Covered by the Plan

The Plan **does not cover** the following types of dental services:

- Any work performed directly by a laboratory and billed to you without a prescription from a Dentist: such as manufacture or repair of dentures, liners or other devices and appliances; or services and supplies of any kind furnished directly by a lab.
- Treatment by someone other than a Dentist or Physician. The Plan will cover teeth cleaning by a licensed dental hygienist who is supervised by a Dentist.
- Services and supplies that are solely for cosmetic reasons, such as bonding or whitening.

9.06 Orthodontia Services

When your eligible Dependent Child needs orthodontic care, he or she must visit a licensed orthodontist or Dentist. The Plan pays a percentage of the charges for Covered Services, up to a lifetime maximum, as listed in the *Schedule of Benefits*. There is no Deductible.

Payment of Orthodontia Services

Generally, an orthodontist establishes the total cost of his or her services, supplies and appliances before treatment starts. This is paid by an initial down payment with regular monthly payments thereafter. You are responsible for the initial down payment. You will be reimbursed for the down payment (but not more than 16% of the entire treatment — 80% of 20%), and the Plan will make regular, equal monthly payments of the benefit for the remaining costs.

To receive your monthly reimbursements, you must:

- Continue to qualify as a Plan participant; and
- Submit paid receipts from your orthodontist for your monthly payment
- You cannot receive your total reimbursements in less than 24 months, unless your Dentist certifies that the orthodontia correction is completed

Orthodontia Expenses Covered by the Plan

If it is determined to be Medically Necessary by the utilization review organization, an eligible Dependent Child under the age of 19 will no longer be subject to the lifetime maximum for orthodontic dental care. However, if the Dependent Child is age 19 to age 26, the Plan's lifetime maximum indicated in the *Schedule of Benefits* will apply even if the orthodontia dental care is Medically Necessary.

Orthodontia expenses that are not considered Medically Necessary will be subject to the Plan's lifetime maximum.

Orthodontia Expenses Not Covered by the Plan

The Plan **does not cover** the following orthodontia expenses:

- Expenses incurred by someone other than an eligible Dependent Child
- Replacement of lost or stolen retainers
- Services and supplies that are solely for cosmetic reasons
- Treatment by someone other than a licensed orthodontist or Dentist

Section 10: Vision Benefits

10.01 Eligibility Requirements

The Vision Benefit applies to you and your Dependents if you are an Active Employee or Retiree, and you are eligible for medical benefits.

10.02 Network and Non-Network Vision Providers

EIT Vision Clinic

Visit the EIT Vision Clinic in Alsip and you will receive a:

WellTech Exam
WellTech Fit
Free Retinal Imaging
Free Adjustments
90-Day Guarantee
Excellent Customer Service

Call (312) 795-5841 or visit www.vsponsiteclinic.com/eit to make an appointment.

The Plan has contracted with Vision Service Provider ("VSP") to provide services and supplies to you and your Dependents at discounted rates through Network Providers. You will maximize your vision benefits when you visit a licensed optician, optometrist or ophthalmologist through the VSP network because Network Providers have agreed to accept a negotiated rate for their services. Advantages of using the VSP network include the following:

- Reduced out-of-pocket costs due to discounted fees
- No Balance Billing
- Providers will submit claims for you (claims for Network Providers must be submitted within one (1) year of when the expense was incurred)
- Discounted prices on all your vision care needs, including those that are not covered by the Plan, such as extra supplies and laser vision correction services

To locate a Network Provider near you, please contact:

Vision Service Plan (VSP)
Member Services at 1-800-877-7195
Website at www.vsp.com

10.03 Payment of Vision Benefits

You will be responsible for any applicable copayment listed in the *Schedule of Benefits*. You are also responsible for paying for any expenses that the Plan does not cover, including costs that exceed the maximum benefit or allowance. There is no Deductible.

For services from a Network Provider, the Plan pays the cost of Covered Services after you pay your applicable copayment listed in the *Schedule of Benefits*. For Non-Network Providers, the Plan will reimburse you for part of your expenses for eye exams, frames and lenses, after you have paid your applicable copayment, in accordance with the *Schedule of Benefits*.

If you choose to receive services from a Non-Network Provider, be aware that Non-Network Providers may balance bill you for Covered Services. In addition, you must submit claim forms within six (6) months of the date the expense was incurred for Non-Network Providers. When you submit claim forms, you must include receipts.

10.04 Vision Expenses Covered by the Plan

Benefits are based on a calendar year, beginning in January and ending in December. The Plan covers the following types of Medically Necessary vision services:

- Complete vision analysis, including eye exam, refraction, visual therapy and case history
- Contact lenses, up to the allowance listed in the *Schedule of Benefits*, and a contact lens exam (including fitting and evaluation)
- Frames, up to the allowance listed in the *Schedule of Benefits* for a single pair, with additional savings on the cost that exceeds the amount over the allowance. Participants only are eligible for a second pair of prescription eyewear. Frames for Dependent Children under age 19 will be covered at 100% after the applicable copayment
- Lenses, fully covered for single vision, lined bifocal, lined trifocal, lenticular, progressive, or polycarbonate lenses or photochromic adaptive lenses and tints

Additional savings may be available for sunglasses and additional eyewear, including lens enhancements, from the same Network Provider on the same day as your vision exam.

10.05 Vision Expenses Not Covered by the Plan

The Plan **does not cover** the following types of vision services:

- Any type of lenses, frames, services, supplies or options that are not specifically listed as covered
- Any surgical treatment in place of corrective lenses such as LASIK, photorefractive keratectomy ("PKR") or radial keratotomy ("RK")
- Claims for a Network Provider filed more than one (1) year after the date the expense was incurred
- Claims for a Non-Network Provider filed more than six (6) months after the date the expense was incurred. Non-prescription lenses
- Replacement of lost or stolen glasses, or broken frames beyond the annual limit listed in the *Schedule of Benefits*
- Services in connection with vision therapy, orthoptics, vision training, aniseikonia, or medical or surgical treatment of the eye, unless performed by a Physician or licensed therapist

Section 11: Health Reimbursement Arrangement

The Health Reimbursement Arrangement ("HRA") is designed to allow you and your eligible Dependents to obtain reimbursement of Eligible Expenses (as defined below) on a tax-free basis. The HRA is employer-funded and administered and managed by HealthEquity.

Effective January 1, 2019, you may submit requests for and receive reimbursements from your HRA to cover Eligible Expenses that are not otherwise covered under the Plan.

11.01 Eligibility

The HRA is a notional account established for each Active Employee for whom the Plan receives contributions under a Collective Bargaining Agreement or participation agreement. If you are eligible for coverage under the Plan as an Active Employee or Retiree or based on disability-related hour credits, self-payments or COBRA coverage, you may utilize your HRA credit balance to pay for Eligible Expenses (defined below) incurred by you and your eligible Dependents, provided you are covered on the date the Eligible Expense was incurred.

You may continue to utilize your HRA credit balance as long as you remain eligible for medical benefits under the Plan. If you are not eligible for Retiree Health Benefits, you may utilize your HRA credit balance once you become eligible for Medicare.

11.02 Suspension of HRA

If you are not otherwise eligible for medical benefits under the Plan and you do not choose to elect COBRA coverage, then your HRA will be suspended. You may not submit or receive reimbursements from your HRA credit balance for Eligible Expenses incurred while your HRA is suspended. However, any contributions the Plan receives under a Collective Bargaining Agreement or participation agreement will still be allocated to your HRA.

Your HRA will remain suspended until one of the following events occurs:

- You reestablish eligibility for coverage under the Plan
- You become eligible for Medicare
- Your HRA is ultimately forfeited under the terms of the Plan (as explained below).

11.03 HRA Funding

Your HRA is a notional account funded by contributions made on your behalf pursuant to a Collective Bargaining Agreement or participation agreement for each clock hour reported by your Employer. An HRA contribution will **not** be made for any amounts received by the Plan as self-payments, and no contributions will be made to your HRA if you are not performing work covered under a Collective Bargaining Agreement or participation agreement.

The Fund Office keeps track of your HRA credit balance as a bookkeeping entry, which is adjusted at the discretion of the Trustees. The Trustees manage and control the assets in which the HRA credit balances are invested ("HRA Investment Fund"). The HRA Investment Fund is valued at fair market value annually for net earnings, losses, appreciation, depreciation and forfeitures. Any adjustment to your HRA credit balance is made in accordance with the Policy for Allocation of HRA Investment Fund Earnings/Losses and Forfeitures, which is available upon written request to the Fund Office, and which may be amended from time to time at the sole discretion of the Trustees.

If the Fund issues a reimbursement to you for an Eligible Expense from your HRA credit balance, your HRA credit balance will be reduced by the amount of such reimbursement. Your HRA credit balance will be carried over from year to year, except as specified below.

11.04 No Vesting of HRAs

HRAs are not savings accounts from which you can withdraw at will. You and your Dependents are not vested in your HRA credit balances. Amounts accumulated in your HRA can only be used for Eligible Expenses, subject to the rules and provisions set forth in this section.

Benefits payable under the HRA shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment or encumbrance of any kind, except as required under applicable law.

11.05 Crediting of Reciprocal Contributions

If you work outside the jurisdiction under a reciprocity agreement and you elect to transfer your contributions to the Plan, your contributions will first be applied to maintain your eligibility under the Plan. Any excess amount above Local 134's "core" contribution rate will be allocated to your HRA.

Core Contribution Rate

The "core" contribution rate is calculated by subtracting the HRA allocation from Local 134's health and welfare contribution rate.

11.06 Eligible Expenses and Reimbursements

Your entitlement to reimbursement from your HRA and the amount of any such reimbursement will be based on your HRA credit balance at the time the reimbursement is requested and your eligibility for benefits under the Plan on the date of service. You may receive reimbursement from your HRA only for Eligible Expenses. An expense is an Eligible Expense if it satisfies the following requirements:

- The expense is incurred on or after June 1, 2018;
- The expense is incurred by an eligible individual while covered under the Plan (including any periods during which coverage is extended because of self-payments, disability-related credit hours or COBRA coverage) or Medicare;
- The expense is not payable under any other benefit provisions of the Plan, has not been and will not be reimbursed by other insurance or any other source, and has not been and will not be claimed as a tax deduction; and
- The expense is an "Eligible Expense" (as defined below).

Eligible Expense

To be an Eligible Expense, the expense must be a "qualified medical expense" under Section 213(d) of the Internal Revenue Code of 1986, as amended ("IRC"). Examples of a "qualified medical expense" include the following:

- Self-payments, including COBRA coverage self-payments and Retiree Self-Pay Contributions
- Deductibles and copayments under the Plan

- Medical expenses not covered by or in excess of the benefits provided under the Medical Benefit
- Expenses for dental treatment, including orthodontia
- Prescriptions and over-the-counter medications. Such items shall not include toiletries, sundries or cosmetics
- Guide dogs for blind or deaf persons
- Certain travel expenses of the patient when necessary to receive essential medical care, and the travel and lodging expenses of another family member whose presence is necessary for the treatment. The patient's Physician must certify that the family member's presence is necessary for the treatment
- Special telephone and television equipment for hearing-impaired persons
- Hearing aids and examinations
- Smoking cessation programs
- Vision expenses, including surgery or laser treatments to correct vision
- Schooling for the mentally impaired or physically disabled
- Acupuncture
- Weight loss programs, but not food or dietary supplements

For a complete list of IRS Section 213(d) eligible expenses, please visit www.irs.gov/pub/irs-pdf/p502.pdf. However, note that just because an expense is listed in Publication 502 does not automatically make it an Eligible Expense under the HRA rules.

Expenses That Do Not Qualify as Eligible Expenses

No reimbursement will be made from your HRA for expenses that are not Eligible Expenses (i.e., do not qualify as "qualified medical expenses" in Section 213(d) of the IRC). Some examples of expenses that are not covered include the following:

- Athletic club, health and/or spa or gym memberships
- School fees for boarding schools or school fees not related to a medical necessity
- Cosmetic surgery, procedures and supplies
- Health programs offered by resort hotels, health clubs and gyms
- Child and elder care
- Funeral expenses
- Hair transplants
- Household help other than that qualifying as long-term care
- Personal use items
- Premiums for coverage through a state or federal Health Insurance Marketplace
- Teeth whitening

11.07 Reimbursements

Reimbursements from your HRA are subject to the following requirements:

- You must submit a claim for reimbursement of any Eligible Expense by either: (1) using your Health Equity debit card to pay for eligible expenses at the time of service; or (2) submitting a reimbursement form, along with a copy of your Explanation of Benefits ("EOB") or other itemized receipts to Health Equity through the EZ Receipt app, online or by fax or mail.
- HRA reimbursement requests can only be submitted by you or by your Dependent spouse pursuant to your written authorization on file at the Fund Office or, in the event you are deceased, by your surviving Dependent(s). HRA reimbursement requests may not be submitted by a former spouse (unless your former spouse has elected COBRA), and an HRA credit balance is not subject to division pursuant to a domestic relations order under the preemption provisions of ERISA Section 514.
- HRA reimbursement requests must be submitted within 365 days from which the Eligible Expense was incurred. Note that the expense is incurred on the date you received services or items for which you were charged the expense, not the date of payment or invoicing.

11.08 Your Right to Opt-Out

You may choose to permanently opt-out of your HRA and forfeit your right to reimbursement from your HRA at any time by notifying the Fund Office in writing. Any credit balance in your HRA as of the date the Fund Office receives notice of such opt-out will be permanently forfeited. Any notice of opt-out received by the Fund Office is irrevocable. You will not receive any increase in you other benefits under the Plan as a result of opting-out of the HRA.

11.09 Forfeiture of HRA Credit Balance

Your HRA credit balance will be forfeited on the earliest to occur of the following:

- You lose eligibility under the Plan for one (1) year and your HRA credit balance is less than $25.00;
- You lost eligibility under the Plan for a period of two (2) consecutive years and your HRA credit balance is between $25.00 and $49.99;
- You lose eligibility under the Plan for a period of three (3) consecutive years and your HRA credit balance is between $50.00 and $74.99;
- You lose eligibility under the Plan for a period of four (4) consecutive years and your HRA credit balance is between $75.00 and $99.99;
- You attained age 80, you have not submitted a claim for reimbursement for at least one (1) year and your HRA credit balance is less than $25;
- The Fund Office receives written notice that you irrevocably elect to opt-out of the HRA; or
- You die and you have no surviving Dependent on the Plan at the time of your death.

11.10 Payment of HRA Credit Balance upon Your Death

If you have a credit balance in your HRA upon your death and have eligible Dependents, your surviving spouse may use your HRA credit balance for his or her Eligible Expenses or for any surviving eligible Dependent covered under the Plan at the time of your death, by submitting reimbursement requests to the Fund Office. If there is no surviving spouse or your surviving spouse dies, then the remaining balance will be divided equally between the surviving eligible Dependent(s) at the time of death. The eligible Dependent may then use the HRA credit balance by submitting reimbursement requests.

If you die and you have no surviving Dependents, your HRA credit balance, if any, will be forfeited. Any remaining balance in an eligible Dependent account will be forfeited upon the eligible Dependent's death. The HRA is a notional account and cannot be paid out, except in the form of reimbursement for Eligible Expenses incurred by you or your eligible Dependents.

Section 12: Disability Benefits

The Plan provides you with disability coverage that gives you and your family protection against some of the financial hardships that can occur if you become Disabled or injured. The benefits include Short-Term Disability Benefits and Long-Term Disability Benefits.

12.01 Disability Related Hour Credits

If you are unable to work because of a disability, you may be credited with up to 25 hours for each week of proven disability while eligible for Short-Term Disability or Long-Term Disability Benefits during any one period of continuous disability.

To receive credited hours, you *must* be:

- Receiving Short-Term Disability or Long-Term Disability Benefits from the Plan or disability benefits from your employer's Workers' Compensation insurance; or
- Eligible for but not receiving benefits from the Plan because Social Security disability benefits are greater.

Eligibility credit will be given for up to 118 weeks if you were continuously covered under the Plan (not including COBRA coverage) for at least 12 consecutive months, or 7 of the last 8 consecutive coverage quarters prior to the date of your disability, or for up to 14 weeks if you were covered for fewer than 12 consecutive months prior to your disability (not including COBRA coverage).

12.02 Limitations and Exclusions

You will not receive either Short-Term Disability or Long-Term Disability Benefits for any period of disability:

- During which you are not under the regular care of a Physician
- During which your disability is not certified by the case management service
- For which you are paid by an employer
- That results from an accident while intoxicated or under the influence of narcotics not administered by a Physician
- That occurs after the date you retire
- During which you are covered under COBRA continuation coverage
- That results from any of the circumstances listed under the *General Plan Limitations and Exclusions* section of the Plan

12.03 Short-Term Disability Benefits

Eligibility Requirements

If you are an Active Employee and you are eligible for coverage under the Plan at the time of your disability (not including COBRA coverage), you may be eligible for Short-Term Disability Benefits. To be eligible for Short-Term Disability Benefits you must be Disabled under the terms of the Plan.

To receive Short-Term Disability Benefits, the Fund Office **must** receive your application for short-term disability benefits within 90 days of the later of (1) the date you last worked Contributed Hours, or (2) the date of your injury or illness.

Payment of Short-Term Disability Benefits

Your Short-Term Disability Benefits will start on the eighth consecutive calendar day of your disability. If you remain Disabled, payments will continue for up to 13 weeks, but not beyond the date your Physician allows you to return to work.

The amount of the Short-Term Disability Benefit payable is listed in the *Schedule of Benefits*. You will receive your Short-Term Disability benefit at the end of each pay period during which you have provided proof of your continuing disability. As required by federal law, Social Security and Medicare taxes will be withheld from your weekly Short-Term Disability Benefit check. If you want federal income and state taxes withheld from your check, you must notify the Fund Office.

Benefits will be paid for no more than two (2) periods of disability during any rolling, or consecutive, 60-month period.

Recurring Disabilities

If you recover from a Short-Term Disability, return to work and are later Disabled again from the same cause, the two periods will count as one period of disability, unless your Physician released you for full-time unrestricted work and:

- The disabilities are separated by four consecutive weeks of full-time employment where you are doing the same or similar work as you did before your disability; or
- You are registered with the Referral Hall and Available for Work and did not turn down gainful employment for at least four consecutive weeks.

If you recover from one Short-Term Disability and then become Disabled from a different cause, you will receive benefits for up to 13 weeks for *each* period of disability if:

- Your Physician allowed you to return to full-time unrestricted work between the two periods of disability; and
- You either returned to full-time unrestricted work or registered with the Referral Hall and were Available for Work and did not turn down gainful employment.

For Example – Recurring Short-Term Disability – One Period: You hurt your arm and qualify as Disabled on March 1. On March 9, payment of your Short-Term Disability Benefit begins. Your Physician authorizes you to return to full-time unrestricted work on April 19, which you do. At this point, you have received Short-Term Disability Benefits for seven weeks. Three weeks later, on May 3, you reinjure your arm and qualify as Disabled. Since these two disabilities (from the injury on March 1 and the injury on May 3) are not separated by four weeks of full-time employment, the second disability is considered part of the same period as the first disability, and you are eligible for only six additional weeks of Short-Term Disability Benefits because the Plan only offers a total of 13 weeks of Short-Term Disability Benefits for each period of disability.

For Example – Recurring Short-Term Disabilities – Multiple Periods: You hurt your leg at home and qualify as Disabled on July 15. On July 23, payment of your Short-Term Disability Benefit begins. Your Physician authorizes you to return to full-time unrestricted work on September 24, which you do. At this point, you have received Short-Term Disability Benefits for nine weeks. On March 10 of the following year, you injure your arm through a cause unrelated to your leg injury the year before, and you qualify as Disabled. Since more than 4 consecutive weeks of full-time unrestricted work have elapsed, you must begin a new disability claim. You receive ten weeks of Short-Term Disability Benefits on your new claim. Your Physician authorizes you to return to full-time, unrestricted work on May 19. Since the Plan has provided Short-Term Disability Benefits for two separate periods of disability, you are not eligible for any further Short-Term Disability Benefits until five years after the original July 15 disability.

12.04 Long-Term Disability Benefits

Eligibility Requirements

If you are an Active Employee and you have been continuously covered under the Plan for the 12-consecutive month period before the date your disability began (excluding COBRA coverage) or seven (7) of the last eight (8) consecutive Coverage Quarters before the Short-Term Disability effective date, you may be eligible for Long-Term Disability Benefits.

Applying for Social Security Disability Benefits

If your disability is expected to last 5 months or longer, you must have applied for Social Security Insurance Disability benefits to be eligible for Long-Term Disability Benefits under the Plan.

To be eligible for Long-Term Disability Benefits, you must:

- Have exhausted your Short-Term Disability Benefits
- Be Disabled under the terms of the Plan
- Not have engaged in any gainful employment for 14 consecutive weeks
- Have an application for Social Security Disability Insurance benefits pending (if your disability has lasted at least five months) or be eligible to receive Social Security benefits

The Fund Office determines disability and the right of any participant to receive disability benefits from the Plan.

Payment of Long-Term Disability Benefits

Your Long-Term Disability Benefits will automatically start after 14 weeks of disability (inclusive of the waiting period) provided you meet the requirements for Long Term Disability benefits. If you remain Disabled, payments will continue for up to 24 months, but not beyond the date your Physician allows you to return to work. Your payments will also end when you receive a disability award from Social Security and elect to receive a disability pension from Pension Plan No. 2 or have attained normal retirement age with Social Security and will not be eligible for an SSDI award based on your age.

The monthly amount of the Long-Term Disability Benefit is listed in the *Schedule of Benefits* and based on the formula shown below:

60% of your average monthly pay

(subject to a $2,000 minimum benefit; $3,000 maximum benefit)

MINUS

Any disability benefits paid or payable by Social Security or any other group disability plan

For Example – Since your benefit is 60% of your average monthly pay, if your average monthly pay is $3,333 or less, your monthly benefit will be $2,000. If your monthly pay is between $3,333 and $4,999, you will receive 60% of your average monthly pay. If your average monthly pay is at least $5,000, your maximum benefit is $3,000 per month, reduced, in all cases, by any amount of disability benefits payable by Social Security or any other group disability plan.

Vacation and holiday pay, bonuses and commissions are not included in calculating your average monthly pay for purposes of your Long-Term Disability Benefit.

Average Monthly Pay

Average monthly pay means the wages or salary paid to you by participating employers in the 12 calendar months before your disability began, divided by 12.

Rehabilitative Employment

Your Long-Term Disability Benefit will continue if you participate in rehabilitative employment, but it will be reduced by 80% of your income from such employment. The reduction may apply for the whole 24-month benefit period.

Recurring Disabilities

If you recover from a Long-Term Disability and then are considered Disabled again within six months from the same or a related cause, you are considered to have a continuation of the first disability. If more than six months have passed since your recovery, and you have worked doing the same or similar work for six consecutive months as you did before your first disability, you are considered to have a new disability for which you may receive up to 24 months of benefits, subject to a 14-week waiting period.

Social Security Disability Benefits (SSDI)

Social Security may also provide disability benefits to you and your eligible family members. You **must** apply for a Social Security Disability Insurance ("SSDI") benefit within five months of the onset of your disability to remain eligible for Long-Term Disability Benefits under the Plan. You must provide the Fund Office with a copy of the confirmation from the Social Security Administration that the application was submitted. If your initial application for SSDI benefits is denied, you **must** pursue your right to appeal the denial. This means you must complete each of the following steps on a timely basis until you receive a final and non-appealable decision on your claim:

- A reconsideration
- A hearing before an administrative law judge
- A review by an Appeals Council

For each step, you must apply in writing within 60 days of notification that your appeal was not granted at the earlier step.

After you have been determined to be eligible for SSDI benefits for 24 months, you become eligible for Medicare — regardless of your age. This is another important reason to pursue your claim for Social Security benefits throughout the entire appeals process.

Disability Advancement

While you wait for the Social Security Administration to make a final determination of your right to SSDI benefits, the Trustees may grant an advancement from the Plan. This disability advancement is secured by your benefit under the Plan or any other benefits that you may receive from the Trustees.

Prior to your first month of Long-Term Disability benefits, the Fund Office will send you a "Disability Advancement Agreement" for you to complete and return.

The disability advancement begins after your first month of Long-Term Disability. The amount of the disability advancement is determined based on your estimated SSDI benefit from Social Security. If your application for SSDI benefits is approved, the advancement portion must be paid back to the Plan within 30 days after you receive an SSDI benefit.

If your application for SSDI benefits is not approved after you have completed the entire appeal process, as described above, you will not be required to repay the disability advancement as there will be no retroactive benefits from SSDI to offset the disability advancement.

If you will not be eligible for SSDI benefits because you have already reached your normal retirement age as determined by the Social Security Administration, you will not be eligible for Long Term Disability payments after the first month.

Coordination with Pension Plan Disability Benefits

If you become totally and permanently Disabled and have been granted an SSDI benefit from Social Security, you may be eligible to receive benefits from Pension Plan No. 5 and/or Pension Plan No. 2. However, if you start your disability pension from Pension Plan No. 2, you are no longer eligible for Long-Term Disability benefits under the Plan. **Please note, delaying these benefits may affect your eligibility for retroactive benefits under Pension Plan No. 2 and your Retiree Health Benefits under this Plan.** Please contact the Fund Office for more information.

12.05 Coordination with Workers' Compensation Claims

When you are hurt on the job, **you are responsible for notifying the Fund Office of your injury as soon as possible. <u>Any delay in reporting the injury may result in benefits being denied</u>.** The Fund Office will notify the Claims Administrator of the injury and reject claims relating to the injury, as the Workers' Compensation insurance carrier will be responsible for payment of any claims relating to the injury or illness.

You must complete and file a Workers' Compensation Disability Statement, available on the Fund Office website, **within 90 days** of the later of (1) the date you last worked Contributed Hours, or (2) the date of your injury or illness, including contested Workers' Compensation claims. Your employer may notify the Fund Office if you file a Workers' Compensation claim with its insurance carrier, however, it is ultimately your responsibility to ensure the Fund Office has been notified. **Workers' Compensation Disability Statements received after the 90-day deadline will be denied.**

Credited Hours and Workers' Compensation

If you become Disabled because of an occupational injury or illness and have been awarded Workers' Compensation benefits (even if you contest the amount of the Workers' Compensation benefits), you are **not** eligible to receive any disability payment under the Plan. You may, however, be eligible to receive hours credited towards your eligibility for coverage under the Plan.

To receive disability-related credit, you must:

- Submit your Workers' Compensation Disability Statement to the Fund Office within the 90-day period described above;
- Have been covered under the Plan at the time of your injury or illness (not including COBRA coverage); and
- Provide the Fund Office with proof of continued payments from the Workers' Compensation insurance carrier along with an updated Attending Physician Statement quarterly, as requested. Failure to provide the necessary documentation within 90 days of the request will result in a suspension of benefits. Your claim for Workers' Compensation credited hours will be permanently closed if the requested documentation has not been received by the Fund Office within 180 days of the initial request.

Disability related hours credit will be given for up to 118 weeks if you were continuously covered under the Plan for at least 12 consecutive months before the date of your injury or illness (not counting any periods of COBRA coverage), or for up to 14 weeks if you were covered for fewer than 12 consecutive months before your injury or illness (not counting any periods of COBRA coverage).

Contested Workers' Compensation Claims

If you filed a claim for Workers' Compensation that has been denied, are not receiving or have never received any Workers' Compensation benefits from such claim and are appealing the denial with the applicable court or governmental agency ("WCCGA"), you may be eligible to receive reduced Short-Term Disability Benefits and Long-Term Disability Benefits under the Plan until your claim is ultimately denied or awarded by the WCCGA.

In such cases, you would be eligible to receive 50% of the Short-Term Disability payment for up to a maximum of 13 weeks and 50% of the Long-Term Disability payment for up to an additional 24 months if you meet all the following requirements:

- You submit your application for Short-Term Disability Benefits within 90 days of the later of (1) the date you last worked Contributed Hours, or (2) the date of your injury or illness;
- **For Short-Term Disability payments**, you were covered under the Plan at the time of your injury or illness (not including COBRA coverage);
- **For Long-Term Disability payments**, you were covered under the Plan for 12 consecutive months before the date of your injury or illness (not including COBRA coverage) or seven (7) of the last eight (8) consecutive Coverage Quarters before the Short-Term Disability effective date;
- You execute a reimbursement agreement with the Trustees, which requires, upon receipt of any recovery whatsoever for your injury or illness from whatever source, you agree to reimburse any Short-Term Disability payments, Long-Term Disability payments and medical expenses paid by the Plan on account of the injury or illness, and you agree that no reductions or deductions are allowed for litigation costs, court costs, or attorney's fees (i.e., the Illinois Common Fund Doctrine, Make Whole Doctrine, and/or any other state law affecting these rights are preempted by the Plan provisions under ERISA);

- You provide proof of the denial by the Workers' Compensation insurance carrier, proof of the appeal to the WCCGA; and quarterly proof that you are unable to return to work;
- Your Workers' Compensation claim is still pending before the WCCGA; and
- You satisfy all other requirements to qualify for Short-Term and/or Long-Term Disability Benefits, as appropriate, under the terms of the Plan.

During the time that your Workers' Compensation claim is contested and pending a final and non-appealable decision, you will be credited disability related hours for purposes of determining eligibility for coverage under the Plan, which will cover medical expenses for the injury or illness until a final and non-appealable decision is made as to whether your injury or illness is determined to be work-related.

Final and Non-Appealable Decision

If your claim is ultimately denied by the WCCGA, your claim will be converted to a Short-Term Disability Benefit and/or Long-Term Disability Benefit, as appropriate, and you will be paid the balance of disability payments not previously paid to you.

If you are awarded any Workers' Compensation benefits, regardless of classification, by any WCCGA, you must fully reimburse the Plan for the disability payments made and the medical expenses covered for treatment related to the injury or illness, consistent with the terms of the reimbursement agreement.

If you fully reimburse the Plan for the disability and medical expense payments made on your behalf during the time your Workers' Compensation claim was contested, the period of Short-Term Disability Benefits paid to you during the time your Workers' Compensation claim was contested will not count towards one of your two periods of Short-Term Disability Benefits permitted within any rolling, or consecutive, 60-month period.

If you do not fully reimburse the Plan, amounts due to the Plan will be offset from any future benefit amounts otherwise payable to you by the Plan to the extent permitted by law, including suspension of coverage. In addition, this will be counted as one of your two periods of Short-Term Disability Benefits permitted within any rolling, or consecutive, 60-month period.

Section 13: Maternity Leave Benefits

If you are an Active Employee and are out of work due to your pregnancy, you may be eligible to receive Maternity Leave Benefits under the Plan.

13.01 Eligibility Requirements

To qualify for Maternity Leave Benefits, you must be covered as an active Participant by the Plan (not including COBRA coverage) at the onset of your maternity leave. You cannot receive the Maternity Leave Benefit and the Short-Term Disability Benefit or Long-Term Disability Benefit at the same time.

13.02 When Benefits Begin and End

Your Maternity Leave Benefits may begin no earlier than 13 weeks before your expected due date, except in the case of delivery prior to 13 weeks. Total payments for Maternity Leave Benefits may not exceed 26 consecutive weeks.

13.03 Payment of Maternity Leave Benefits

You will receive the weekly benefit shown in the *Schedule of Benefits* for each period during which you are eligible to receive the benefit. Because of federal law, Social Security and Medicare taxes will be withheld from your weekly Maternity Leave Benefit. If you want federal income and state taxes withheld from your benefit payment, you must notify the Fund Office.

13.04 Maintaining Coverage While on Maternity Leave

If you are unable to work because of a verified maternity leave, you may be eligible to receive credit for five (5) hours per day, for each day of maternity leave, up to a maximum of 25 hours per week. One credited hour of maternity leave is equivalent to one accumulated Contributed Hour for purposes of determining eligibility under the Plan. Maternity leave hour(s) will be credited for up to a maximum of 26 weeks.

13.05 Extended Leave Due to Disability

If your maternity leave has been exhausted, and you are unable to return to work due to a disability (whether due to pregnancy or other reason), you may apply for Short-Term Disability Benefits. All eligibility rules, requirements and payment amounts under the Short-Term Disability Benefit section would apply with respect to extended leave due to disability, except for the 7-day waiting period, which would be waived in such cases. Please contact the Fund Office should you need further information or need to request a Short-Term Disability Benefit application.

Section 14: Life Insurance Benefits

14.01 Eligibility Requirements

If you are an Active Employee and you are eligible for coverage under the Plan, you are eligible for the Life Insurance Benefit. If you are a retiree who retired under the early pension provision (as stated in Pension Plan No. 2) and have not attained age 65, and you are eligible for coverage under the Plan, you are also eligible for the Life Insurance Benefit.

The Board of Trustees has contracted with a third-party insurance carrier to provide the Life Insurance Benefit, and this fully insured benefit will be paid in accordance with the terms of the insurance policy, which is incorporated by reference into the Plan. In the event of a conflict between the terms of the Plan and the insurance policy, the terms of the policy govern. If you wish to receive a copy of the insurance policy, please contact the Fund Office.

Your Basic Life Insurance Benefit is paid to your Designated Beneficiary as a single lump-sum payment, provided he or she is living on the earlier of the date the insurance carrier receives proof of death or the 10^{th} day following your death. The amount of the Life Insurance Benefit is shown in the *Schedule of Benefits*.

14.02 Designated Beneficiary

You may designate your beneficiary by completing and returning the beneficiary designation form available from the Fund Office. Your beneficiary designated in the beneficiary designation form ("Beneficiary Request") will apply to both the Life Insurance Benefit and the AD&D Benefit. You may change your beneficiary designation at any time by filing a new beneficiary request form with the Fund Office. To be valid, a completed beneficiary request form must be received by the Fund Office before your death, and beneficiary request forms are effective upon receipt by the Fund Office of an accurately completed beneficiary request form.

If you do not designate a beneficiary, or if your Designated Beneficiary is not living at the time of your death, your death benefit will be divided equally among the then living members of the first surviving class listed below:

- Your spouse
- Your children
- Your parents
- Your estate

14.03 Accelerated Death Benefit

If you are diagnosed with a terminal condition, you may receive the Accelerated Death benefit. A terminal condition means that based on the nature and severity of your condition, your life expectancy is no more than 24 months. You may receive this benefit while you are still living.

The Accelerated Death benefit is equal to 60% of the Basic Life insurance benefit. The remaining 40% of the Accelerated Death benefit will be paid out to your Designated Beneficiary upon your death. The Accelerated Death benefit is paid in one lump sum and paid only once. If an additional terminal diagnosis is given, the benefit cannot be paid again.

To receive the Accelerated Death benefit, you must meet the following conditions:

- You must request this benefit in writing while you are still living. If you are unable to request this benefit yourself, your legal representative may request it for you.
- You must be eligible for the Basic Life Insurance benefit.
- You must provide a doctor's statement which gives the diagnosis of your medical condition and states that because of the nature and severity of such condition, your life expectancy is no more than 24 months to the insurance carrier. The insurance carrier may require that you be examined by a doctor of its choosing. If the insurance carrier requires this, it will cover the cost of the exam.
- You must provide written consent from any irrevocable beneficiary, assignee, and, in community property states, from your spouse.

Please note that receipt of the Accelerated Death benefit may be considered taxable. You should consult your personal tax advisor to assess the impact of this benefit. Additionally, the amount of your Basic Life Insurance benefit will be reduced if you receive the Accelerated Death benefit.

14.04 Conversion Privilege

If your Basic Life Insurance benefit ends because your eligibility for this benefit ends or because the group insurance policy terminates, you may purchase an individual life insurance policy from an insurance carrier designated by the Board of Trustees without giving evidence of insurability. The Fund Office will provide the Life Conversion Request form in advance which includes premium and coverage information.

To use this conversion privilege, a written application and payment of the first premium must be made to and received by the insurance carrier within 31 days after termination of coverage. The individual policy issued will be of the form used by the insurance company for conversion of group life insurance at the time conversion is made. The effective date will be the date following the date coverage ends under the Plan.

Section 15: Accidental Death & Dismemberment (AD&D) Benefits

15.01 Eligibility Requirements

If you are an Active Employee and you are eligible for coverage under the Plan, you are eligible for AD&D benefits. The Board of Trustees has contracted with a third-party insurance carrier to provide the AD&D Benefit, and this fully insured benefit will be paid in accordance with the terms of the insurance policy, which is incorporated by reference into the Plan. In the event of a conflict between the terms of the Plan and the insurance policy, the terms of the policy govern. If you wish to receive a copy of the insurance policy, please contact the Fund Office.

The AD&D Benefit is payable to you if you sustain one of the losses listed in the *Schedule of Benefits* as a result of an accident. The loss must have occurred within 180 days of the accident. To qualify as a loss, the severance of a limb must occur above the wrist joint or ankle joint. Loss of sight means the total and permanent loss of sight. If more than one loss (listed in the *Schedule of Benefits*) is sustained as the result of the same accident, benefits are paid only for the loss that provides the greatest payment.

The AD&D Benefit is payable to your Designated Beneficiary if you die as a direct result of an accident and independent of all other causes within 180 days of the date of the accident. The beneficiary designation rules for the AD&D Benefit are the same as those for the Basic Life Insurance Benefit. For more information on designating a beneficiary, see Section 14.02.

The types of losses covered under the AD&D Benefit and the corresponding benefit amounts are shown in the *Schedule of Benefits*. The AD&D Benefit is in addition to any other benefits you may receive under the Plan.

15.02 Safe Driver Benefit

If you die while driving or riding in an automobile accident equipped with a factory installed airbag that operated properly upon impact, the Plan will pay to your Designated Beneficiary a Safe Driver Benefit, which is in addition to the full AD&D benefit amount. If loss of life occurs and you are wearing only a safety belt, your Designated Beneficiary will be eligible for an additional 10% of the full amount of the AD&D benefit. If loss of life occurs and you are wearing a seat belt and the air bag is deployed, the Plan will pay an additional 15% of the full amount of the AD&D benefit.

The Safe Driver Benefit will not be paid if the loss of life was directly caused by any use or intoxicating liquors, marijuana, narcotic drugs, depressants or similar substances, whether or not prescribed by a doctor, by you or by the driver of the automobile in which you were riding.

15.03 Coma Benefit

You may be eligible for a Coma Benefit if, due to an accident, you are in a coma. Coma Benefit payments will stop when you are no longer in a coma or the maximum benefits have been paid, whichever comes first. The Plan will pay you an additional 2% of the full AD&D benefit amount each month for up to 12 months up to the maximum full AD&D benefit amount.

Coma means that you remain unresponsive to any stimuli and speechless for a period not less than 30 days, as determined by a competent medical authority.

If you are physically and mentally incapable of receiving and cashing Coma Benefit payments, then the payments instead will be made to the person legally authorized to receive the payments on your behalf.

15.04 Education Benefit

The Plan pays an Education Benefit in addition to the AD&D benefit and subject to the conditions below if you die due to an accident. The amount of this benefit is 5% of the full AD&D benefit amount. This benefit will be paid to your dependent who is enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond grade 12 within 365 days following the date of your death. It will be paid at the end of each annual period following your death for up to 4 years to a maximum of $3,000 per year. Education benefits are paid to each eligible dependent student, or to the dependent's legal guardian.

Benefit payments will stop if either of the following is true during the preceding annual period:

- The student's full-time school attendance is less than 6 months; or
- The student would no longer be considered your eligible dependent under the definition of dependent in the policy.

15.05 Transportation Benefit

The Plan pays a Transportation Benefit in addition to the AD&D benefit if you die due to an accident that occurs at least 75 miles from your primary residence. The amount of this benefit is 2% of the full AD&D benefit amount up to a maximum of $2,000 and is payable to your beneficiary or beneficiaries.

15.06 Child Care Benefit

The Plan pays a Child Care Benefit in addition to the AD&D benefit if you die due to an accident, and your dependent child under age 13 years is enrolled in a licensed day care center within 90 days of your death. This benefit is paid on behalf of each eligible dependent child at the end of each annual period following your death. This benefit is in the amount of 3% of the full AD&D benefit amount each year for up to 6 years and a maximum of $2,000 per year.

Benefit payments will stop if either of the following is true during the preceding annual period:

- Your dependent child does not attend a licensed day care center for at least 1,000 hours; or
- Your dependent child is not under age 13 for any part of that year.

Child Care Benefits are paid to the person who has incurred the cost of day care expenses for your eligible dependent child.

15.07 Occupational Assault Benefit

The Plan pays an Occupational Assault Benefit in addition to the AD&D benefit if you suffer a covered loss due to an accident, and:

- The loss is due to an intentional and unlawful act of physical violence directed at you by another person;
- You are actively at work, performing assigned duties on behalf of the employer at the time of the assault; and
- A report of criminal activity has been filed on your behalf with the appropriate law enforcement authority within 48 hours of the assault

The benefit amount is the AD&D amount otherwise payable for this loss, up to a maximum of $10,000. Occupational Assault benefits are paid to you if living, otherwise to your Designated Beneficiary.

15.08 Exclusions

The AD&D Benefit is not payable if death or dismemberment results from:

- Bacterial infection or bacterial poisoning (except infection from a cut or wound caused by an accident or accidental ingestion of a poisonous food substance)
- Physical or mental illness
- Suicide or intentionally self-inflicted injury, while sane or insane
- Riding in or descending from an aircraft as a pilot or crew member
- Any armed conflict, whether declared as war or not, involving any country or government
- Injury suffered while in the military service for any country or government

  Injury which occurs when you commit or attempt to commit a felony
- Use of any drug, narcotic or hallucinogenic agent –
  - Unless prescribed by a doctor
  - Which is illegal
  - Not taken as directed by a doctor or the manufacturer
- Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred

Section 16: Member Assistance Program

16.01 Eligibility

The Member Assistance Program applies to you and your Dependents if you are an Active Employee or Retiree and you are eligible for medical benefits under the Plan.

16.02 Member Assistance Program

The Member Assistance Program ("MAP") provides short-term counseling and assessment-referral services to Participants and their families. Professional phone support is available 24 hours a day, 365 days a year, and Participants and their families are eligible for up to three face-to-face counseling sessions per problem, situation or issue at no additional cost.

MAP counselors will provide you and your eligible Dependents with short-term counseling and referrals for a variety of work and life issues, including marital or family problems, parenting challenges, depression, anxiety, alcohol or substance abuse, medical issues, financial and legal concerns, identity theft protection and recovery consultation, and web-based work life resources.

All contact with the MAP is confidential. The MAP counselor will not speak with the Fund Office, a supervisor, co-worker or family member without permission from the person using the Member Assistance Program. Confidentiality may be compromised only when a threat to life exists (e.g., suicidal or homicidal risk, stalking or child abuse).

Section 17: General Plan Limitations and Exclusions

The following is a list of procedures, services, supplies and types of treatment for which Plan benefits are not payable or for which the benefits are limited as indicated below. The following list is not all-inclusive or exhaustive; rather, it is only representative of the types of services and supplies for which charges may be incurred which are not payable by the Plan. Notwithstanding anything listed below, the Plan does not exclude charges for treatment of injuries resulting from an act of domestic violence or medical condition.

- Charges for a Participant's injury or illness arising from any electrical work or any other paid work finally adjudicated to be payable (including lump sum settlements) under any Workers' Compensation law or occupational disease law

- Charges for services or supplies provided by a person, facility or organization acting outside the scope of the applicable license

- Charges for care, treatment, procedures, services or supplies provided to a Dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) or occupational disease law

- Charges for care, treatment, procedures, services or supplies provided to a person who is not covered and/or eligible under the Plan at the time such care, treatment, procedures, services or supplies are provided

- Charges for services or supplies that are provided by hospitals or medical institutions owned or operated by a federal, state or local government, or their medical practitioners, unless you are required to pay such charges

- Charges caused by your voluntary participation in a riot

- Charges caused by war or any act of war, whether declared or undeclared

- Charges incurred during the commission of a felony or involvement in a criminal enterprise

- Charges for treatment of any intentionally self-inflicted injury (except in cases of mental illness or relating to a medical condition)

- Charges for travel or transportation except as otherwise specifically provided

- Charges for services or supplies that are in the nature of education or vocational testing and training, except as otherwise specifically provided

- Charges ordered by a court, including without limitation court-ordered safety counseling courses

- Charges incurred while in the military service of any country, or a civilian non-combatant unit serving with such forces. However, the Plan will cover expenses as required under USERRA

- Charges for which you do not have to pay (e.g., services provided without charge or paid through any other plan)

- Charges for Experimental or Investigational treatments and procedures

- Charges for services and supplies that exceed the Eligible Charge
- Charges for treatments received in any penal facility or jail or equivalent institution
- Charges for any treatments, services or supplies furnished by a person who resides in your home, or who is a member of your immediate family (i.e., your spouse, child, brother, sister or parent)
- Charges for failure to keep scheduled visits or appointments
- Charges for completion of claim forms or other forms required by the Plan for processing of claims
- Charges for reports or medical requests not requested by the Fund
- Charges that would not have been made if the Plan did not exist
- Charges for claims not received by the Fund Office within one (1) year after the date the expense was incurred, except as otherwise provided in the Plan
- Charges incurred as the result of an injury or sickness for which a Participant has the right to recover payment from a third party, except to the extent provided under the Plan's reimbursement and subrogation procedures
- Charges for treatment rendered outside the United States or its territories except if for non-work-related emergency care or for Participants with established residence outside of the United States

Section 18: Coordination of Benefits

The Plan contains a coordination of benefits ("COB") provision. This provision ensures that if you or your eligible Dependents are covered by more than one group health plan, benefits from all plans combined will not exceed 100% of the maximum allowable expense.

18.01 Other Plans Defined

The Plan coordinates benefits with the following types of plans:

- Group, blanket, or franchise insurance coverage
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans, or any other arrangement of benefits for individuals or a group
- Any coverage required or provided by statute

Prescription Drug Benefits

Prescription drug benefits under the Plan are not coordinated with any other coverage. You or your Dependents must receive prescription drug benefits through the primary plan to have them covered.

18.02 Order of Benefit Payment

If you have a claim that is covered by two or more plans, the primary plan will pay its benefits first as if the other plan does not exist. The other plan, or the secondary plan, will adjust its benefits so that the total benefits paid to you will not be greater than the total allowable expense.

The Plan will not pay benefits for expenses which would have been covered by another plan, but which are not paid because the person failed to follow the other plan's rules. For example, if your Dependent is covered under a health maintenance organization ("HMO") and voluntarily elects not to follow their referral guidelines or procedures, no benefits will be payable from the Plan.

A plan without a COB provision is always the primary plan. If all plans have COB provisions, the following rules apply:

- A plan that covers a person as an employee is primary over a plan that covers the person as a dependent.
- A plan that covers a person as an employee is primary over a plan that covers a person as a retired or laid off employee.
- For a dependent child covered under both parents' plans, the primary plan is determined as follows:
  - The plan of the parent whose birthday (month and day) falls earlier in the calendar year is primary.
  - If both parents have the same birthday, the plan that has covered the parent the longest is primary.
  - If the other plan coordinates benefits based on the gender of the parents, the plan covering the male parent is primary.
- For a dependent child whose parents are separated or divorced, the primary plan is determined as follows:

Claims for Secondary Coverage

If the provider will not submit a claim for secondary coverage, it is *your* responsibility, as the participant, to file the claim in a timely manner.

  - If a court decree establishes financial responsibility for the child's health care expenses, the plan of the parent with financial responsibility is primary.
  - If there is no court decree establishing financial responsibility, the plan covering the parent with custody of the child is primary.
  - If there is no court decree establishing financial responsibility and the parent with custody has remarried, the order of payment is as follows:
    - ✓ The plan of the parent with custody is primary and pays benefits first
    - ✓ The plan of the stepparent with custody pays benefits second
    - ✓ The plan of the parent without custody pays benefits third
    - ✓ The plan of the stepparent without custody, if any, pays benefits fourth
- A plan that covers a person as a dependent spouse is primary over a plan that covers the person as a dependent child. The Fund Office requires a copy of the ID card from the other insurance to ensure proper coordination of benefits.
- If you and your spouse are both covered as employees under the Plan, the Plan will coordinate benefits and will pay primary employee benefits and secondary dependent benefits. In all other circumstances where a person has multiple sources of eligibility for coverage under the Plan, such a person will receive only one set of benefits under the Plan, as if the other source of eligibility did not exist.
- If a person who has COBRA coverage is also covered under another plan as an employee, retiree or dependent, the COBRA coverage is secondary.
- If none of the above rules apply, the plan that has covered a person the longest is primary.

18.03 Right to Information and Recovery

The Plan has the right to receive and release necessary information to determine whether coordination of benefits or any similar provisions apply to a claim. If the Plan makes larger payments than are necessary under the COB provision, the appropriate claims administrator has the right to recover those excess payments. Recovery may be made from any insurance company, any organization and/or any persons to or for whom those payments were made. In the case of underpayment, the Plan may reimburse another plan directly instead of paying the person requesting benefit payment.

18.04 Coordination with Medicare

Active Employees

If you are actively employed, regardless of your age, the Plan will be primary to Medicare for you and your eligible Dependents. Benefits under the Plan are determined before Medicare's benefits.

Retired or Disabled Employees

If you and/or your Dependents are entitled to Medicare due to age or disability, Medicare will have primary responsibility, and the Plan will pay second. If you or your Dependents are entitled to Medicare benefits, the Plan will pay benefits as though you are enrolled in Medicare Part A and Part B, regardless of whether you or your Dependents are actually enrolled. If you and/or your Dependents do not enroll, you must pay the amount Medicare would otherwise have paid (e.g., 80% of Medicare eligible expenses). The Plan does not cover the cost of Medicare premiums. Therefore, you and/or your Dependents should enroll in both Medicare Part A and Part B at the earliest possible opportunity.

Expenses not reimbursable by Medicare may be covered by the Plan if you have followed Medicare procedures. You are required to seek treatment from a provider that has been approved by Medicare and is eligible to receive reimbursement from Medicare. **All Medicare eligible Retirees and Dependents MUST satisfy the calendar year Deductible (as listed in the *Schedule of Benefits*) before the Plan will pay any benefits.** Any expenses not approved by Medicare because the person failed to follow any Medicare guidelines or procedures will not be covered.

If Medicare is the primary payer, the Plan will calculate its payment as if there was no Medicare coverage, and apply the Deductible, Copayments and other Plan limits first. Then, the Plan will pay the remaining amount, minus what Medicare will pay.

The process used in determining benefits under the Plan is as follows:

- Determine what the payment for a Covered Service would be under the Plan's Schedule of Benefits.
- Deduct from the charges eligible under Medicare, the amount paid by Medicare. *Note: If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether you have enrolled and/or received payment from Medicare.*
- The lesser of the two amounts determined in accordance with step 1 and step 2 above is the amount that will be paid under the Plan.

Medicare Coverage for Individuals with End-Stage Renal Disease

If you and/or your Dependents are entitled to Medicare based solely on End Stage Renal Disease ("ESRD"), the Plan will be primary to Medicare during the first 30 months of the person's entitlement to Medicare. After the first 30 months of ESRD entitlement, Medicare will have primary responsibility, and the Plan will pay second.

Section 19: Reimbursement and Subrogation

19.01 Fund’s Right to Reimbursement

The Plan is entitled to 100% reimbursement of all medical, dental and disability claims paid on your behalf and/or your Dependent’s behalf if any of the following applies:

- You or your covered Dependent recovers money from a “Third Party” (as defined below) for expenses incurred due to an illness or injury for which a benefit has been paid under the Plan. The amount to be reimbursed is the amount of benefits paid by the Plan.

  A “Third Party” means a person or business entity and shall include, but is not limited to, any person or entity legally responsible for your injury; other benefit plans; an insurance company; any other person or entity that is obligated to make payments, which the Plan would otherwise be obligated to make.

- The Plan pays benefits for an ineligible individual you had listed as a covered Dependent.

19.02 Subrogation

You or your covered Dependent may, at some time, suffer an injury and incur expenses (eligible for coverage under the Plan) as a result of an accident or act (“Accident”) for which a Third Party is financially responsible. If a Third Party is responsible for paying any expenses for which the Plan has already issued payment, you automatically assign the Plan any rights you or your Dependent may have to recover payments from the Third Party—this assignment is known as “subrogation.” Subrogation allows the Plan to pursue any claim you or your Dependent has against any Third Party, regardless of whether you or your Dependent chooses to pursue that claim. Examples where subrogation may be applicable include injuries sustained:

- In an automobile accident caused by someone else; or
- On someone else’s property, if that person is also responsible for causing the injury.

Subrogation does not apply to any expenses that are not eligible for coverage under the Plan (e.g., medical expenses incurred for injuries or illnesses resulting from any electrical work or any other paid work under Workers’ Compensation).

The Plan may make a claim directly against the Third Party and you and/or your Dependent shall fully cooperate with the Plan to secure its right to subrogation. If the Plan pays for a claim for you or your Dependent, the Plan has a right to any amount recovered by you or your Dependent, regardless of whether it is designated as payment for the claim paid by the Plan, until the Plan is reimbursed in full.

Once the claim or lawsuit arising out of the Accident has been settled or judgment reached, the Plan is not responsible for the payment of claims related to the Accident that arise or are submitted after the date of settlement or the entry of the judgment, or that were not timely submitted to the Plan up to the amount of the settlement or judgment received in connection with the Accident. However, the Trustees, within their discretionary authority, may, but are under no circumstance obligated, agree in writing prior to the final settlement or resolution of the claim or legal action that some or all future medical expenses related to the Accident will be covered.

19.03 Plan's Priority

When you or your Dependent(s) accept benefits under the Plan, you acknowledge the Plan's right to reimbursement and subrogation. The Plan's right to reimbursement and subrogation will not be reduced or affected as a result of any fault or claim on the part of you and/or your Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Therefore, if you and/or your Dependent receive payment from a Third Party for claims paid by the Plan, you must reimburse the Plan for 100% of the benefits paid under the Plan. The proceeds from the settlement or judgment must be divided as follows:

- First, **the Plan has priority over all monies recovered**. Accordingly, you or your representative must pay a sum sufficient to fully reimburse the Plan for 100% of benefits paid related to the injury or illness. You must pay your own legal fees and costs of litigation in connection with the recovery from a Third Party. No reductions or deductions from the reimbursement owed to the Plan are allowed for litigation costs, court costs, or attorney's fees (i.e., the Illinois Common Fund Doctrine, Make Whole Doctrine, and/or any other state law affecting these rights are preempted by the Plan under ERISA); then
- Any remainder may be paid to you and/or your Dependent.

The proceeds of any claim against a Third Party must be divided as stated above, even if you and/or your Dependent are not fully compensated for the loss. The Plan is not entitled to receive reimbursement more than the amount you and/or your Dependent receive from all third parties.

19.04 Failure to Reimburse the Plan

If you and/or your Dependent receive payment from a Third Party for Plan benefits already received and you do not reimburse the Plan for 100% of the benefits paid under the Plan (thereby resulting in an "overpayment" by the Plan), the Plan may take actions, including but not limited to any of the following (separately or in the alternative):

- Initiating a claim to compel compliance with the terms of the Plan and/or the terms of the Subrogation Agreement and Reimbursement Agreement
- Suspension or withholding of benefits payable to you and/or your Dependents until you demonstrate that you have incurred future medical, dental, vision and prescription drug expenses that equal the overpayment had the expenses been covered by the Plan. The Fund Office will base reimbursement on 80% of Billed Charges for proven medical expenses that would have otherwise been covered under the Plan. Any recoupment obtainable through a vision claim will be based on the applicable out-of-network reimbursement offered by our vision care provider. The reimbursement rate for expenses that the Fund Office would have otherwise been the secondary payer will be based accordingly on standard Coordination for Benefits practices
- Offsetting unpaid reimbursements by any future benefits payable under the Plan, including without limitation for Short-Term Disability, Long-Term Disability Benefits and Supplemental Unemployment Benefits

Upon 100% reimbursement to the Plan, future claims related to the injury or illness not already paid by the Plan will be your and/or your Dependent's responsibility, unless and until you and/or your Dependents incur related expenses which exceed the proceeds from your and/or your Dependent's ultimate recovery.

19.05 Your Responsibilities

By accepting benefits under the Plan, you and your Dependent's responsibilities include, but are not limited to, the following:

- You and/or your Dependent must immediately notify the Fund Office whenever a claim against a Third Party is made for yourself and/or your Dependent regarding any loss for which benefits are received from the Plan.
- You and/or your Dependent must timely cooperate with the Plan by providing, among other things, information requested by the Plan concerning reimbursement or subrogation. You must timely provide the Fund Office with a signed Reimbursement Agreement or Subrogation Agreement, with a completed Questionnaire, any accident reports and any other information the Fund Office requests.

If you fail to meet your responsibilities, the Plan may suspend or withhold future benefits from you and/or your Dependents (as described in Section 19.04) until you comply with these requirements.

19.06 Claims for Attorney's Fees Against the Plan

By accepting benefits under the Plan, you and your Dependent agree to be wholly responsible for all attorney's fees or other expenses incurred to obtain the Third-Party recovery.

If the attorney(s) that you and/or your Dependent retain in relation to the Third Party action brings a separate claim or lawsuit against the Plan to recover his/her attorney's fees under the Common Fund Doctrine, *quantum meruit*, unjust enrichment or other similar state laws, you and/or your Dependent are required to reimburse the Plan from the money you and/or your Dependent recover from any Third Party for the following:

- Any money judgment entered against the Plan in the lawsuit brought by the attorney; and
- The Plan's attorney's fees and costs defending the lawsuit, regardless of whether the Plan prevails or loses.

If the Plan is required to initiate a formal proceeding against you and/or your Dependent(s) to enforce its reimbursement rights, you and/or your Dependent(s) will be responsible for the Plan's attorney's fees and costs incurred. If the expenses, including attorney's fees and costs, expended by the Plan exceed the amount you and/or your Dependent recover from any Third Party and you and/or your Dependent do not reimburse the Plan from the Third Party recovery, the Plan has the right to withhold benefits to you and/or your Dependent until the Plan is reimbursed in full for all expenses, including attorney's fees and costs.

You and/or your Dependent(s) grant the Plan a lien on the monies recovered from any Third Party in the amount of the following:

- All claims paid on you and/or your Dependent's behalf relating to the accident, illness or injury for which a Third Party is financially responsible
- Any money judgment against the Plan in the lawsuit brought by the attorney
- The Plan's attorney's fees and costs in defending the lawsuit, regardless of whether the Plan prevails or loses

Section 20: Fraudulent Conduct Benefit Policy

20.01 General Provisions

A Participant who acts with the intent to defraud the Plan, including, but not limited to, acts of deception, forgery, false representation, or concealment of material facts, will be considered in violation of this Policy.

These wrongful acts result in a loss and harm to the Plan. Below is a general list of types of wrongful acts and general guidelines on the corresponding consequences of such acts. The Fund Office will assist the Trustees (or their delegate) in reviewing the circumstances of each wrongful act, calculate the approximate amount of financial harm/loss caused to the Plan and notify the Participant in writing of its findings under this Policy. Any Participant that is determined to be in violation of this Policy shall have his or her and his or her Dependent's benefits otherwise payable by the Plan offset by the amount listed below to the extent offset is available, or the Trustees could terminate the individual's eligibility under the Plan, including retroactively.

The Fund shall determine the amount and manner of the offset, taking into account the gravity of the wrongful act and harm/loss caused to the Plan. The Fund's determination of a Participant's violation of this Policy is an Adverse Benefit Determination and subject to the Plan's claims and appeals procedures.

A Participant that cooperates with the Fund in discovering and remedying wrongful acts under this Policy may reduce or eliminate any potential offset of benefits associated with his or her wrongful acts.

20.02 Possible Offenses and Associated Harm or Loss to the Plan

- Participant is acquiescent or complicit in a contributing employer's acts to defraud the Plan
    - Benefits otherwise payable by the Plan will be offset by a maximum of $1,000
- Participant instigates actions to defraud the Plan
    - Benefits otherwise payable by the Plan will be offset by a maximum of $2,500
- Participant is an owner of and/or exercises control over the contributing employer and under-reports hours worked thereby diminishing the required contributions to the Plan
    - Benefits otherwise payable by the Plan will be offset by a maximum of $5,000
- Participant is an owner of and/or exercises control over the contributing employer and engages in wrongful acts that cause significant harm/loss to the Plan
    - Benefits otherwise payable by the Plan will be offset by a maximum of $7,500, and the Participant will not be eligible for Retiree Benefits under the Plan
- Participant enrolls or maintains enrollment of an ineligible dependent
    - Coverage for the ineligible dependent will be terminated retroactive to the date eligibility was lost or to the date of initial enrollment, to the extent permitted by the Affordable Care Act

The Trustees reserve the right to terminate an individual's eligibility under the Plan, including retroactively to the extent consistent with Affordable Care Act rules, in any instance of wrongful act

Section 21: Claims and Appeals Procedures

21.01 General Provisions

In all circumstances relating to any claim or appeal for benefits under the Plan, the Plan Administrator or claims administrator responsible for making a determination on the claim or appeal will have discretionary authority in making the determination, including but not limited to, interpreting and applying the terms and conditions of the Plan, making any necessary factual determinations and determining eligibility under the Plan. Benefits under the Plan will be paid only when the Trustees, or persons delegated by them to make such decisions, decide in their sole and unrestricted discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

You must exhaust all the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. After you have exhausted all the procedures in this section and if you are dissatisfied with the written decision of the Board of Trustees on review, you may institute legal action. If you institute legal action after the denial of your internal appeal or after the denial of your external review, your lawsuit must be filed within twelve (12) months of the date of the internal appeal denial.

21.02 Definition of a Claim

The following special definitions apply to the Claims and Appeals Procedures described in this section:

A **claim** or a **claim for benefits** is a request for Plan benefits that you make in accordance with the Plan's claim procedures. If you make an inquiry about the Plan's provisions without a claim form, the Plan will not treat the inquiry as a claim for benefits. In addition, if you request prior authorization for a benefit that does not require prior authorization by the Plan, it will not be treated as a claim for benefits.

A health claim may fall into one of the following categories:

- A **pre-service** claim is a claim for prior authorization for a treatment or supply that requires approval in advance of obtaining care. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered pre-service claims.
- An **urgent care** claim is a pre-service claim where the application of time periods for making non-urgent care determinations could seriously jeopardize the claimant's life, health or ability to regain maximum function, 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.
- A **post-service** claim is a claim for payment that is requested for a treatment or supply that has already been received.
- A **concurrent care** claim is a claim where a request is made to extend a course of treatment beyond the period or number of treatments previously approved. A concurrent care claim can be either an urgent care claim, a pre-service claim or a post-service claim.

A **denial** or **adverse claim decision** is an Adverse Benefit Determination.

A **disability claim** is a claim for Short-Term Disability benefits, Long-Term Disability benefits or Maternity Leave benefits.

A **health claim** is a claim for medical benefits, including behavioral health, substance abuse, hearing aid benefits; dental benefits; vision benefits; prescription drug benefits; and HRA benefits.

A document, record or other information is **relevant** if:

- It was relied upon by the Claim Administrator in making the decision
- It was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon)
- It demonstrates compliance with the Claim Administrator's administrative processes for ensuring consistent decision-making
- For purposes of a health claim or disability claim, it constitutes a statement of Plan policy regarding the denied treatment or service

21.03 Initial Claim Filing Deadline

You must generally file your claims for benefits within 365 days of the date they are incurred, or payment will be denied. Refer to the Claim Administrator summary below for specific claim filing deadlines that may apply.

You may file claims for Plan benefits and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial. The notice will explain the reason for the denial and the review procedures.

An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

21.04 How to File a Claim

The section below outlines the appropriate claims administrator for each benefit under the Plan and provides telephone contact information.

Medical Claims

The claims administrator for medical benefits is Blue Cross/Blue Shield of Illinois (BCBS). Network Providers will submit a claim directly to BCBS on your behalf. However, if you need to submit the claim, call BCBS at (800) 862-3386 for a Request for Benefit Payment form. Complete the form and attach the bills that explain your treatment. Submit your claim forms to the address listed on the back of your BCBS card. All paper medical claims should be submitted to:

Blue Cross/Blue Shield of Illinois
P.O. Box 660603
Dallas TX 75266-0603

When you submit your Request for Benefit Payment form, it should be completed fully, following the instructions printed on the form. Failure to do so may delay payment or result in a denial of benefits. Attach a statement from your Physician, or other health care provider, together with bills or receipts for all covered expenses, including those that count toward the Deductible. To make sure you receive all the benefits you are entitled to, you should keep copies of bills or receipts for supplies, as well as those for hospitalization and treatment. If all charges are not detailed on the request form, attach an itemized statement.

If a person entitled to benefits is unable to complete a Request for Benefit Payment form, the Trustees may pay benefits to the spouse or a blood relative, or to any person whom the Trustees determine is rightfully entitled to the payment.

Behavioral Health and Substance Abuse Claims

The claims administrator for behavioral health and substance abuse benefits is Blue Cross/Blue Shield of Illinois (BCBS). Network Providers will file a claim on your behalf. Non-Network Providers may file a claim for you, but if you are required to file a claim for behavioral health and substance abuse, call BCBS at (800) 851-7498 to obtain a claim form. All Non-Network behavioral health and substance abuse claims should be submitted to:

Blue Cross/Blue Shield of Illinois
P.O. Box 660603
Dallas TX 75266-0603

Hearing Aid Claims

The claims administrator for the hearing aid benefit is Blue Cross/Blue Shield of Illinois (BCBS). Network Providers will file a claim on your behalf. Non-Network Providers may file a claim for you, but if you are required to file a hearing aid claim, call BCBS at (800) 862-3386 to obtain a hearing aid claim form. All Non-Network hearing aid claims should be submitted to:

Blue Cross/Blue Shield of Illinois
P.O. Box 660603
Dallas TX 75266-0603

Dental Claims

The claims administrator for dental claims is Blue Cross/Blue Shield of Illinois (BCBS). Network Providers will file a claim on your behalf. Non-Network Providers may file a claim for you, but if you are required to file a dental claim, call BCBS at (800) 862-3386 to obtain a dental claim form. All Non-Network dental claims should be submitted to:

Blue Cross/Blue Shield of Illinois
c/o DNoA
P.O. 660247
Dallas TX 72566-0347

When you submit your dental claim form, it should be completed fully, following the instructions printed on the form. Failure to do so may delay payment or result in a denial of benefits. Attach a statement from your Physician or Dentist together with bills or receipts for all covered expenses, including those that count toward the Deductible. To make sure you receive all the benefits you are entitled to, you should keep copies of bills or receipts for supplies, as well as those for hospitalization and treatment. If all charges are not detailed on the request form, attach an itemized statement.

Prescription Drug Claims

The claims administrator for the prescription drug benefit is CVS/Caremark. If you do not have your prescription drug card when you make a retail purchase, you must pay for the prescription when purchased and have the pharmacist fill out a CVS/Caremark claim form. You must then submit your claim to:

CVS/Caremark
P.O. Box 52116
Phoenix, AZ 85072

Vision Claims

The claims administrator for vision benefits is VSP. All claims from a Network Provider are filed directly with VSP by the provider.

To submit a claim from a Non-Network Provider, you must contact VSP at (800) 877-7195 to obtain a claim form. The reimbursement rate is significantly less than it would be if you used a VSP provider.

Important Note!
If you see a Non-Network Provider for vision benefits, you must file your claim(s), and the filing limit is **six months** from the date of service.

Short-Term and Long-Term Disability Claims

To collect Short-Term Disability or Long-Term Disability benefits, you must contact the Fund Office and obtain a claim form. To be eligible for disability benefits, time limits apply for when notice must be provided to the Fund Office. See Section 12 for more information.

The Fund Office will send a claim form to you. It must be completed by you, your employer and your Physician and returned to the Fund Office. You also must supply the Fund Office with information the Trustees require (i.e., proof of your claim).

The Fund Office will forward your completed claim form to a third-party case management service for medical review before any benefits are paid. All benefits are subject to certification by the case management service.

If the Fund Office determines that you received Short-Term Disability or Long-Term Disability benefits to which you were not entitled, you will be required to reimburse the Fund for any benefit payments made to you.

Your proof of claim must show the following:

- That you are under the regular care of a licensed Physician or behavioral health provider
- The date your disability began
- The cause of your disability
- The extent of your disability — including restrictions and limitations preventing you from performing your regular job
- The name and address of any Hospital or facility where you received treatment, as well as all attending Physicians

The Plan reserves the right to request an independent medical exam by a selected Physician to review your eligibility for disability benefits.

Maternity Leave Claims

To collect Maternity Leave Benefits, you must contact the Fund Office and obtain a maternity leave statement. It must be completed by you and your doctor and returned to the Fund Office. The completed statement must be filed with the Fund Office no later than 90 days after your due date or delivery date, whichever is later. You must also supply the Fund Office with any other information the Trustees require to process your claim for Maternity Leave Benefits.

Basic Life Insurance and AD&D Claims

To collect the Basic Life Insurance Benefit, your Designated Beneficiary must advise the Fund Office of your death and obtain a claim form. The completed claim form must be filed with the Fund Office within 91 days of the date of your death. Your Designated Beneficiary must supply the Fund Office with information the Trustees require.

To receive AD&D Benefits, you or your Designated Beneficiary must contact the Fund Office and obtain a claim form. The completed claim form must be filed with the Fund Office within 91 days of the date of your accident or death. You or your Designated Beneficiary must supply the Fund Office with information the Trustees require.

All Other Claims

For any other claim, you must contact the Fund Office and obtain a claim form.

21.05 Claims Processing Timeframes

The Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by ERISA. The period the Plan must evaluate and respond to a claim begins on the date the claim is first filed with the applicable claims' administrator, regardless of whether the Plan has all the information necessary to decide the claim. The amount of time the Plan can take to process a claim depends on the type of claim.

Pre-Service Claims

BCBS will notify you of the decision on your claim within 15 days from receipt of the claim. BCBS may extend this period one-time for up to 15 days if the extension is necessary due to matters beyond its control. If an extension is necessary, BCBS will notify you before the end of the initial 15-day period of the circumstances requiring the extension of time and the date by which BCBS expects to render a decision.

If an extension is needed because BCBS needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that BCBS has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of 1) 45 days, or 2) the date you respond to the request. BCBS then has 15 days to make a decision and notify you of the determination.

Urgent Care Claims

BCBS will notify you of the decision on your claim within 72 hours of BCBS's receipt of the claim.

If an extension is needed because BCBS needs additional information from you to process your claim, BCBS will notify you of such an extension within 24 hours. In that case you will have 48 hours from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided based on the information that BCBS has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of either 48 hours or until you respond to the request. BCBS then has 48 hours to make a decision and notify you of the determination.

Concurrent Care Claims

If the concurrent care claim is urgent and made 24 hours prior to the end of the already authorized treatment, BCBS will notify you of its decision within 24 hours. If the concurrent care claim is not an urgent claim, then it will be decided according to the pre-service or post service claim time frames, whichever applies.

Post-Service Claims

BCBS will notify you of the decision on your claim within 30 days of BCBS' receipt of the claim. BCBS may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of BCBS. If an extension is necessary, BCBS will notify you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which BCBS expects to render a decision.

If an extension is needed because BCBS needs additional information from you to process your claim, the extension notice will specify the information needed. In that case, you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided based on the information that BCBS has at that time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of either 45 days or until the date you respond to the request (whichever is earlier). BCBS then has 15 days to make a decision and notify you of the determination.

Disability Claims

The Plan will make a decision on your Short-Term Disability, Long-Term Disability or Maternity Leave Benefit claim and notify you of the decision within 45 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you (within the 45-day period) of the reason for the delay and the time when the decision will be made. The Plan will make its decision within 30 days of the time the Plan notifies you of the delay. If the 30-day extension is not sufficient, the Plan may delay the period for making a decision for an additional 30 days, provided the Plan notifies you of the circumstances requiring the extension and the date as of which the Plan expects to render a decision, before the expiration of the first 30-day extension period.

If an extension is needed because the Plan needs additional information from you to process your claim, the extension notice will specify the information needed. In that case, you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided based on the information that the Plan has at that time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of either 45 days or until the date you respond to the request (whichever is earlier). Once the Plan has received a response to its request, the Plan has 30 days to make a decision and notify you of the determination.

Life and Accidental Death and Dismemberment Claims

The Claim Administrator will notify you of the decision on your claim within 90 days of receipt of the claim. The Claim Administrator may extend this period one time for up to 90 days if an extension is necessary due to matters beyond the control of the Claim Administrator. If an extension is necessary, the Claim Administrator will notify you before the end of the initial 90-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If you have any questions regarding how to file or appeal a claim, contact the Fund Office.

21.06 Notice of Initial Decision

If your claim is denied, in whole or in part, you will receive a written explanation of the Adverse Benefit Determination, in a culturally and linguistically appropriate manner, within certain timeframes after your claim is received. The information included in this written notice varies depending on the type of claim. All notices will include:

- The specific reason(s) for the denial of benefits or other Adverse Benefit Determination
- A specific reference(s) to the Plan provisions on which the denial is based
- If applicable, a description of any additional information that is needed to process your claim and the reason the information is needed
- A copy of the internal review procedures and time periods to appeal your claim, and a statement of your right to bring a civil action lawsuit under ERISA section 502(a) following a denial of your claim on review

If the claim was for a health benefit, the written explanation will also include:

- If an internal rule, guideline, protocol or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or a statement that a copy is available to you at no cost upon request
- If your claim was denied based on Medical Necessity, Experimental or Investigational Treatment, or a similar exclusion or limit, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request

If the claim was for a health benefit *except* for dental or vision benefits, the written explanation will also include:

- Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable), and a statement that, upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
- The denial code and its corresponding meaning
- A statement of your right to request an external review with an independent review organization following denial on appeal, including a description of how to initiate an expedited external review, if applicable

- If applicable, a notice in any applicable non-English language describing how to access the Plan's language services

- If applicable, the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes

If the claim was for a disability benefit, the written explanation will also include:

- Information sufficient to identify the claim involved, including the date of service
- An explanation of the decision, including the basis for disagreeing with or not following, as applicable:
  - The views you presented to the Plan of the health care and vocational professionals who treated or evaluated you
  - The views of medical or vocational experts obtained by the Plan in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the adverse benefit determination
  - A disability determination by the Social Security Administration
- If an internal rule, guideline, protocol, standard or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist
- If your claim was denied based on Medical Necessity, Experimental or Investigational Treatment, or a similar exclusion or limit, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits
- The timeframe for bringing a civil action under ERISA

21.07 Appealing the Denial of an Internal Claim

If your claim has been denied, in whole or in part, you may request a full and fair review (referred to in this section as an "appeal") by filing a written notice of appeal with the Plan, unless otherwise provided herein. Only one level of appeal—review by the Claims Review Committee of the Board of Trustees or the Claims Administrator—exists for all claims except for medical claims, which have two levels of appeal, as detailed below.

You must file your appeal in writing, unless your appeal is an urgent care claim, which may be submitted orally or by telephone. You must make your request within 180 days after receiving notice of the denial, except with respect to Basic Life Insurance and AD&D claims.

You must file a request for an appeal of the denial of a Basic Life Insurance or AD&D claim within 60 days after receiving notice of the denial. Your appeal application must be in writing and it must include the specific reasons you feel the denial was improper. You may submit any document you feel appropriate, as well as submitting your written statement.

Besides having the right to appeal, you or your authorized representative can examine any documents, records and other information relevant to your denied claim. Additionally, for health claims *except* dental and vision claims and for disability claims, the Plan or claim administrator will:

- Provide you, free of charge with any new or additional information considered, relied upon or generated during the appeal as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to that date. For health claims only, if the new or additional information is received so late that you would not have a reasonable opportunity to respond, the period for issuing the final internal Adverse Benefit Determination will be tolled to provide you with time to respond. The Plan/Claim Administrator will issue its decision as soon as reasonably practical after you respond or the period you were provided to respond has ended.

- Provide you, free of charge, with any new rationale for denying your claim as soon as possible and sufficiently in advance of the Plan's/claim administrator's final decision, to give you a reasonable opportunity to respond.

A different person will review your appeal than the one who originally denied the claim. The reviewer will not give deference to the initial Adverse Benefit Determination. You have the right to present evidence and written testimony as part of your appeal. The decision will be made based on a full and fair review of the record, including such additional evidence and testimony that you may submit.

If your health claim or disability claim was denied based on a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Experimental or Investigational Treatment), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, you will be provided with the identification of medical or vocational experts, if any, who gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

Additional procedures for appealing particular claims are outlined below.

Medical Claims

If your claim is denied, in whole or in part, you may appeal the denial. There are two levels of the appeals process, as described below.

You must submit your first appeal to Blue Cross/Blue Shield of Illinois (BCBS) within 180 days of the date of the BCBS non-favorable decision. In addition, your provider may opt to perform a peer-to-peer review. A peer-to-peer review must be requested prior to filing an appeal with BCBS.

If BCBS denies your appeal, you may then request a second level of appeal with the Claims Review Committee within 180 days of the date of the BCBS non-favorable decision.

21.08 Timing of Notice of Decision on Internal Appeal

Urgent Care Claims

If the appeal is for an urgent care claim, you will be notified of the decision on appeal as soon as possible, but not later than 72 hours after the receipt of the request for appeal.

Note

An appeal of a concurrent care decision to reduce or terminate previously approved benefits may be an urgent care, pre-service or post-service claim, depending on the facts.

All Non-Urgent Pre-Service Care Claims

If the appeal is for a non-urgent preservice claim, you will be notified by BCBS no later than 15 days after receipt of the request for appeal, or 15 days for each level of appeal, if two mandatory appeals are allowed (no extensions).

Post-Service Care Claims

If the appeal is for a post-service claim, you will be notified no later than 30 days after receipt of the request for appeal, or 30 days for each level of appeal, if two mandatory appeals are allowed (no extensions).

All Other Claims

The Plan will send you a notice of the decision on appeal within 60 days of the receipt of the appeal (up to 60-day extension).

21.09 Notice of Decision on Internal Appeal

The Plan/Claim Administrator will provide you with a written decision on any internal appeal of your claim. However, if your claim is an urgent care claim, the Plan may notify you of the decision in writing, via fax or orally via telephone. The information included in the notice of a denial of a claim on appeal varies depending on the type of claim. All notices will state:

- The specific reason(s) for the determination
- References to the Plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A statement of your right to bring a civil action under ERISA following an Adverse Benefit Determination on appeal

If the appeal was for a health benefit, the notice will also include:

- If an internal rule, guideline or protocol was relied upon, you will receive either a copy of the rule or a statement that it is available upon request at no charge
- If the determination was based on medical necessity or because the treatment was Experimental or Investigational Treatment or other similar exclusion, the Plan will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge

If the appeal was for a health benefit *except* for dental or vision benefits, the notice will also include:

- Sufficient information to identify the claim involved, including the date of service, the health care Provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
- An explanation of the Plan's/claim administrator's decision
- For claims involving medical judgment or the balance billing protections of the No Surprises Act, a statement of your external appeal rights, an explanation regarding how to initiate those rights

- if applicable, the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes
- If applicable, a notice in any applicable non-English language describing how to access the Plan's language services

If the appeal was for a disability benefit, the written explanation will also include:

- Sufficient information to identify the claim involved, including the date of service;
- A discussion of the decision, including an explanation for disagreeing with or not following, as applicable:
  - The views you presented to the Plan of the health care and vocational professionals who treated or evaluated you;
  - The views of medical or vocational experts obtained by the Plan in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the adverse benefit determination; and
  - A disability determination made by the Social Security Administration regarding you and presented to the Plan
- If an internal rule, guideline, protocol, standard or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist
- If the determination was based on medical necessity or because the treatment was Experimental or Investigational Treatment or other similar exclusion, the Plan will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- A description of any contractual limitations period that applies to your right to bring a civil action under ERISA following an Adverse Benefit Determination on appeal, including the calendar date on which the Plan’s 90-day limit for filing suit expires

21.10 External Appeal Process

External Review Filing Deadline

If your health care claim *except* dental and vision claims involved medical judgment, rescission of coverage, or compliance with cost-sharing and surprise billing protections under the No Surprises Act and was denied, resulting in an Adverse Benefit Determination, you have the right to file a request for an external review by an independent review organization (“IRO”) with the Fund Office within four months of the date of the appeal decision.

However, you do not have a right to request external review if your health care claim did not involve medical judgment, a rescission of coverage or compliance with cost-sharing and surprise billing protections under the No Surprises Act. For example, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your Dependent fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

Dental claims, vision claims, disability claims and Basic Life and AD&D claims are also not eligible for external review.

External Review Process

The external review process works as follows:

- **Request for External Review**

  Within five days of the Plan's receipt of your written request for external review, the Plan must determine whether:

  - You are or were covered under the Plan at the time of service or requested service
  - The Adverse Benefit Determination does not relate to your failure to meet the Plan's eligibility requirements
  - You have provided all information and forms required to process an external review

- **Determination of Eligibility for External Review**

  Within one business day after the completion of this review, the Plan must notify you (or your authorized representative) whether the request is complete and is eligible for external review. If the request is not complete, the Plan must provide notice of what information or materials are needed and allow you to perfect the request within the four-month filing period or 48 hours following receipt of the notification, whichever is later. If the request is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

- **Referral to an Independent Review Organization (IRO)**

  If your request is eligible for external review, the Plan will utilize an unbiased method to assign the external review to an IRO. An IRO is a third party accredited by URAC (or other similar nationally-recognized accrediting organization) to conduct external review of benefit claims. The IRO is not eligible for any financial incentives based on the likelihood that it will deny a claim. The Plan will contract with IROs and will rotate claim assignments among them in accordance with applicable law. The timeline for completion of the external review is as follows:

  - The IRO will timely notify you of receipt of the assignment of the external review and such notice will inform you that you may provide additional information within ten business days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.
  - The Plan must provide the claim file and any information considered in making the Adverse Benefit Determination within five business days after the date of assignment to the IRO. Failure by the Plan to submit the information to the IRO may result in an immediate reversal of the Adverse Benefit Determination. The IRO must send notice of such to you and the Plan within one business day.
  - The IRO must forward any additional information received from you to the Plan within one day of receipt and the Plan may reconsider and reverse its decision, terminating the external review. The Plan must provide notice within one business day of such a decision to you and the IRO.

- The IRO will review all information received de novo. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:
    - The claimant's medical records
    - The attending health care professional's recommendation
    - Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider
    - The terms of the Plan
    - Appropriate practice guidelines, which must include all evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations
    - Any applicable clinical review criteria developed and used by the Plan, unless the criteria is inconsistent with the terms of the Plan or applicable law; and
    - The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider it appropriate.

Request for an Expedited External Review

You may make a request for an expedited external review if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum function or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

An expedited external review will occur in accordance with the procedures stated above for a standard external review, except that each step must be performed in the most expeditious method and the IRO must provide the claimant notice of its decision as expeditiously as the circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the decision is not communicated in writing, the notice must provide written confirmation to you and the Plan within 48 hours after notice is provided.

Timing of Notice of Decision on External Review

The assigned IRO must provide written notice of the final external review to the claimant and the Plan within 45 days after the IRO first receives the request for review.

Content of Notice of Decision on External Review

The IRO will provide you and the Plan with a written decision. The notice of the decision will contain all the following:

- A general description of the reason for the request for external review including sufficient information to identify the claim involved, including the date of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial.

- The date the IRO received the assignment and the date of the IRO decision.
- Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making its decision.
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant.
- A statement that judicial review may be available to the claimant.
- Current contact information, including phone numbers, for any applicable office of health insurance consumer assistance or ombudsmen established under PHS Act section 2793.

21.11 Physical Examination

The Trustees have the right and opportunity, at the Plan's expense, to have a Physician they designate examine you or your Dependent as often as is reasonable while your claim for Plan benefits is pending.

21.12 Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete it yourself and have previously designated the authorized representative to act on your behalf. You may obtain a form from the Fund to designate an authorized representative.

The Fund may request additional information to verify that this person is authorized to act on your behalf. The Fund reserves the right to withhold information from a person who claims to be the authorized representative, if there is suspicion about the qualifications of the individual claiming to be the authorized representative.

21.13 Benefit Payment to an Incompetent Person

Benefit payments under the Plan may become payable to a person who is adjudicated incompetent or to a person who, by reason of mental or physical disability, in the opinion of the Trustees, is unable to administer such payments properly. In that event, the Trustees may make payments for the benefit of the incompetent person as they deem best. The Trustees will have no right or obligation to see that the funds are used or applied for the purpose(s) for which if they are paid:

- Directly to such person
- To the legally appointed guardian or conservator of such person
- To any spouse, child, parent, brother or sister or such person for the welfare, support and maintenance of that person or
- By the Trustees directly for the support, maintenance and welfare of such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

21.14 Misrepresentation or Falsification by Participant

If you make an intentional misrepresentation or falsification of any information or a matter in connection with any application or claim for benefits, the Trustees or their representative(s) may deny all of part of the benefits that might otherwise be due.

21.15 Prohibition of Rescission

The Fund cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage initiated by the Fund that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Fund must provide thirty (30) calendar days advance notice to a covered person before coverage may be rescinded.

Section 22: Your ERISA Rights

As a participant in the EIT Health and Welfare Plan for Construction Workers, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Although ERISA does not require an employer to provide benefits, it does set standards on how a Plan is run. It also requires that you be kept fully informed of your rights and benefits — the details of which are included in this Summary Plan Description (SPD)/Plan.

ERISA provides that all Plan participants shall be entitled to the following rights:

22.01 Receive Information about Your Plan and Benefits

You may examine, free of charge, all documents governing the Plan including insurance contracts, collective bargaining agreements and the latest annual report (Form 5500 Series). These documents are available at the Plan Administrator's office and at other specified locations. The annual report is also filed with the U.S. Department of Labor and is available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), SPD and all Summaries of Material Modifications (SMM). The Plan Administrator may make a reasonable charge for the copies.

You may also 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.

22.02 Continuing Group Health Plan Coverage

Under COBRA, you may continue health care coverage for yourself, your spouse or your Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. However, you or your Dependents may have to pay for such coverage. Review this SPD/Plan and the documents governing the Plan for the rules governing your COBRA coverage rights.

22.03 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for operating the Plan. These people are called "fiduciaries" of the Plan. They have a duty to act 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 to which you are otherwise entitled or from exercising your rights under ERISA.

22.04 Enforcement of Your Rights

If your claim for a welfare benefit is denied, in whole or in part, the Plan Administrator must give you a written explanation of the reason for the denial, and you can obtain copies of documents relating to the decision, without charge. You also have the right to appeal any denial, all within certain defined time schedules. Please note that you or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeal procedures.

Under ERISA, there are steps you can take to ensure the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan Administrator 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 your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. You may also file suit in a federal court if you disagree with a decision, or the lack of a decision concerning the qualified status of a medical child support order. If 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 (for example, if the court finds your claim is frivolous), it may order you to pay these costs and fees.

22.05 Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or contact 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 find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA filed offices by contacting the EBSA:

- By calling (866) 444-3272;
- Sending electronic inquiries to www.askebsa.dol.gov; or
- Visiting the ESBA website at www.dol.gov/ebsa.

Section 23: Your HIPAA Rights

23.01 Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice will be available from the Plan Administrator.

The Plan and the Plan Sponsor will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan. The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan will require all of its business associates to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Plan maintains a privacy notice that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Fund Office if:

- You need a copy of the Privacy Notice;
- You have questions about the privacy of your health information; or
- You wish to file a complaint under HIPAA.

23.02 Use and Disclosure of Protected Health Information (PHI)

How the Plan Uses and Discloses Your PHI

The Plan will use your protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care and health care operations.

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Plan will disclose PHI to Pension Plan No. 2, Pension Plan No. 5, reciprocal benefit plans or Workers' Compensation insurers for purposes related to administration of those plans.

Definition of Payment

Payment includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (e.g., cost of a benefit, Plan maximums and copayments as determined for an individual's claim);

- Coordination of benefits
- Adjudication of medical benefit claims (including appeals and other payment disputes);
- Subrogation of medical benefit claims
- Establishing Employer contributions
- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Billing, collection activities and related health care data processing
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant (and their authorized representatives) inquiries about payments
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance)
- Medical necessity reviews, or reviews of appropriateness of care or justification of charges
- Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review
- Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social security number, payment history, account number, and name and address of the provider and/or health plan); and
- Reimbursement to the Plan.

Definition of Health Care Operations.

Health Care Operations include, but are not limited to, the following activities:

- Quality assessment
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care Providers and patients with information about treatment alternatives and related functions
- Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or medical benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance)
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

- Business management and general administrative activities of the entity, including, but not limited to:
    - management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
    - customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
    - resolution of internal grievances; and
    - due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or following completion of the sale or transfer, will become a covered entity.

The Plan's Disclosure of PHI to the Board of Trustees

The Board of Trustees is the Plan Sponsor. With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by this SPD or as required by law
- Ensure that any agents, including a subcontractor to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual
- Not use or disclose the information in connection with any other benefit or employee benefit plan of the plan sponsor unless authorized by the individual
- Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA
- Make the information available that is required to provide an accounting of disclosures
- Make internal practices, books and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the group health Plan with HIPAA
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees will be given access to PHI:
- The Executive Director; and
- Staff designated by the Executive Director.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this SPD, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Section 24: Important Plan Information

24.01 Plan Name

The official name of the Plan is the Electrical Insurance Trustees Health and Welfare Plan for Construction Workers. This combination Plan document and SPD describes the benefits provided under the Plan.

24.02 Board of Trustees

A Board of Trustees is responsible for the administration and operation of the Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the employers and the Union, which have entered into Collective Bargaining Agreements relating to the Plan. If you wish to contact the Board of Trustees, you may use the addresses below. As of the date of this SPD, the Trustees are as follows:

Employer Trustees

Kenneth J. Bauwens
Jamerson & Bauwens Electrical Contractors, Inc.
3055 MacArthur Blvd
Northbrook, Illinois 60002
(847) 291-2000

Kevin O'Shea
Shamrock Electric Co., Inc.
1281 East Brummel Avenue
Elk Grove Village, Illinois
(847) 593-6070

Thomas Rivi
G&M Electrical Contractors
1746 N. Richmond Street
Chicago, Illinois 60647
(773) 278-8200

Jeff Weir
KB Advanced Technologies
200 W. Jackson Blvd, Suite 1200
Chicago, Illinois 60606
(312) 447-5750

David Witz
Continental Electrical Construction Co.
815 Commerce Drive, Ste 100
Oak Brook, Illinois 60523
(630) 288-0222

2722 S. Martin Luther King Drive
Chicago, Illinois 60616
(312) 454-1340

24.03 Plan Administrator and Sponsor

The Board of Trustees is the Plan Administrator and Plan Sponsor. The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change all provisions of the Plan at any time and from time to time. The Plan is maintained for the exclusive benefit of its participants and beneficiaries.

24.04 Plan Number

The Plan number assigned to the Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Code is 501.

24.05 Employer Identification Number

The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is 36-1033970.

24.06 Plan Year

The Plan year begins on July 1 and ends on the following June 30.

24.07 Amendment and Termination of the Plan

Although the Trustees intend to continue the Plan indefinitely, the Trustees have the authority and unconditionally reserve the right, in their sole and unrestricted discretion, to change, amend or end the Plan at any time, or from time to time, for any reason. You do not earn a vested right to health benefits.

Changes may be made retroactively, if necessary, to qualify or maintain the benefits under the Internal Revenue Code or ERISA. If the Plan is amended or ends, you may not receive benefits as described in this SPD. However, you may be entitled to receive different benefits, or benefits under different conditions or no additional benefits.

24.08 Plan Funding

The benefits described in this SPD are provided through contributions and self-payments. The amount of Employer contributions and the Employees on whose behalf contributions are made are determined by the provisions in the applicable Collective Bargaining Agreements and other participation agreements. The amount of self-payments are determined by the Trustees.

All assets are held in Trust for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. All the benefits are provided on a self-funded basis, except for the Life Insurance Benefit and Accidental Death and Dismemberment Benefit, which are insured.

24.09 Collective Bargaining Agreement

The Plan is maintained in accordance with a Collective Bargaining Agreement between the Electrical Contractors' Association of City of Chicago and the Local Union No. 134 International Brotherhood of Electrical Workers. Other agreements may be in effect from time to time. The agreements specify the contributions required.

The Fund Office will provide you, upon request, information as to whether a particular Employer is contributing to this Fund under a Collective Bargaining Agreement or a list of participating Employers.

24.10 Agent for Service of Legal Process

The agent for service of legal process concerning the Plan is:

Erin Keane
Executive Director
6195 W. 115th Street
Alsip, Illinois 60803

Service of legal process may also be made on the Board of Trustees or any individual Trustee at the addresses listed under "Board of Trustees."

24.11 Non-Assignment of Benefits

Generally, benefits from the Plan belong to you. You may not anticipate, alienate, sell, assign, transfer, pledge, garnish or otherwise encumber any interest in benefits to which you are or may become entitled under the Plan and any attempt to do so shall be void. No benefits under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person. If any person entitled to benefits under the Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, pledge or garnish any benefit under the Plan, or if any attempt is made to subject any such benefit to the debts, contracts, liabilities, engagements or torts of the person entitled to any such benefit, except as specifically provided in the Plan, then such benefit shall cease and terminate in the discretion of the Trustees, and they may hold or apply the same or any part thereof to the benefit of any eligible dependent of such person, in such manner and proportion as they may deem appropriate.

24.12 Trustee Authority and Interpretation

The Trustees and/or their delegates have full discretionary authority and expressly reserve the right in their sole and unrestricted discretion to interpret the terms of the Trust Agreement, this SPD and the procedures of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits. Benefits under the Plan will be paid only if the Trustees or their delegates decide in their sole and unrestricted discretion that the Participant or beneficiary is entitled to benefits under the terms of the Plan. The Trustees' interpretation is binding on all Participants, Active Employees, Retirees, Dependents and beneficiaries and all other individuals unless the Trustees' interpretation is found by a court of competent jurisdiction to be arbitrary and capricious. All questions or controversies of any type arising in any manner or between ay persons in connection with the Plan or its operations must be submitted to the Trustees or their delegates for decision.

The Trustees, at any time and from time to time, in their sole and unrestricted discretion, have the authority to increase, decrease or change benefits, eligibility rules or other provisions of the Plan. All benefits of the Plan are conditional and subject to the Trustees' authority under the Trust Agreement to change them.

24.13 Severability Clause

If a provision of the Trust Agreement or this SPD or any amendment made to the Trust Agreement or to this SPD is determined or judged to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions of the Trust Agreement or SPD.

24.14 Pronouns

In this SPD, masculine personal pronouns (he, him, his) include the feminine (she, her, hers) wherever they apply. Also, wherever the term "you" or "your" is used, it refers to an Active Employee (or Retiree, as applicable), eligible to receive benefits under the Plan.

24.15 Recovery of Benefits Paid in Error

If for any reason, any benefit paid to a covered person under the Plan is determined to have been in error, or wholly or partially more than the amount to which such payee was entitled to receive under the Plan, the Trustees may collect such erroneous benefit payment or overpayment by any remedy as the law may provide.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Plan, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole and unrestricted discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

24.16 Governing Law

The Plan is governed by federal law, where applicable federal law exists; if there is no applicable federal law, the internal laws of the State of Illinois will apply in all matters.

24.17 For More Information

All questions and requests for information should be sent to the Trustees at the following address:

Attention: Executive Director
6195 W. 115th Street
Alsip, IL 60803

Section 25: Glossary

This section contains definitions of terms used throughout this booklet. The terms are listed in alphabetical order.

Active Employee

A person who meets the definition of Employee, who is actively at work or Available for Work for a contributing employer, and who is not a Retiree.

Administrator Program

Programs for which a Hospital has a written agreement with the Claims Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

Adverse Benefit Determination

A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on (1) a determination of a person's eligibility to participate in the Plan (including a rescission of coverage), (2) a determination that a benefit is not a covered benefit, (3) the imposition of a source-of-injury exclusion, network exclusion or other limitation on otherwise covered benefits, or (4) a determination that a benefit is Experimental, Investigational or not Medically Necessary or appropriate.

Affordable Care Act

The Patient Protection and Affordable Care Act, as amended, and corresponding regulatory and sub regulatory guidance.

Ambulance Transportation

Local transportation in specially equipped certified vehicle ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under the Plan.

Ancillary Services

Emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided if there is no Network Provider who can furnish such item or service at Network facility.

Apprentice School

The Electrical Joint Apprenticeship and Training Trust.

Autism Spectrum Disorder

A pervasive developmental disorder described by the American Psychiatric Association or the World Health Organization diagnostic manuals as an autistic disorder, atypical autism, Asperger Syndrome, Rett Syndrome, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified; or a special education classification for autism or other disabilities related to autism.

Balance Billing

The difference between the amount billed by a Non-Network Provider and the Eligible Charge, which the Non-Network Provider bills or seeks to recover from the Participant.

Billed Charge

The total gross amount billed by your provider to the Plan.

Board of Trustees, Trustee or Trustees

The Board of Trustees of the Electrical Insurance Trustees Health and Welfare Plan for Construction Workers. The Board of Trustees is both the Plan Sponsor and Plan Administrator.

Chemical Dependency

Any abuse of, addiction to, or dependency on the use of drugs, narcotics, alcohol or any other chemical (except nicotine).

Child(ren)

The biological, adopted, step or foster child. The definitions of the terms are:

- Biological child: You are shown as a parent on the child's birth certificate or paternity order.
- Adopted child: Legally adopted or child placed with you pending legal adoption.
- Stepchild: Biological (born before your marriage) or adopted child of your current spouse.

A child for whom you are required to provide health care due to a QMCSO will also be considered your Child.

Chiropractic and Naprapathic Care

Skeletal adjustments, manipulation or other treatment (including naprapathy) in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Treatment is performed to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Claims Administrator

A neutral third party retained to comply with the requirements set forth in this Plan and applicable Medical Policy.

Coinsurance

The percentage of Covered Services you must pay after you have met your annual Deductible.

Collective Bargaining Agreement

Any applicable collective bargaining agreement now existing or executed in the future between the Union and an Employer which provides for contributions to the Trust Fund, as well as any extensions, amendments, or renewals thereof.

Contributed Hours

Hours you worked in Covered Employment for which an Employer made contributions on your behalf to the Fund.

Coordinated Home Care Program

An organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician, a physician assistant who has been authorized by a Physician to prescribe those services, or an advanced practice nurse with a collaborating agreement with a Physician that delegates that authority. This program includes physical, occupational and speech therapists and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Services or Custodial Care Services. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

Copayment

A specified dollar amount that you are required to pay towards a Covered Service.

Cosmetic Surgery

Plastic or reconstructive surgery or other services and supplies which improve, alter or enhance appearance, whether performed or used for emotional or psychological reasons.

Covered Employment

Employment of an Active Employee by an Employer for which contributions to this Fund are required.

Covered Service

A service, procedure, treatment and/or supply specified in this benefit booklet for which benefits will be provided.

Credited Service

Credited service is used to determine the amount of your pension benefit under Pension Plan No. 2. It also may be used to determine eligibility for health care coverage after you retire.

Generally, you receive one full year of credited service for each calendar year in which you have 1,600 hours of covered employment. Before 1976, you received one-fourth of a year of credited service for each 400 hours you worked during each year — up to the maximum full year of credited service. After 1975, you receive one full year of credited service for each year in which you work 1,600 hours. For each year in which you have at least 400, but fewer than 1,600 hours, you receive credited service in proportion to your number of hours — up to the maximum full year of credited service.

Refer to Pension Plan No. 2 for more information on credited service.

Custodial Care Service

Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (including but not limited to dressings, administration of routine medications, ventilator suctioning and other care) and are to assist with activities of daily living (including but not limited to bathing, eating and dressing).

Deductible

The amount you pay for Covered Services each year before the Plan begins to pay benefits. The deductible may not apply to all Covered Services.

Dentist

A person licensed to practice dentistry by the governmental authority having jurisdiction over the license and practice of dentistry and who is acting within the scope of that license.

Dependent

A person who is:

- A participant's lawful spouse (i.e., the person legally married to the Employee or Retiree)
- Each Child of a participant from the date he or she first becomes a Child of the participant to the end of the month in which such attains age 26
- A Child who has been diagnosed with severe physical or mental disability, and the disability is expected to last for a continuous period of 12 months or more, provided:
    - Such incapacity began before the end of the month such Child attains age 19
    - Such Child was covered by the Plan on the day prior to his or her 19th birthday
    - Such Child is dependent on the Employee or Retiree for more than 50% of his or her financial support and maintenance for the calendar year
    - Such Child resides with the Employee or Retiree
    - Such Child's disability is not solely due to alcoholism or drug addiction.

The Trustees may request the Employee or Retiree provide proof of the Child's disability, including that he became disabled before reaching age 26 and annual proof of the Child's continued disability. It is the responsibility of the Employee or Retiree to provide all proof of disability at his or her own expense. If the proof is not provided when required, the Child's eligibility for coverage under the Plan as a Dependent will terminate.

Any Dependent you acquire after your Retirement Date is **not** eligible for Retiree Health Benefits.

Designated Beneficiary

The person you designate on the beneficiary designation form is available from the Fund Office. Your Designated Beneficiary applies to both the Life Insurance Benefit and the AD&D Benefit. A beneficiary designation form is valid upon receipt by the Fund Office before your death.

Disabled

If you suffer from an illness or accidental injury that prevents you from being continuously able to perform your job, and you are under the care of a Physician or licensed behavioral health provider.

Durable Medical Equipment

Equipment that (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose related to the person's physical disorder, (3) generally is not useful in the absence of illness or injury, and (4) is appropriate for use in the home.

Examples of Durable Medical Equipment covered under the Plan include, but are not limited to, the following: glucose and apnea monitoring devices, transneuromuscular stimulators, wheelchairs, manually operating hospital beds and oxygen machines.

Examples of equipment that are not Durable Medical Equipment and are not covered under the Plan include, but are not limited to, the following: exercise and sports equipment, wheelchair lifts, extended warranties, air cleaners, air purifiers, vacuum systems and filters.

Eligible Charge

The amount of expenses billed by a Provider that is covered under the Plan, subject to all applicable limitations and restrictions.

For a Network Provider, the Eligible Charge is the negotiated fee or rate set forth in the Plan's agreement with the participating network, health and/or dental provider, facility or organization.

For medical services from a Non-Network Provider, the Eligible Charge shall be the lesser of (a) the Provider's Billed Charges, or (b) an amount determined by BCBSIL to be approximately 100% of the base Medicare Reimbursement Rate, excluding any Medicare adjustment(s) which is/are based on information on the claim; or (ii) if there is no base Medicare Reimbursement Rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under (i) above based upon the information submitted on the claim, the lesser of (a) the Provider's Billed Charges and (b) an amount determined by the Claims Administrator to be 100% of the maximum allowed if the services were rendered by a Network Provider on the date of service; or (iii) if the base Medicare reimbursement amount and the Eligible Charge cannot be determined under (i) or (ii) above, based upon the information submitted on the claim, then the amount will be 100% of the Provider's Billed Charges; provided, however, that the Claims Administrator may limit such amount to the lowest contracted rate that the Claims Administrator has with a Network Provider for the same or similar services based upon the type of provider and the information submitted on the claim, as of January 1 of the same year that the Covered Services are rendered to the covered person.

For all other services from a Non-Network Provider, the Eligible Charge is the amount as determined by the Board of Trustees for a particular service or supply.

Emergency Medical Condition

A bodily injury or sickness, 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 would result in 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services

With respect to an Emergency Medical Condition means:

- A medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including

Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and

- Medical examination and treatment that are within the capabilities of the staff and facilities available at such hospital or independent freestanding emergency department, as applicable, to Stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

- Unless the covered individual's consent to Non-Network services is provided to the Plan by the provider or facility, items and services for which benefits are provided by the Plan that are furnished by a Non-Network provider or Non-Network emergency facility after the covered individual is Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Emergency Medical Condition which gave rise to the initial Emergency Services.

Employee

An individual who is working in Covered Employment and is eligible for benefits under the Plan. In connection with Retiree Benefits, Employee also means a Retiree who is eligible for Retiree Benefits as the context deems appropriate.

Employer

An association or corporation that has a Collective Bargaining Agreement with the Union that requires contributions to the Plan. The Fund, the Union and the fringe benefit funds associated with the Union are also considered to be Employers with regard to their own employees. As the context deems appropriate, Employer also includes an association, corporation or organization that has entered into a participation agreement with the Trustees to make contributions to the Plan on behalf of employees who are not covered under a Collective Bargaining Agreement.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational

Treatment, procedures, facility, equipment, drugs, devices, services and/or supplies which are not accepted as Standard Medical Treatment for the condition being treated or, if any such items required federal or other governmental agency approval, such approval was not granted at the time services were provided. Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated
- are appropriate for the Hospital or Facility in which they are performed; and
- the Physician or Professional Provider has had the appropriate training and experience to provide the treatment or procedure

The Trustees have the authority to determine whether a service, procedure drug, device or treatment modality is Experimental or Investigational. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.

Fund Office

The administrative office for the Fund located at 6195 W. 115th Street, Alsip, Illinois 60803.

Hospice Care Program Provider

An organization duly licensed to provide Hospice Care Program Service, when operating within the scope of such license.

Hospice Care Program Service

A centrally administered program designed to provide physical, psychological, and spiritual care for dying people and their families. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special hospice care unit.

Hospital

A lawfully operating institution for the care and treatment of sick and injured persons with organized facilities for diagnosis and treatment, medical supervision, 24-hour nursing service by registered nurses, and surgery (or provides for surgical facilities on a formal arrangement). In no event, however, does the term Hospital include any institution or part of an institution which is used principally as a rest facility or facility for the aged, nor does it include a hospital operated by the United States Government, unless the claimant is required to pay such expense.

Inpatient

A person who is a registered bed patient and is treated as such in a health care facility.

Maintenance Care

Services administered to a Participant or Dependent to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur. This includes Occupational, Physical and Speech Therapy.

Medically Necessary

A specific medical, health care, supply or Hospital service that is required for the treatment or management of a medical symptom or condition, and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary, does not make the hospitalization, services or supplies Medically Necessary and does not mean the Claims Administrator will approve and pay the cost of the hospitalization, services or supplies.

Only those services, supplies and treatments that, in the judgement of the Trustees based on the opinion of a medical professional who is qualified to render an opinion on the issue, meet all the following conditions:

- Provided by a licensed provider, acting with the scope of his or her license;
- Required to identify or treat an injury or sickness
- Not Experimental or Investigational
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies
- Consistent with the symptoms or diagnosis of the patient's condition

- Required for reasons other than the convenience of the patient or Physician

Medical Care

The ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

Medical Policy

The guidelines used by the Claims Administrator for determining if a service, procedure, treatment or supply is Medically Necessary.

Medicare Reimbursement Rate

A listing of fees developed by the Centers for Medicare and Medicaid Services and used by Medicare to determine appropriate payment for providers or suppliers of medical care and treatment.

Mental or Nervous Disorder

A condition or disorder that involves a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Morbid Obesity

A condition that exists when weight is at least twice the ideal weight for frame, age, height and gender according to the Federal Guidelines on Obesity.

Network Pharmacy

A pharmacy who participates in the CVS/Caremark network of pharmacies. The Plan currently contracts with CVS/Caremark and its network of pharmacies, and prescriptions purchased through a Network Pharmacy are covered under the Plan.

Network Provider

A provider who participates in a Preferred Provider Organization (PPO) by agreeing to accept certain pre-determined, negotiated and discount rates or fees for health care services provided. The Plan contracts with a PPO to provide access to Network Providers to participants. You will maximize your benefits when you visit a provider in the PPO network with which the Plan contracts.

No Surprises Act

The federal No Surprises Act (Public Law 116-260, Division BB), and corresponding regulatory and sub-regulatory guidance.

Non-Network Pharmacy

A pharmacy who does not participate in the CVS/Caremark network of pharmacies. Prescriptions purchased at a Non-Network Pharmacy are not covered under the Plan.

Non-Network Provider

A provider that does not participate in a Preferred Provider Organization (PPO) with which the Plan contracts. These providers have not agreed to accept a PPO Negotiated Rate for their services covered under the Plan. If you choose to receive services from a Non-Network Provider, the Plan will pay a percentage of charges for Covered Services, based on the Eligible Charges (not the Billed Charges), and the Non-Network Provider may choose to balance bill you for any difference between the Eligible Charges and the Billed Charges, except as required by the No Surprises Act.

Outpatient

Receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

Partial Hospitalization Treatment Program

A Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment in which patients spend days or nights. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an Inpatient unit, i.e., medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24-hour supervision and are not considered a resident at the program.

The Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Participant

An Employee or Retiree who is eligible and covered under the Plan.

Pension Plan No. 2

The Electrical Contractors Association and Local Union 134 I.B.E.W. Joint Pension Trust of Chicago Pension Plan No. 2.

Pension Plan No. 5

The Electrical Contractors Association and Local Union 134 I.B.E.W. Joint Pension Trust of Chicago Pension Plan No. 5.

Pharmacy Benefits Manager (PBM)

A third-party administrator of the prescription drug program that is primarily responsible for processing and paying prescription drug claims under the terms of the Plan.

Physician

A medical practitioner who is licensed to practice medicine, perform surgery, and administer drugs under the laws of the state or jurisdiction where the services are rendered, and who is acting within the scope of that license.

Plan

The Electrical Insurance Trustees Health and Welfare Plan for Construction Workers.

Plan Administrator

The Board of Trustees of the Electrical Insurance Trustees Health and Welfare Plan for Construction Workers. The Plan Administrator controls and manages the operation and administration of the benefits and programs of the Plan.

PPO Negotiated Rate

The amount for services and supplies, as negotiated between the Network Provider and the PPO network, that the Network Provider has agreed to accept as full payment for services. For services provided by a Network Provider, the PPO Negotiated Rate is the Eligible Charge under the Plan.

Preferred Provider Organization (PPO)

A medical organization that allows you to choose from a list of Network Providers. A PPO is comprised of a network of Hospitals, Physicians and other health care providers, which have agreed to provide health care services to Participants of the Plan for a pre-determined and discounted fee or rate.

Preventive Services

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

- Immunizations for routine use in children, adolescents and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention)

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

- With respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Provider

Any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity licensed to render Covered Services to a Participant and operating within the scope of such license.

- Participating Provider – an administrator Hospital or Professional Provider which has a written agreement with the Claims Administrator or another affiliated plan to provide services to you in the Preferred Provider Organization (PPO) program or an administrator facility which has been designated by the Claims Administrator as a Participating Provider.

- Non-Participating Provider – an administrator Hospital or Professional Provider which does not have a written agreement with the Claims Administrator or another affiliated plan to provide services to you in the Preferred Provider Organization (PPO) program or a facility which has not been designated by the Claims Administrator as a Participating Provider.

- Professional Provider – a Physician, Dentist, podiatrist, psychologist, chiropractor, optometrist, or any Provider designated by the Claims Administrator or affiliated plan.

Qualified Medical Child Support Order (QMCSO)

A judgment, decree or order issued under a state domestic relations law by a court of competent jurisdiction that requires a parent to provide medical support to a child.

Qualifying Event

Certain events that cause you and/or your covered Dependents to lose coverage under the Plan and become eligible for COBRA coverage. Qualifying Events include the death of a Participant, a reduction of the Participant's hours or loss of employment (except due to gross misconduct), the Participant's entitlement to Medicare benefits, a Dependent losing his or her Dependent status under the Plan, and legal separation or divorce from the Participant.

Qualifying Payment Amount (QPA)

The median contracted rate on January 31, 2019, as adjusted, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation.

Referral Hall

The Union office where members must register their availability for work and from where employment is assigned.

Residential Treatment Center

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and onsite nursing care and supervision for at least one shift a day with on call availability for other shifts for patients with Mental Illness and/or Substance Use Disorders. The Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy and otherwise meets all other credentialing requirements set forth in such policy. Residential Treatment Center (RTC) programs/services for the treatment of Mental Illness and/or Substance Use Disorders that do not provide 24-hour medical availability and that do not provide on-site nursing care and supervision for at least one shift a day with on call availability for other shifts are not considered Medically Necessary.

Retiree

An individual who formerly worked in Covered Employment and who is eligible for Retiree Health Benefits.

Retiree Interim Coverage

Retiree Interim Coverage is an extension of COBRA coverage for an additional six months to bridge health care for members who retire at age 60 and meet the requirements for Retiree Health Benefits.

Retirement Date

The effective date of your retirement benefit under Pension Plan No. 2.

Review Quarter

The three-month period running from January through March, April through June, July through September or October through December, as the context deems appropriate.

Skilled Nursing Facility

A licensed facility that provides 24-hour professional nursing services on an inpatient basis to persons convalescing from injury or sickness. Skilled Nursing Facilities maintain a complete medical record on each service recipient and are supervised on a full-time basis by a Physician.

Stabilize(d)

With respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result for or occur during the transfer of the individual from a facility.

Substance Abuse Disorder

A condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorder chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorder.

Surgery

The performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claims Administrator.

Trust Agreement

The Agreement and Declaration of Trust that establishes the Plan, including all amendments, establishing the Trust Fund and its rule of operation and known as the Insurance Trust Agreement between the Electrical Contractors' Association of the City of Chicago and the Local Union 134 I.B.E.W.

Union

The Local Union No. 134 International Brotherhood of Electrical Workers (I.B.E.W.), AFL-CIO and any successors.

Usual and Customary Rate (U&C)

The charges considered appropriate in your geographic area for Medically Necessary services, treatments, supplies or drugs.

Welfare Fund or Fund

Refers to the assets held in trust for the EIT Benefit Funds Health and Welfare Plan for Construction Workers.