NECA-IBEW LOCAL NO. 364
HEALTH & WELFARE FUND

SUMMARY PLAN DESCRIPTION

BENEFITS AND ELIGIBILITY RULES
Effective January 1, 2025

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INTRODUCTION

About Your Plan

For you and your fellow workers, your Employer and the Union have created a Health and Welfare Fund, which provides a specific, dependable plan of benefits. This Plan has been improved in order to provide the best benefits possible consistent with sound financial management of the Plan.

The NECA-IBEW Local No. 364 Health and Welfare Fund is maintained as a result of a collective bargaining agreement, sometimes referred to as a labor contract, between your Employer and the Union.

Your Health and Welfare Fund receives its money from Employer contributions, on dates and in amounts called for by the labor contract negotiated with the Employer by your Union. **Money is not withheld from your paycheck to support the Fund.**

Decisions on Plan operations and benefits are made by a Board of Trustees on which labor and management are equally represented.

Working together, the Board of Trustees establishes the eligibility rules, strives to maintain the schedule of benefits, supervises the investment of the Fund's money, and sees that the Fund is in compliance with all applicable Federal laws and regulations.

In carrying out these responsibilities, the Trustees are assisted by a team of professionals including:

- The **Administrative Manager** who handles the day-to-day business activities of the Fund such as collecting employer contributions, keeping records of money received, crediting each participant's account with the correct number of hours worked, paying claims, and answering inquiries from participants about their eligibility and benefits.
- The **Fund Attorney** advises the Trustees about what must be done to assure that all operations of the Fund comply with Federal and State laws.
- The **Fund Consultant** assists the Trustees in determining the level of benefits which can be provided from Fund resources and advises the Trustees on other matters important to the Fund's operations.

The largest part of the contributions the Fund receives is returned directly to participants in the form of benefits. Some of the contributions received are set aside for reserves. The Fund's reserves can be drawn on at times when the claims expenses exceed income.

As required by law, the Fund has an independent auditor examine the financial records each year and certifies them as to their accuracy, completeness, and fairness. In addition, the Trustees are required to submit annual financial statements and other reports to the U.S. Department of Labor and the Internal Revenue Service. These reports are available for inspection at the Fund Office during normal business hours.

This, then, is a brief description of how your Fund was established, what its purpose is, and how it operates.

Your Responsibilities as a Participant

There are certain responsibilities which you, as a participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable.

1. Take time to read this Summary Plan Description.
2. File an Employee Data (Enrollment) Card.
3. Notify the Fund Office promptly, in writing, if you have:
   a. a change of address; or
   b. a change in marital status; or

c. a change in beneficiary; or

d. a change in dependents.

4. Fully complete a claim form information sheet once per calendar year or upon request.
5. Make self-payments on time and in the correct amount.

A detailed explanation of your responsibilities can be found in the appropriate section of the Plan Description. Please refer to the Table of Contents for page numbers.

How to Collect Benefits

Once you become eligible, this Fund has the responsibility for helping you receive all the benefits to which you are entitled. You must also assume some responsibility to receive these benefits. Benefits are not paid automatically; you must file a claim with all the necessary information for the Fund to make payment.

General Instructions

1. In most cases, the provider of services will file your claim. A new claim form may be required when your circumstances change (such as marriage, birth of a child or change in a spouse's insurance coverage).
2. A claim will not be considered complete unless all the following information is provided:
   a. name and unique identification number of Fund member;
   b. name of patient, if different from member;
   c. date of service;
   d. an itemized list of services, with a description and the exact charge for each service; "Balance Due" notices will not be accepted as the basis for claim payment; and
   e. the service provider's name, address and phone number, and federal tax identification number.

Special Claim Circumstances

1. Claims for medical goods and services should be sent directly to the Fund's Preferred Provider Organization (PPO), Blue Cross Blue Shield of Illinois. Claims for Dental Benefits can be sent directly to the Fund Claims Office. Claims for Vision Care Benefits can be sent directly to VSP.
2. If you are making a claim due to accidental injury, be sure to give complete details about when and how the accident occurred.
3. If you are making a claim for Weekly Accident and Sickness (Loss of Time) Benefits, you and your physician must complete a special Loss of Time Claim Form. If your disability continues for an extended time, you will have to complete additional claim forms because the physician must certify that you are still disabled and when you will be able to return to work.

Notice of Claim

You should file your claims with the Fund just as soon as possible. All members must comply with every claim rule, and the Trustees reserve the right to deny benefits to any member who is, in their opinion, attempting to subvert the purposes of the Fund or who does not present a completely documented and bona fide claim.

SCHEDULE OF BENEFITS

Class A: Active Members & Their Dependents

Marathon Health & Wellness Center

Marathon clinics provide the following health care services at **NO CHARGE**:

- Primary Care Services
- Urgent Care Services
- Preventive Care
- Prescription Drugs (for common generic drugs prescribed at the clinic)

Comprehensive Basic Medical Expense Benefits

Calendar Year Deductible Amount	In-Network	Non-Network
Per One Person or	$400.00	$700.00
Per Family (cumulative)	$800.00	$1,400.00

The deductible for in-network is combined with the non-network deductible to equal not more than $700.00 per person or $1,400.00 per family.

Co-Payment Rate
- PPO Plan Pays (of the Negotiated Fees) 80%
- Patient Pays 20%

- Non-PPO Plan Pays (of the Reasonable and Customary Charge) 70%
- Patient Pays 30%

Coinsurance Maximums (per calendar year)
- Individual $2,000.00
- Family – 2 Members must satisfy $4,000.00

Hospital Benefits

Ward, Semi-Private Room ..... Semi-Private Room Rate
Intensive Care ..... Reasonable and Customary
Miscellaneous Charges ..... Reasonable and Customary
(Includes Out-Patient Treatment)

Emergency Room Benefits

PPO or Non-PPO Plan Pays 80%

NOTE: PRE-CERTIFICATION IS REQUIRED FOR ALL INPATIENT ADMISSIONS

Surgical Benefits

Surgeon and Assistant Surgeon ..... Reasonable and Customary
Diagnostic X-Ray and Laboratory Benefits ..... Reasonable and Customary

Weekly Loss of Time Benefits (Employee Only)

Benefits for Non-Occupational injury or illness
- Payment Begins - for Accident or Hospital Confinement ..... 1st Day
- Payment Begins - for Sickness ..... 1st Day
- Weekly Benefit $500.00
- Maximum Payment Period ..... 26 Weeks
- Benefits for Work Related Injury or Illness ..... NOT COVERED

Death Benefits

Employee Only $15,000.00

Accidental Death and Dismemberment Benefits

Employee Only (Principal Sum) $15,000.00

NOTE: THE ENTIRE PRINCIPAL SUM MAY NOT BE PAYABLE FOR ALL LOSSES; SEE THE SECTION DEATH AND DISMEMBERMENT LATER IN THIS SPD.

Mental and Nervous and Substance Abuse - Out-Patient Treatment Only

PPO Plan Physician's Expense Plan Co-Payment (After deductible) 80%
Non-PPO Plan Physician's Expense Plan Co-Payment (After deductible) 70%

NOTE: RESIDENTIAL CARE AND PARTIAL HOSPITALIZATION WILL BE COVERED AT THE BENEFIT LEVEL AS OUT-PATIENT.

Mental and Nervous and Substance Abuse - In-Patient Hospital Treatment

PPO Plan - Allowable Expense (After deductible) 80%
Non-PPO Plan - Allowable Expense (After deductible) 70%

Bariatric Surgery

Plan Co-Payment (After deductible) 80%
Out-of-Network Co-Payment (After deductible) 70%
Lifetime Maximum Benefit per Person $50,000.00

Chiropractic Treatment (Effective January 1, 2009)*

In-Network Plan Co-payment (After deductible) 80%
Maximum Amount Allowed (Per calendar year) $2,100.00
Out-of-Network Plan Co-payment (After deductible) 70%

**These out-of-pocket amounts do not accumulate to the co-insurance maximum.*

Hearing Aid Care Benefits

Plan Co-Payment (After deductible) 80%
Out-of-Network Co-Payment (After deductible) 70%
Annual Maximum Benefit Per Person $3,000.00
Lifetime Maximum Benefit per Person $6,000.00

Fertility Benefits

Lifetime Maximum Benefit per Person ..... Two Smart Cycles

FERTILITY BENEFITS ARE AVAILABLE THROUGH PROGYNY AND ARE LIMITED TO TWO SMART CYCLES PER LIFETIME. SEE PAGE 34 FOR MORE INFORMATION.

Prescription Drug Benefit – Retail & Mail Order

Co-Pays	Generic	Brand	Brand with Generic
30-day supply	$10	$20	$30 + Difference in Cost
60-to-90-day supply	$20	$40	$60 + Difference in Cost

PARTICIPANTS CHOOSING BRAND WHEN GENERIC IS AVAILABLE, WILL BE RESPONSIBLE FOR THE DIFFERENCE IN COST BETWEEN THE BRAND DRUG AND THE GENERIC DRUG.

Colonoscopies (Routine Screening)

In Network 100%
Out of Network 100%

Cologuard is covered under the Preventive Services benefit, at 100%.

Mammogram Benefit (Medical or Diagnostic)

Co-Payment Rate 100%

Wellness / Routine Physical Examination Benefit

Co-Payment Rate 100%
Routine Immunizations (up to age 18) 100%
(Based upon the immunizations recommended by the Center for Disease Control)

Temporomandibular Joint Dysfunction (TMJ) Benefits

In-Network Co-Payment Rate 80%
Lifetime Maximum per Person $1,500.00
Out-of-Network Co-Payment Rate 70%

Dental Benefits

Plan Co-Payment Rates
- Preventative and Diagnostic (Exams, Cleanings, & Bitewings) 100%
  Two Visits Per Year of Reasonable & Customary.
  One Bruxism mouth guard is covered every five years.

Deductible
- Annual Deductible (per person, per calendar year) $100.00

Schedule of Benefits (Reasonable & Customary Charges)
- Restorative Services 65%
- Oral Surgery 65%
- Prosthodontic Services 65%
- X-rays (Full Mouth) 65%

Maximum Allowable Benefit
- Preventative, Diagnostic and Restorative Services ..... $4,000.00 per Calendar Year

Orthodontic Services
- Aggregate Lifetime Maximum (Payable at 95%) $3,000.00
  or 24 months treatment – whichever comes first

Vision Benefits through Vision Service Plan (VSP)

Amounts Payable Per Calendar Year
- Complete Eye Examination $0.00
  $45.00 Out-of-Network
- Lenses or Glasses (Each Lens)*:
  - Single Vision ..... $0.00 In-Network
    $30.00 Out-of-Network
  - Bifocal ..... $0.00 In-Network
    $50.00 Out-of-Network
  - Trifocal (progressive) ..... $0.00 In-Network
    $65.00 Out-of-Network
  - Double Segment Bifocal ..... $0.00 In-Network
    $50.00 Out-of-Network

Frames.....$200.00 In-Network
$70.00 Out-of-Network

Contact Lenses:
Conventional or Disposable (per Calendar Year).....$200.00
$105.00 Out-of-Network

**Plan pays for either one set of lenses/frames or contacts per year – one or the other, but not both.*

Lasik Eye Surgery

In-Network Co-Payment Rate 80%
Lifetime Maximum per Person.....$1,000.00 per Eye
Out-of-Network Co-Payment Rate 70%

Flexible Benefit Account

Per family per calendar year $250.00
(See Section II)

Spousal Insurance Reimbursement

.....$300.00
(See Section II)

CLASS B: Retired or Disabled Members & Their Eligible Dependents Who Are Not Eligible for Medicare

Marathon Health & Wellness Center

Marathon clinics provide the following health care services at **NO CHARGE**:

- Primary Care Services
- Urgent Care Services
- Preventive Care
- Prescription Drugs (for common generic drugs prescribed at the clinic)

Death Benefit

Retired Employee Only $2,500.00

Accidental Death and Dismemberment Benefits (Under Age 65)

Retired Employee.....NONE

Health Care Benefits

In General, the same as Benefits for Active Employees in **Class A**

Calendar Year Deductible Amount	In-Network	Non-Network
Per One Person or.....	$400.00	$700.00
Per Family (cumulative)	$800.00	$1,400.00

The deductible for in-network is combined with the non-network deductible to equal not more than $700.00 per person or $1,400.00 per family.

Co-Payment Rate (Reasonable Expenses Only)
PPO Plan Pays 80%
Patient Pays.....20%

Non-PPO Plan Pays 70%
Patient Pays.....30%

Fertility Benefits
..... Not Covered

Dental Care Benefits
.....Same as those in Class A

Vision Care Benefits and Lasik Surgery
.....Same as those in Class A

Hearing Care Benefits
.....Same as those in Class A

Weekly Loss of Time Benefits
..... Not Covered

Prescription Drug Benefit
.....Same as those in Class A

Colonoscopy Benefit (Medical or Diagnostic)
.....100%

Mammogram Benefit (Medical or Diagnostic)
.....100%

Routine Physical Exam Benefit
.....Same as those in Class A

CLASS C: Retired Or Disabled Members & Their Eligible Dependents Who are Eligible For Medicare

Marathon Health & Wellness Center

Marathon clinics provide the following health care services at **NO CHARGE**:

- Primary Care Services
- Urgent Care Services
- Preventive Care
- Prescription Drugs (for common generic drugs prescribed at the clinic)

Death Benefit
Retired Employee Only $2,500.00

Accidental Death and Dismemberment Benefits (Under Age 65)
Employee .....NONE

Health Care Benefits

In General, the same as Benefits for Active Employees in **Class A** with Limitations as shown below:

Weekly Loss of Time Benefits
..... Not Covered

Comprehensive Major Medical Expense Benefits
Deductible Amount Per Person.....$100.00

Medicare Part A (Hospital)

Deductible Amount..... Covered

Medicare Part B (Professional Services)

Deductible Amount..... Covered
Patient's 20% of Medicare's Allowance (Plan Pays)..... 100%
Amounts in Excess of Medicare's Allowance..... Not Covered

Prescription Drug Benefit – Retail & Mail Order

Co-Pays	Generic	Brand	Brand with Generic
30-day supply	$10	$20	$30 + Difference in Cost
60-to-90-day supply	$20	$40	$60 + Difference in Cost

PARTICIPANTS CHOOSING BRAND WHEN GENERIC IS AVAILABLE, WILL BE RESPONSIBLE FOR THE DIFFERENCE IN COST BETWEEN THE BRAND DRUG AND THE GENERIC DRUG.

Dental Care Benefits

.....Same as those for Active Employees in Class A

Mammogram Benefit (Medical or Diagnostic)

.....100%

Vision Care Benefits and Lasik Surgery

.....Same as those in Class A

Colonoscopy Benefit (Medical or Diagnostic)

.....100%

Chiropractic Benefit

.....Covered only for manipulation if covered by Medicare

Hearing Care Benefits

..... Not Covered

ELIGIBILITY RULES

Work in Trust Fund Jurisdiction

When you work for one or more contributing Employer(s) within the jurisdiction of a collective bargaining agreement which requires contributions to this Trust Fund, you will be eligible to receive benefits if you meet the following eligibility requirements.

Initial Eligibility (Bargaining Unit Employees Only)

You will become initially eligible on the first day of the second calendar month after you have been employed by a contributing Employer or Employers and those Employers have made contributions to the Fund on your behalf for at least 600 hours worked within a period of six consecutive calendar months or less. Your initial period of eligibility continues for the remainder of that "Benefit Month".

If you are not actively at work due to disability on the day you would otherwise become initially eligible, you will not become eligible for Benefits until you return to active employment as described in that section. Unless they themselves are disabled, your eligible Dependents, if any, become eligible for Plan benefits immediately on your normal eligibility date, even if you are disabled.

Work Outside Trust Fund Jurisdiction – Reciprocity

Once you are eligible in this Fund, the Trustees of this Fund have entered into contracts known as Reciprocity Agreements which may allow contributions you earn for work outside the jurisdiction of this Trust Fund to be transferred for eligibility credit in this Fund. Transfer of work hours under Reciprocity Agreements is not automatic; you must provide the other Fund with a written request and authorization to make transfers to this Fund on your behalf. If you plan to work at covered employment outside the jurisdiction of this Fund, you should contact the IBEW Local 364 Union Office or this Fund's Administration Office to ask whether you would be allowed to transfer contributions for that work. The amounts to be transferred and the way those transfers are credited to your records are covered by the Reciprocity Agreements and by the administrative procedures adopted by the Trustees from time to time.

You will not be allowed to transfer contributions to establish initial eligibility under this Plan, however transferred contributions may be utilized for eligibility reinstatement.

Eligibility for Employees in Covered Employment Outside IBEW Local No. 364 Jurisdiction

When an eligible Employee leaves the jurisdiction of IBEW Local No. 364 to work in the trade at covered employment under the jurisdiction of another IBEW Local Union, the Employee's eligibility in this Plan is governed by the requirements of this Section of the Eligibility Rules.

Continuation of Eligibility – Hour Bank (Bargaining Unit Employees Only)

After your period of initial eligibility, you continue to be eligible so long as you are working for a contributing Employer or Employers and those Employers made contributions on your behalf for at least 120 hours in each consecutive Contribution Month. When you begin working, contribution hours that you accumulate for initial eligibility are credited to your individual hour bank. When you have 600 contribution hours in six consecutive months or less, 600 hours are subtracted from the bank to provide initial eligibility. All hours over the 600 are left in your bank for future use.

Once having become eligible, contribution hours that you earn during each following month are credited to your hour bank. For each eligibility month, 120 hours are subtracted from your hour bank to provide benefits during the corresponding Benefit Month. If you earn more than 120 contribution hours during a month, the excess hours stay in your hour bank for future use. You can accumulate up to a maximum balance of 1,440 hours in your bank for future use. Your hour bank is used for eligibility purposes only; it has no cash value and cannot be converted to cash or "withdrawn."

After becoming eligible, you will continue to be eligible on a month-to-month basis so long as you have at least 120 hours in your hour bank. However, there is a "lag month" between the Contribution Month (the month during which the hours are earned) and the Benefit Month (the month the earned hours provide coverage for). The Contribution Months and corresponding Benefit Months are shown below.

Initial Eligibility (Non-Bargaining Unit Employees Only)

Employers must contribute 160 hours per month for all full-time (32 or more hours per week) non-bargaining unit Employees regardless of the number of actual hours worked by such Employees. An employee may opt out of plan coverage providing the employee signs a waiver of coverage, and they are not a dependent under another Fund member. If a NBU employee was once eligible under the plan and then opts out, they must re-apply to the Plan Office for coverage. However, they will not be eligible for coverage until after a 90-day waiting period. If the initial 600 hours of contribution hours were paid, this will not have to be re-paid. If eligibility lapses, the 600 hours would have to be re-contributed. No more than 30% of eligible employees may opt out of the plan.

You will become initially eligible on the first day of the second calendar month after you have 600 employer contribution hours in a period of six consecutive months or less.

Continuation of Eligibility (Non-Bargaining Unit Employees Only)

After your period of initial eligibility, you continue to be eligible so long as you are working for a contributing Employer or Employers and those Employers made contributions on your behalf for at least 160 hours in each consecutive Contribution Month. There is a "lag month" between the Contribution Month (the month during which the hours are earned) and the Benefit Month (the month the earned hours provide coverage for). The Contribution Months and corresponding Benefit Months are shown below.

Non-Bargaining Employees are **not eligible** to maintain an Hour Bank.

Continuation of Eligibility Chart

Because the contributions for hours worked in any month are not made to the Plan until the following month, your **current** work earns **future** eligibility, as follows:

CONTRIBUTION MONTHS	ELIGIBILITY MONTHS
Work Performed During	**Determines Eligibility For**
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Self-Payment of Contributions (Bargaining Unit Employees Only)

After you exhaust your Hour Bank, you may be eligible to continue your health coverage at a self-contribution level based on the actual cost of coverage to the Plan using the provisions of the Federal "Consolidated Omnibus Budget Reconciliation Act" (COBRA). Please see **COBRA Continuation** Coverage at the end of this section.

Reinstatement of Eligibility

If you remain ineligible for more than 36 months, you must meet the requirements under the "Initial Eligibility" provisions. This change gives the Participants 24 more months to re-establish eligibility based upon the Reinstatement of Eligibility provisions.

Self-Payment of Contributions (Non-Bargaining Unit Employees Only)

After losing employment with a covered Employer, you may be eligible to continue your coverage at a self-contribution level based on the actual cost of coverage to the Plan using the provisions of the Federal COBRA. Please see **COBRA Continuation Coverage** at the end of this section.

When you are eligible by self-payments, you and your eligible Dependents are covered by the same benefits as all other Employees: all normal Plan provisions apply.

Self-Pay When Disabled

If a Participant is prevented from engaging in covered employment by total disability, he will be allowed to make self-payment of contributions for up to six consecutive Benefit Months after his automatic continuation due to disability hour credits would expire. The self-payment amount is determined by the Board of Trustees.

Continuation of Eligibility During Disability

If you become disabled as described below **while you are eligible in this Plan**, your eligibility may be continued without the use of self-contributions for a period of six months.

Disability Hours Credit – Short Term Disability

To qualify for Disability Hours, you must be unable to perform covered employment and must:

1. Be eligible for payment of Weekly Loss of Time Benefits under the Plan, or
2. Submit evidence satisfactory to the Trustees that you are eligible for Weekly Worker's Compensation benefits as a result of a disability incurred within the jurisdiction of any Local Union participating in this Plan.

Thirty (30) Disability Hours will be credited for each full week of such disability, or 120 hours per month, up to a maximum of 780 credited hours:

1. For any single period of disability, or
2. For all disability hours credited in any continuous twelve calendar month period.

All active participants may self-pay the difference in hours from the earned Disability Hours and those necessary to maintain eligibility.

If you were an active employee who went on COBRA Continuation Coverage, you are eligible for Disability Hours credit.

All disability absences will be considered a single disability *unless*:

1. You return to active covered employment for at least one day and you submit evidence satisfactory to the Trustees that the cause(s) of the latest disability absence cannot be connected with the cause(s) of any prior disability absences, or
2. You return to active covered employment for at least two weeks even though a connection can be established between the cause(s) of two successive disability absences.

The Trustees retain the right to have you medically examined by a physician of their own choice at the Plan's expense to determine whether a disability qualifies under this Rule.

Return to Work from Disability – Reinstatement

When you return to work from a continuation of eligibility by disability, your eligibility continues under the disability section of these Rules for the Benefit Month in which your disability ended. To remain eligible after this extension of disability coverage, you must meet the requirements under "Continuation of Eligibility" in these Rules.

Total and Permanent Disability Self-Payment

In order for you to be eligible to make self-payments when totally and permanently disabled, you must:

1. Be totally and permanently disabled on or after January 1, 1992, and so unable to perform any work for remuneration or profit on the date you would otherwise lose eligibility under these Rules, and
2. Be awarded a disability benefit from the Social Security Administration, and
3. Have a minimum of five years of continuous eligibility in this Plan prior to the disability.

This self-payment provision applies to the Employee coverage and your Dependents (if any) until the earlier of:

1. Date you are eligible in any other group health care plan; or
2. Date you are no longer totally disabled, or
3. Date you become eligible for Medicare, or
4. End of 36 months continuation coverage under this Section.

When you are covered by a total and permanent disability self-payment, you are **not** covered by Weekly Accident and Sickness (Loss of Time) Benefits.

Self-Payment

You will be required to make self-payments in the amount equal to the self-payment rate(s) established for active participants.

Covered Benefits

Bariatric Surgery is covered for an eligible member, retiree, or spouse, if ALL of the following requirements are met:

- The patient must be at least 100 pounds over their medically desirable weight and have a Body Mass Index (BMI) of at least 40;
- The obesity must be a threat to the patient's life due to the existence of complicating health factors such as diabetes, heart trouble, hypertension, etc.;
- Before the proposed surgery, the patient must have a documented history of at least six consecutive months of physician-assisted attempts to reduce weight by more conservative measures;
- The surgery must be performed in a Blue Cross Blue Shield PPO facility by a PPO physician/surgeon; and
- The surgery must be reviewed by the review organization to determine medical necessity before the surgery is performed.

Only one course of treatment will be covered during the eligible member, retiree, or spouse's lifetime. Coverage is limited to a maximum of $50,000.

Hospital Emergency Room Care for:

An **accidental injury** - physical damage caused by action, object, or substance from outside the body. This includes strains, sprains, cuts and bruises, allergic reactions, frostbite, sunburn, sunstroke, swallowing poisons, medication overdosing, or inhaling smoke, carbon monoxide or fumes.

A **medical emergency** - a condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury.

Hospital In-Patient Care for a medically necessary illness or injury including surgery, anesthesia, room and board charges and physician consultations.

Diagnostic, x-ray and laboratory services for medically necessary illnesses or injuries. Benefits include outpatient diagnostic, radiology and laboratory services required for the diagnosis of an illness or injury performed and billed by a physician. Services may be performed in a physician's office, or the outpatient hospital facility.

The **non-Emergency items** or services received from an out-of-network provider working at an in-network facility will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider. In other words, the coinsurance percentage and any co-payments applicable to such services will be the same as if the services were furnished by an in-network provider.

Your coinsurance responsibility will be based on the Recognized Amount (as defined above). Any cost-sharing payments you make with respect to covered non-Emergency services will count toward your Network deductible and Network out-of-pocket maximum in the same manner as those received from an in-network provider.

An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to the out-of-network billing practices in compliance with applicable law.

If the exception applies, the applicable out-of-network coinsurance to be paid by the Plan will be based on the Allowable Charge, and the out-of-network deductible and out-of-pocket maximum will apply.

No exception is available with respect to providers of Ancillary Services, however, or with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or services is furnished, regardless of whether the notice and consent requirements have been satisfied.

The Plan will cover expenses associated with **air ambulance services**. The co-insurance rate that you pay for air ambulance (medial transport by fixed wing airplane or rotary wing helicopter) will be the same whether the provider is an in-network or out-of-network provider, and your coinsurance responsibility will be calculated based on the lesser of the billed amount for the services or the median of the Network's contracted rates with participating providers in the geographic region for the respective services as of January 31, 2019, indexed for inflation thereafter, and any co-insurance payments you make with respect to covered air ambulance services will count toward your Network deductible and out-of-pocket maximum, regardless of whether received from a Network or Non-Network Provider.

If you are a **Continuing Care Patient** and the Plan's PPO terminates its contract with your Network Provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will:

- Notify you in a timely manner of the Plan's termination of its contracts with the Network Provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and
- Allow you 90 days of continued coverage with benefits paid on the same terms and conditions under the Plan as if the provider or facility had remained in the Network in order to allow time for you to transition your care to a Network Provider.

Continuation of Eligibility for Dependents in the Event of an Employee's Death

If you die while you are eligible under these Rules, your eligible Dependents may continue to be eligible according to the following requirements.

Automatic Continuation, Active Employees

Eligibility for your surviving Dependents will continue automatically, without self-contribution, so long as they continue to meet the definition of Dependent until the later of the:

1. Normal eligibility termination date based on your hour bank; or
2. The last day of the third calendar month following the month in which you die.

Eligibility When Entering Military or Uniformed Service

If you leave covered employment to serve in the military or other uniformed services, you may elect to continue eligibility for yourself and your Dependents up to eighteen months by paying monthly self-contributions. However, your right to continue coverage by self-contributions ends if you do not begin working for a covered employer within the time period by law:

1. If you served fewer than 31 days, on the first business day after your discharge under honorable conditions;
2. If you served between 31 and 180 days, within fourteen days after your discharge under honorable conditions;
3. If you served over 180 days, within 90 days after your discharge under honorable conditions;
4. If you are delayed due to illness or injury caused or aggravated by your service, within 24 months after your discharge under honorable conditions.

If you serve fewer than 31 days, you and your Dependents will continue eligibility without charge to you during that period. If you serve for 31 or more days, you must pay to the Fund a monthly self-contribution equal to 102% of the Fund's cost to maintain eligibility for yourself and your Dependents. Any hours you had accumulated on the date you entered military or other uniformed service will be applied to meet the Fund's eligibility requirements when you return to work.

Remember that in order for you and your Dependents to be eligible for coverage while you are in the military or other uniformed service, you are required to notify the Fund immediately when you enter that service and immediately when you are discharged.

Eligibility Rules – Retiree Program

General Eligibility Requirements

Each normal or early retired Employee may continue coverage for himself and his Dependents through this Plan under the Retiree Program provided he meets all of the following requirements:

1. He is at least 55 years old; and
2. He has been eligible in this Plan at least 60 months, or 74 of the last 100 months, immediately prior to his request for coverage under this Retiree Program; and
3. He is eligible in this Plan at the time of his retirement.

The cost of coverage for pre-Medicare retirees ages 57 to age 65 or Medicare entitlement is subsidized by the Fund. Below are the requirements for receiving the subsidy.

- The Participant must be at least 57 years old and;
- The Participant must be completely retired from all employment;
- If the Participant is under age 60 the participant must have a minimum of 12,000 hours worked within the 10 years immediately prior to the request for coverage under the Early Retirement program to receive the full subsidy and;
- Once the Participant has elected the Early Retirement option, they may not return to work in the trade and receive the early retiree subsidy at a later date and;

- The Participant must have been on the out of work list immediately prior to applying for the Early Retiree Subsidy but is no longer eligible to sign the out-of-work book.

If you are eligible to participate in the Retiree Program, you must exercise that option when first eligible to do so. If you do not exercise your option to participate in the Retiree Program immediately upon retirement, you will not be allowed to begin participation at a later date.

Coverage Classifications Defined

Employees eligible to participate in the Retiree Program and their eligible Dependents, if any, are covered under one of two benefit classes, depending on whether the covered person is also eligible for Medicare.

Class B: Coverage for Employees and/or eligible Dependents who are NOT eligible for Medicare

Class C: Coverage for Employees and/or eligible Dependents who ARE eligible for Medicare (Medicare coverage includes Part A [hospital] and Part B [medical])

For example, you and your spouse would both be covered under Class B if neither of you are eligible for Medicare. If you are eligible for Medicare and your Spouse is not, you would be eligible in Class C and your spouse would be eligible in Class B.

Self-Payment of Contribution

The self-payment amounts required for eligibility in the Retiree Program are those determined by the Trustees to be necessary to run the Plan. Self-payments must be received at the Fund Office on or before the first day of the Benefit Month for which the payment is due. You will receive only one Notice describing the self-payment procedure; you are responsible for making subsequent monthly payments on time and without further Notice. All Notices are sent by mail to the last known address on file at the Fund Office so it is important that any address changes are reported immediately.

Self-payments are required on a monthly basis. A change in coverage circumstances (such as eligibility for Medicare) will re-determine the covered person's Coverage Class effective the first day of the calendar month coincident with or next following the date the change in circumstance occurs.

Retiree rates vary based upon age.
Please contact the Fund Office for further information.

Benefit Limitations

All normal Plan provisions apply to Retiree Program coverages. Employees and their Dependents eligible in Classes B and C **are not** covered by Weekly Accident and Sickness Benefits (Loss of Time). Please see the Schedule of Benefits and the Benefits Section as described for more information.

Effective Dates of Coverage

Employees

Your effective date of coverage as an Employee will normally be the date you satisfy the requirements of the Eligibility Rules.

Dependents

Your effective date of coverage as a Dependent will be the date the Employee who sponsors you becomes eligible or the date you first satisfy the definition of Dependent, whichever is later.

Termination Dates of Coverage

Employees

Your coverage as an Employee under all benefit provisions of the Plan terminates when the earliest of the following events occurs:

1. Failure to meet the requirements for continuing eligibility as shown in the Eligibility Rules, including a failure to make any self-payments of contributions in a timely manner;
2. Termination of the coverage classification under which you were continuing your eligibility;
3. Induction into the Armed Forces of the United States, except for temporary duty of 30 days or less;
4. Termination of the Plan itself.

Dependents

Your coverage as a Dependent under all benefit provisions of the Plan terminates when the earliest of the following events occurs:

1. Termination of eligibility for the Employee who sponsors you (for reasons other than the receipt of a Maximum Amount Payable);
2. On the date of divorce from the participant;
3. On the first of the month next following the date you fail to meet the definition of Dependent for Dependent Children;
4. Failure to meet the requirements for continuing eligibility as shown in the Eligibility Rules, including failure to make any self-payment of contributions in a timely manner;
5. Termination of the coverage classification under which you were continuing your eligibility;
6. Induction into the Armed Forces of the United States, except for temporary duty of 30 days or less;
7. Termination of the Plan itself.

General Provisions

Change of Eligibility Rules

The Trustees, in their discretion, are empowered to change or to amend these Eligibility Rules at any time.

A Note of Explanation

The Eligibility Rules represent the requirements which must be satisfied for you and your dependents to become and to remain eligible for benefits from this Plan. In the event the requirements are not satisfied, eligibility is lost and benefits are not payable. The Trustees reserve the right to deny benefits to any claimant who is, in their opinion, attempting to subvert the purpose of the Plan or who does not present a bona fide claim.

Remember: Changes in employment may have an effect on Employer contributions paid on your behalf. For example, Employer contributions may cease in the event you change from coverage under a Collective Bargaining Agreement to a non-collectively bargained position or from covered to non-covered employment, even if that employment is with the same employer.

You and your dependents may obtain, upon written request to the Union Office, information as to the address of a particular Employer and whether that Employer is required to pay contributions to the Plan.

Family and Medical Leave

You may be eligible for up to 12 weeks of unpaid, job protected leave for certain family and medical reasons under the Family and Medical Leave Act of 1993. You are eligible under the Act if:

1. You are employed by an employer with at least 50 employees at your work site or with at least 50 employees within a 75 mile radius of your work site; and
2. You have been employed by the employer at least 12 months; and
3. You have worked at least 1,250 hours for the employer during the 12 months immediately before the requested leave.

Your employer determines whether you are eligible for family or medical leave under the Act, not this Plan or its Trustees.

Both you and your employer are required to notify the Fund Office if you take a family or medical leave and to provide specific other information as required by the Trustees. Your coverage in the Plan will continue during the period of your family or medical leave, provided your employer makes contributions to the Plan at the same rate and in the same amount as if you were continuously employed during the period of your leave and fully complies with all requirements established by the Trustees.

COBRA Continuation Coverage

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to participants and their dependents when they would otherwise lose group health coverage.

Nature of COBRA Continuation Coverage

1. COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A Participant, his Spouse, and dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.
2. A Participant will become a qualified beneficiary if coverage is lost under the Plan because either one of the following qualifying events happens:
    a. Hours of employment are reduced such that hours are insufficient to maintain eligibility, or
    b. Employment ends for any reason other than gross misconduct.
3. The Spouse of a Participant will become a qualified beneficiary if coverage is lost under the Plan because any of the following qualifying events happens:
    a. Death of spouse;
    b. Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;
    c. Spouse's employment ends for any reason other than his or her gross misconduct;
    d. Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
    e. Divorce or legal separation from the participant.
4. Dependent Children become qualified beneficiaries if coverage is lost under the Plan because any of the following qualifying events happens:
    a. The parent-Participant dies;
    b. The parent-Participant's hours of employment are reduced such that hours in the hour bank are insufficient to maintain eligibility;
    c. The parent-Participant's employment ends for any reason other than his or her gross misconduct;
    d. The parent-Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
    e. The parents become divorced or legally separated; or
    f. The Child stops being eligible for coverage under the plan as a "dependent Child."

When COBRA Coverage Is Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the Participant, the Employer must notify the Plan Administrator of this qualifying event within 30 days of the death. The Plan

Administrator will monitor whether a qualifying event has occurred due to reduction in hours, termination of employment, or Medicare eligibility.

Participant/Spouse Obligation to Give Notice to Plan of Certain Qualifying Events

In the event of divorce, legal separation, or a dependent Child loses eligibility for coverage as a dependent Child (for example, exceeds age limitations), or if after COBRA coverage is elected a qualified beneficiary becomes covered under another group health plan, the Participant and his Spouse both have an obligation to notify the Plan Administrator of such event within 60 days after this qualifying event occurs. This notice must include: the name of the Participant, the social security number of the Participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce), and the date on which the qualifying event occurred. If timely notice is not provided, the right to COBRA coverage is forfeited.

Further, failure to timely notify the Plan of a divorce, legal separation, or a Child losing eligibility gives the Plan the right to hold the participant and his/her Spouse separately and fully liable for any benefits paid by the Plan which would not have been paid had the Plan received timely notification of such event. At its sole election, the Plan may suspend the payment of future benefits until such amount has been recovered.

How COBRA Coverage Is Provided

- Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

- The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Plan for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Plan.

- Coverage under the Plan will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium.

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage, as follows:

1. When the qualifying event is the death of the Participant, the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, legal separation, or a dependent Child's losing eligibility as a dependent Child, COBRA continuation coverage lasts for up to a total of 36 months.
2. When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the Participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement.
    a. For example, if a Participant becomes entitled to Medicare eight months before the date on which his eligibility terminates, COBRA continuation coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).
3. In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.
4. Disability Extension

a. If the qualified beneficiary or anyone in his family covered under the Plan is determined by the Social Security Administration to be disabled and notifies the Plan Administrator in a timely fashion, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

b. The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

c. The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

5. Second Qualifying Event Extension

a. If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered Spouse and dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent Children receiving continuation coverage if the participant or former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, legally separated, or if the dependent Child stops being eligible under the Plan as a dependent Child, but only if such event would have caused the Spouse or dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

b. The Plan Administrator must be notified of this second qualifying event within 60 days of such event.

The Election Period for COBRA Continuation.

Qualified beneficiaries have 60 days after receipt of the Election Notice, which will be sent to each qualified beneficiaries' last known address, to elect COBRA continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

Premium Payment for COBRA Coverage.

Following an election, a qualified beneficiary has 45 days to pay the initial COBRA premium. If this is not timely paid, coverage will not be reinstated, and the qualified beneficiary will not be given a second chance to reinstate coverage.

- Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. If payments are not made within this period, coverage will terminate, and the qualified beneficiary will not be given an opportunity to reinstate coverage.

- If, for whatever reason, the Plan pays medical benefits for a month in which the premium was not timely paid, the qualified beneficiary will be required to reimburse the Plan for such benefits.

- The premium equals the cost to the Plan of providing coverage plus a 2% administration fee. In the event of extended coverage as a result of a disability for the 19th – 29th months of coverage, the Plan will charge 150% of the cost of providing coverage.

Scope of Coverage

COBRA coverage only pertains to health benefits available under the Plan. Coverage for such benefits under COBRA is the same as those the qualified beneficiary had the day before coverage initially terminated. Coverage may change while on COBRA coverage due to Plan amendments that effect all Participants in the Plan. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

Enrollment of Dependents During Period of COBRA Coverage and Coverage Options

A Child born to, adopted by, or placed for adoption with a Participant during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the Participant has elected continuation coverage for himself/herself. If a Participant desires to add such a Child to COBRA coverage, he must notify the Plan Office within 30 days of the adoption, placement for adoption, or birth. During the COBRA coverage period, a Participant may add an eligible dependent who initially declined COBRA coverage because of alternative coverage and later lost such coverage due to certain qualifying reasons. If a Participant desires to add such a Child to COBRA coverage, he must notify the Plan Office within 30 days of the loss of coverage.

Qualified Medical Child Support Orders

If a Child is enrolled in the Plan pursuant to a qualified medical child support order while the Participant was an active employee under the Plan, he is entitled to the same rights under COBRA as any dependent Child.

Termination of COBRA Coverage

COBRA continuation coverage terminates the earliest of the last day of the maximum coverage period, the first day timely payment (including payment for the full amount due) is not made, the date upon which the Plan terminates, the date after election of COBRA that a qualified beneficiary becomes covered under any other group health plan, or the date after election if a qualified beneficiary becomes entitled to Medicare benefits and such entitlement would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred.

In the case of a qualified beneficiary entitled to a disability extension, COBRA continuation coverage terminates the later of: (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination from Social Security that the qualified beneficiary is no longer disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

GENERAL DEFINITIONS

Accident

An Accident must contain some degree of unexpected violence, such as a fall, blow, laceration, contusion, or abrasion.

Accidental Bodily Injury and Sickness

Accidental Bodily Injury and Sickness, with respect to a covered person does not include accidental bodily injury or sickness which arises out of or in the course of employment. This provision shall not apply to the Death Benefit and Accidental Death & Dismemberment Benefits.

Ambulatory Surgical Center

An Ambulatory Surgical Center is a free-standing facility, which is wholly owned and operated by a hospital on the same basis as the outpatient department of its main facility or a legally constituted institution, which meets all of the following requirements:

1. Is established, equipped and operated primarily for the purpose of performing surgical procedures; and
2. Operates under the supervision of one or more physicians as defined by the Plan; and
3. Is equipped with at least two operating rooms, at least one post-anesthesia recovery room, and has the ability to perform diagnostic X-ray and laboratory procedures as required in conjunction with the surgery to be performed; and
4. Continually provides nursing services by registered nurses for patient care in the operating rooms and the post-anesthesia recovery room(s); and
5. Is licensed by the appropriate State agency and is recognized by the local medical society.

Ancillary Services

Ancillary Services mean 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 by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

Continuing Care Patient

An individual is a Continuing Care Patient with respect to a provider or facility if the individual is:

- Undergoing a course of treatment for a "serious and complex condition" from the provider or facility;
- Undergoing a course of institutional or inpatient care from the provider or facility;
- Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Determined to be "terminally ill" and receiving treatment for such illness from such provider or facility.

An individual has a serious and complex condition if the individual has a condition that (a) in the case of an acute illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time. An individual is terminally ill if the individual has a medical prognosis that the individual's life expectancy is six months or less.

Custodial Care

Custodial Care means care, services or supplies, which are furnished mainly to train or to assist in personal hygiene or other activities of daily living, rather than to provide therapeutic treatment. Care, services or supplies will also be considered "custodial" if they can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider.

Dental Hygienist

Dental Hygienist means a person who is currently licensed (if licensing is required in the State) to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene and who works under the supervision of a Dentist.

Dentist

Dentist means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Diagnosis

Diagnosis refers to the statement of the medical condition requiring the care of a physician.

Educational Institution

"Educational Institution" means a trade school, college or university or other organization whose primary purpose is training and which regularly charges tuition for such training. "Educational Institution" does not include "work-study" or other training programs during which the trainee receives compensation.

Elective or Voluntary Sterilization

Elective Sterilization is sterilization not medically required but requested by the patient and will include among others, vasoligation, vasectomy, salpingectomy, and tubal ligation.

Eligibility Rules

The Eligibility Rules shall apply to Active Employees and their Dependents, Totally and Permanently Disabled Employees and their Dependents, Self-Pay Employees and their Dependents and Retirees and their Dependents.

Eligible Dependents

Eligible Dependents are the following:

1. The legal spouse of the eligible Employee provided he/she is not legally separated from the eligible Employee; or
2. Any unmarried natural child or children of the eligible Employee and the legal spouse if:
    a. the child is less than 26 years old, excluding a person who would otherwise be entitled to benefits under this Plan as an Employee; or
    b. the child is less than 26 years of age.
    c. the child is over 26 years of age and he/she is totally and permanently disabled because of a qualifying physical handicap or mental retardation. To be considered a qualified physical handicap or mental retardation under this definition, it must:
        - occur before the child reaches age 26 and
        - be certified by a Physician; and
        - render the child incapable of self-sustaining employment so as to make the child dependent upon the parents for financial support and maintenance.

Initial proof of such disability and financial dependency must be furnished to the Trustees within 60 days of the child's reaching 26.

3. Your natural child provided the child's surname is the same as the eligible employee; stepchild, foster child or a legally adopted child; including the legally required trial period prior to the approval of the adoption by a court.

   In order to qualify under the definition of an eligible dependent the following conditions must be met:

   a. the child must be living with the Eligible Employee in regular parent-child relationship, except in the case of divorce; and

   b. the Employee contributes more than 50% toward the maintenance and support of the child; and

   c. legal documentation is presented, upon request, supporting the Dependent's status.

      It is understood that coverage of a dependent child may also be established in those cases where the Welfare Fund has received a "Qualified Medical Child Support Order" (QMCSO) entered by an appropriate court as defined under applicable federal law. Normally, such an order will be issued in a divorce or other family law action, which recognizes the child's right to health benefits under the Plan.

   Dependent coverage terminates on the date:

   a. The qualifying disability ceases; or

   b. The QMCSO terminates; or

   c. The Employee's coverage is terminated.

   If one employee is covered under the Plan pursuant to the terms of a Collective Bargaining Agreement and one spouse is covered under the terms of a Participation Agreement:

   a. Their children may be covered as Dependents of the husband and/or the wife; and

   b. The Member or the Spouse may be covered as the Dependent of the other at the same time.

The term Eligible Dependent does not include a child fathered by a Dependent child or delivered by a female other than the eligible Employee or the Employee's legal spouse.

Eligible Member

An Eligible Member means any person who: (1) is working within the jurisdiction of and covered under the terms of the Collective Bargaining Agreement or Non-Bargaining Participation Agreement entered into between the Union and the Employer, and (2) is eligible for benefits as set forth in the Fund’s Eligibility Rules.

Eligible Person

An Eligible Person means either the eligible Employee or the eligible Employee's Dependents.

Emergency

Emergency means a medical condition that is evidenced by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or seriously impair bodily functions or the function of any bodily organ or part. If symptoms exist that reasonable may be interpreted as an Emergency, that condition will be considered an Emergency even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an Emergency even if a final diagnosis of a heart attack is not made. If you are taken for treatment to the nearest Hospital or trauma center by the police, fire department, or ambulance under circumstances beyond your control, this too will be treated as an Emergency.

Emergency Services

Emergency Services means outpatient and inpatient services provided with respect to an Emergency and include treatment provided by and within the capabilities of the emergency department of a Hospital (including a Hospital outpatient department) or an independent, freestanding emergency department that is geographically separate and licensed separately from a Hospital under applicable state law, including an appropriate medical screening examination and ancillary services routinely available to the emergency department to evaluate such Emergency and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility). Emergency Services include treatment of an Emergency by an urgent care clinic or facility if such urgent care clinic or facility is permitted by applicable state licensure laws to provide such services.

Post-stabilization services provided by out-of-network providers and facilities generally also will be considered Emergency Services for purposes of applying the payment rules with respect to Emergency Services as set forth in the Schedule of Benefits unless certain conditions are met. Post-stabilization services include outpatient observation, or an inpatient or outpatient stay that is related to the Emergency or with respect to the visit in which other Emergency Services are furnished.

Post-stabilization services at an out-of-network facility or from an out-of-network provider are not considered Emergency Services for payment purposes if (i) the attending emergency Physician or treating provider determines that the patient is able to travel using non-medical transportation or nonemergency medical transportation to an available in-network provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition, (ii) the out-of-network facility or provider furnishing such services provides adequate notice to the patient as required by federal law (including notice that the provider is an out-of-network provider with respect to the Plan, the estimated charges for treatment and any advance limitations that the Plan may put on the treatment, of the names of any in-network providers at the facility who are able to provide treatment, and notice that the patient may elect to be referred to one of the in-network providers listed); and (iii) receives informed consent from the patient to continued treatment despite the greater cost, in compliance with applicable law.

Employee

An Employee means a person, actively employed by an Employer, on whose behalf Employer contributions are required to be made.

Employer

Employer or Contributing Employer means any association or individual employer who has duly executed a collective bargaining agreement with the Union and is thereby required to make contributions to this Fund on behalf of its Employees. Any employer not presently party to such collective bargaining agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement is also included in this definition.

Expense Incurred

Expense Incurred includes only those charges made for services and supplies, which are reasonably priced and reasonably necessary for treatment of the injury or sickness.

Health Insurance Portability and Accountability Act

Law, which limits the circumstances under which coverage may be excluded for medical conditions before you enroll.

Hospital

A Hospital is any legally constituted institution, which meets all the following requirements:

1. Maintains permanent and full-time facilities for bed care of five (5) or more resident patients; and

2. Has a doctor in regular attendance; and
3. Continually provides a twenty-four (24) hour-a-day nursing service by registered nurses; and
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics;
5. Is operating lawfully and has proper license(s) in the jurisdiction where it is located; and
6. Is accredited by the National Committee for Quality Assurance (NCQA), the Joint Commission, or other accreditation approved by CMS.

In-patient

In-patient means a person who is a resident patient using and being charged for the room and board facilities of the hospital.

Intensive Care Unit

Intensive Care Unit means a special area of a hospital, exclusively reserved for critically ill patients requiring constant observation, which in its normal course of operation provides:

1. Personal care by specialized registered professional nurses and other nursing care on a 24 hour per day basis;
2. Special equipment and supplies which are immediately available on a stand-by basis; and
3. Care required, but not rendered, in the general surgical or medical nursing units of the hospital. The term "Intensive Care Unit" shall also include an area of the hospital designated and operated exclusively as a Coronary Care Unit or as a Cardiac Care Unit.

Medicare

Government sponsored health insurance program for people 65 or older (as referred to in this document, Medicare means Part A (hospital) and Part B (medical) coverage.

The Fund does not require that you enroll in the Medicare Part D (prescription drug) coverage available through the government.

Medical Equipment

Medical Equipment means equipment, which meets all of the following requirements:

1. Is primarily and customarily used to serve a medical purpose; and
2. Is generally not useful to a person in the absence of illness or injury; and
3. Is necessary and reasonable for the treatment of an illness or injury, which is covered by the terms of this Plan.

To be considered "medical equipment," a device must make a meaningful contribution to the treatment of a patient's illness or injury or to the improved functioning of a malformed or damaged body member. Equipment, which primarily serves a comfort or convenience function for the patient or the patient's caretaker (such as a wheelchair ramp or a vehicle lift device), is not considered "medical equipment."

Mental or Nervous Disorder

Any illness defined with the mental disorder section of the International Classification of Disease (ICD) or identified in the Diagnostic and Statistical Manual of Mental Disorder (DSM).

Optician, Optometrist and Ophthalmologist

Optician, Optometrist and Ophthalmologist means any person who is qualified and currently licensed (if licensing is required in the State) to practice each such profession by the appropriate government agency or authority having jurisdiction over the licensing and practice of such a profession, and who is acting within the usual scope of his practice.

Out-Patient

Out-patient means a person who receives hospital services and treatments but is not an in-patient.

Period of Disability Confinement

Successive periods of disability or hospital confinement are considered one continuous disability and period of confinement for the purpose of determining maximum benefits payable unless:

1. The later treatment period is due to causes entirely unrelated to the causes of the prior treatment; or
2. The periods of treatment are separated by one calendar day; or
3. For an Employee, a return to covered employment for at least two weeks.

Physician, Doctor, or Surgeon (M.D.)

Physician, Doctor, or Surgeon (M.D.) includes Osteopaths, Dentists, and Podiatrists or Chiropodists when practicing within the scope of their respective licenses. A Chiropractor is not considered to be a Physician for most benefits under this Plan. A practitioner of naprapathy is not considered to be a Physician for benefits under this Plan. In addition, the Plan will recognize the services of other health care providers acting within the scope of their license as recognized by the state in which they practice.

Pregnancy

Pregnancy includes resulting childbirth, miscarriage, and any complications of pregnancy.

Reasonable and Customary Charge

Reasonable and Customary Charge is determined by uniform reference standards as adopted by the Board of Trustees. To be considered reasonable and customary, the charge by any provider for a service must be similar to the charges generally incurred for cases of comparable nature and severity by a physician of similar training and experience in that geographical area. Area means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of providers rendering such service or furnishing such supplies.

With respect to medical equipment, a charge will be considered "reasonable" only if the following requirements are met:

1. The expense of the equipment must be clearly proportionate to the therapeutic benefits ordinarily derived from its use; and
2. The equipment may not be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and
3. The equipment may not serve essentially the same purpose as equipment already available to the patient.

Recognized Amount

Recognized Amount means an (i) amount determined by an applicable All-Payer Model Agreement under the Social Security Act, or, (ii) if there is no such applicable agreement, an amount determined by applicable state law, or (iii) if there is no such agreement and no amount determined by state law, the lesser of the billed amount or the median in-Network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter. Currently, there is no applicable All-Payer Model Agreement, nor any applicable state law, meaning that the Recognized Amount will be the lesser of the billed amount or the median in-Network rate ("Qualifying Payment Amount").

Routine Physical Examination

A Routine Physical Examination is an examination done by a physician for screening purposes. If there is no diagnosis or symptoms presented on a claim form or itemized bill by the physician, the care will be considered routine.

Sickness

Sickness means a deviation from a healthy condition which:

1. Alters the state of the body; and
2. Interrupts or disturbs the performance of vital functions; and
3. Tends to undermine or weaken the constitution.

Sickness does not include a limitation on or a loss of body function or a temporary indisposition, which does not progressively undermine or weaken the constitution. Sickness caused or contributed by self-abuse, such as alcoholism or intentional overdose of drugs, are generally subject to special limitations and may be excluded from coverage entirely.

Skilled Nursing Care Facility

Skilled nursing care facility means an institution or that part of any institution, which operates to provide convalescent or nursing care and:

1. Is Primarily engaged in providing to inpatients:
   a. skilled nursing care and related services for patients who require medical or nursing care; or
   b. rehabilitation services for the rehabilitation of injured, disabled or sick persons; and
2. Has a requirement that the health care of every patient be under the supervision of a physician; and
3. Has a physician available to furnish necessary medical care in case of emergency; and
4. Has policies, which are developed with the advice (and with provision for review of such policies from time to time) by a group of professional personnel, including one (1) or more physicians and one (1) or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides; and
5. Has a physician, a registered professional nurse or a medical staff responsible for the execution of such policies; and
6. Maintains clinical records on all patients; and
7. Provides twenty-four-hour nursing services which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph 2, and has at least one (1) registered professional nurse employed full time; and
8. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; and
9. In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature; and
   a. is licensed pursuant to such law; or
   b. is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
10. Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof.

Surgical Procedure

Surgical procedure means certain invasive procedures, as well as reduction of fractures or dislocations, in addition to recognized cutting procedures.

Totally Disabled and Total Disability

Totally Disabled and Total Disability, unless otherwise specifically defined, refer to disability resulting solely from a sickness or accidental bodily injury which prevents an Employee from engaging in any occupation or employment for compensation or profit or prevents a Dependent from engaging in substantially all the normal activities of a person of like age and sex in good health and the person is eligible for Social Security Disability Benefits. A copy of the Social Security Administration Notice of Award Letter is required for proof of total disability.

Trust Agreement

Trust Agreement means the Agreement and Declaration of Trust establishing the NECA-IBEW Local No. 364 Health and Welfare Fund and that instrument as may be amended from time to time.

Trust Fund

Trust Fund or Fund means the NECA-IBEW Local No. 364 Health and Welfare Fund.

Trustees

Trustee means the Employer Trustees and the Union Trustees, collectively, as selected under the Trust Agreement, and as constituted from time to time in accordance with the provisions of the Trust Agreement.

Union

Union means those Unions, which have executed an Agreement of Collective Bargaining with an Employer who, in accordance with such Agreement of Collective Bargaining, participates in and contributes to the NECA-IBEW Local No. 364 Health and Welfare Fund.

SECTION I - COMPREHENSIVE MAJOR MEDICAL BENEFITS

Introduction

When you or your Dependent require hospital confinement, surgery or other eligible medical treatment, most covered expenses will be paid according to a single benefit formula known as "Comprehensive Major Medical Benefits". There may be some other expenses that have other benefit levels. "Treatment With Special Limitations" is explained in a separate Section of this booklet.

Preferred Provider Organization (PPO)

This plan uses a "Preferred Provider Organization," or "PPO" known as BCBS PPO National Network to obtain medical treatment on a discounted basis. Using a PPO hospital or doctor is voluntary, but the Trustees encourage you to do so if possible because it will save money for both you and the Plan. To qualify for the discount, you must identify yourself as a PPO member, so be sure to carry and to present the Identification Card which is issued to you when you become initially eligible.

Marathon Health & Wellness Centers

The Plan has partnered with Marathon to provide you and your eligible dependents access to the Marathon Health & Wellness Centers. The Marathon Health & Wellness Centers provide you with a wide range of health services, including:

- Primary Care Services, including sick visits;
- Urgent Care Services;
- Preventive Care and care for chronic illnesses;
- Prescription Drugs and refills for common generic drugs prescribed at the clinic; and
- Free lab work for tests prescribed at the clinic, as well as bloodwork ordered by other providers.

All services provided by Marathon are confidential and provided by qualified and professional medical staff.

Marathon has a clinic at 3413 Colony Bay Drive in Rockford. You can call to schedule an appointment at (779) 368-0757; appointments are generally available same day.

The Deductible Amount

The deductible amount is the amount that you have to pay from your own pocket before any benefits are payable. That amount, as shown in the Schedule of Benefits, generally applies to each individual person each calendar year.

Maximum Deductible Amount for Families

The deductible amount is applied per one person, or cumulative per family, and can be satisfied by any covered person under the participant's coverage. There is a maximum deductible amount required each year for all persons in the same family. Individual family members may combine eligible expenses incurred to satisfy any deductible amount; expenses incurred in one calendar year may not be "carried over" to satisfy any portion of the deductible for the following year. There is no refund of partial deductibles for other family members once the family deductible is satisfied.

Co-Payment

The Comprehensive Major Medical Benefits do not pay covered expenses in full; the amount you or your Dependent has to pay depends on the type of treatment. Generally, the Plan pays 80% of covered expenses for the most common types of treatment and medical supplies, with the exception of most prescription drugs which will be paid at 100% after the co-payment of $10 for Generic and $20 for Brand, and $30 for Brand drugs dispensed when a generic drug is available has been satisfied.

Co-Payment Limit for Individuals

The Plan limits the out-of-pocket expense due to the co-payment requirement for most (not all) conditions per person, per calendar year. When an individual reaches the co-payment limit of $2,000.00 in a calendar year, the Plan will pay 100% of such person's covered expenses incurred in the rest of the year. This amount is based on eligible expenses only; it does not apply to expenses applied toward any deductibles or "Treatment With Special Limitations".

Two family members must each satisfy the $2,000.00 co-payment before the $4,000.00 family co-payment maximum is established. Other family members' partial co-payments are not refundable once the family co-payment maximum is established.

Getting Utilization Review to Work for You

Utilization Review (UR) is a program in which trained medical nurses, physicians, and specialists review and certify, in advance, hospitalizations, surgeries and other services as required by your UR plan.

UR is designed to help you make informed decisions about your medical care. It also helps you to use your group health benefits in the most cost-effective manner possible.

All it takes to start the certification process is a toll-free telephone call to the UR office. Whenever possible, notify the UR office ahead of time for medical care that requires certifications under this program. You may call the UR office yourself or have your doctor, a relative, friend, or any person call for you.

Remember, your medical treatment plan and ultimate patient care responsibility remains with your attending physician. The certification process does not release him or her from this responsibility. Utilization Review Requirements

The following is an explanation of the services that require certification of medical necessity from the UR office. Notify the UR office at least ten business days or as soon as possible prior to any of the following services:

(Emergencies are to be reported within 48 hours following the incident or as directed by your benefit plan).

UR Plan Requirements

- **Please Contact Hines at 1-888-236-2652 or 815-397-5395 to pre-certify all:**
- **Hospital Admissions**
- **Surgical Procedures (inpatient)**
- **Home Healthcare**
- **Medical Equipment**

To Pre-certify online at www.hinesassoc.com

Expectant mothers are to call within 30 days of diagnosis and upon admission to the hospital.

A UR nurse reviews the clinical information about your condition, the proposed place of service, and the length of stay. Based on nationally recognized standards, UR nurses certify that the services are medically necessary and appropriate.

You, your physician and hospital will be notified. If you do not receive notice, please call the UR office.

UR does not direct your provider to offer or to refuse to offer any course of treatment. You and your provider always make the final decisions on any treatment plan. UR determinations simply indicate whether or not the proposed treatment meets the medical necessity or appropriateness criteria.

The UR nurse will be following your hospital stay and if additional days meet the medical criteria, they will be certified.

UR certification does not guarantee payment of benefits. You may call your Claims Administrator for information regarding coverage.

If your physician disagrees with the initial certification determination, your case will automatically be reviewed at a higher level. This review will be done by a physician who is an advisor to the UR office. Then if you or your physician wishes to contest the result of this review, you may submit a formal appeal in writing or by telephone to the UR office. This appeal needs to be submitted within 30 days after the certification determination. All new information will be reviewed by the physician advisor.

Before you call the Utilization Review office, you should have the following information at hand:

- Participant Identification Number
- Group (Employer) Name and Number
- Doctor's Name and Telephone Number
- Name of Hospital or Outpatient Facility and Telephone Number
- Name of Procedure, diagnosis and procedure codes
- Proposed date of Admission or Procedure

UTILIZATION REVIEW OFFICE CALL HINES AT

1-888-236-2652 or 815-397-5395

To Pre-Certify Online
www.hinesassoc.com

Hospital Expense Benefits

Daily Room Benefit

When the Eligible Person is hospital confined, the Plan pays for each day's room and board charges up to the semi-private room rate and the reasonable and customary amount charged in the area. This benefit is also payable when an Eligible Person, undergoing in-patient treatment for a nervous or mental condition, is temporarily released for up to two consecutive days for therapeutic reasons; with an aggregate maximum of six such days per period of disability.

Miscellaneous Charges While Confined

The Plan pays for miscellaneous charges made by the hospital during the Eligible Person's confinement. Examples of eligible miscellaneous items include: the use of an operating room, X-rays, laboratory tests, blood, drugs and medications prescribed by a physician and used while confined.

Charges Related to Hospital Treatment

The Plan pays for certain charges which are not billed by the hospital but are related to hospital treatment eligible under the Plan. Examples of related charges include:

1. Charges for professional local ambulance services for transportation to or from the hospital; and
2. Charges made by a physician, other than the operating physician or his assistant, for the administration of anesthesia by other than local infiltration; and
3. Charges made by a radiologist or pathologist.

Limitations

Hospital Expense Benefits are *not* payable for:

1. 1.Personal conveniences or grooming items such as guest tray meals, television rental, barber or beautician services or admission kits;

2. 2.Confinement, which is not medically necessary, including early admission or late discharge and confinement related to elective surgical procedures such as sterilization, reversal procedures or cosmetic surgery.

Hospital Expense Benefits are also subject to all General Plan Exclusions and Limitations.

Hospital Pre-Admission Testing

Benefits will be payable if you or your eligible Dependent undergoes diagnostic tests and X-rays in a hospital's out-patient department prior to actual admission to the hospital for treatment of the condition which makes the tests necessary, provided:

1. The tests or x-rays are otherwise eligible expenses under the Hospital Expense Benefit; and
2. The patient is scheduled for subsequent admission to the hospital treatment of the condition which makes the tests necessary, and
3. The tests are ordered by a physician.

However, in the event that the scheduled admission does not take place, the testing may still be covered if the admission is postponed or canceled for one or more of the following reasons:

1. The tests show a condition requiring medical treatment prior to admission; or
2. A medical condition is developed that delays the admission; or
3. A hospital bed is not available on the scheduled date of admission; or
4. The tests indicate, that, contrary to the attending physician's expectation, the admission is not necessary.

Pre-Admission Testing Benefits are also subject to all General Plan Exclusions and Limitations.

In-Hospital Medical Expense Benefits

When you or your Dependent requires non-surgical treatment by a physician for non-occupational sickness or accidental bodily injury while confined in a hospital, the Plan will pay the reasonable and customary medical fee charged by the physician. Pre-Certification is required for all Hospital admissions.

NOTE: If the admission is ***not*** pre-certified, a $500 penalty will apply to all covered services per occurrence.

Benefits may be paid for medical treatment rendered during a period of confinement when a surgical procedure is also performed.

In-Hospital Medical Expense Benefits pay for one physician’s visit per day when you are confined in a hospital for reasons other than surgery. If surgery is recommended and performed, these benefits are not paid on or after the day of surgery unless you are seen by a physician, other than the one who performed the surgery, for a co-existent medical condition.

Limitations

In-Hospital Medical Expense Benefits *are not* payable for:

1. Eye examinations for prescribing corrective lenses, including contact lenses, or examination for fitting of hearing aids.
2. Dental care or treatment.
3. Charges made by a surgeon for hospital visits, which are included in the surgical fee.

In-Hospital Medical Expense Benefits are also subject to all General Plan Exclusions and Limitations.

Out-Patient Hospital Treatment

The Plan pays for hospital charges due to treatment when the Eligible Person is not charged for a room under certain circumstances:

1. When surgery is performed at the hospital on an out-patient basis; or
2. For emergency treatment of a non-occupational accidental bodily injury on the day of the accident or the next two following days.
3. Colonoscopy Screenings when recommended by your physician. (payable every three years).

Surgical Expense Benefits

When a surgical procedure is performed on you or your Dependent for treatment of a non-occupational sickness or accidental bodily injury, the Plan will pay the surgical fee charged by a physician up to the reasonable and customary amount charged in the area and as described in this section.

"Surgical procedure" means certain invasive procedures, as well as reduction of fractures or dislocations, in addition to recognized cutting procedures. Surgical procedures may be performed in a hospital, physician's office or elsewhere. Surgical benefits include charges for necessary and related pre- and post-operative care and any anesthetic customarily administered by the surgeon.

Colonoscopies are covered for routine screenings every three years and are subject to the schedule of benefits. All general plan guidelines and limitations apply.

When a mastectomy is considered an eligible surgical procedure under the Plan, the Plan will also provide benefits for:

1. reconstruction of the breast on which the mastectomy has been performed;
2. reconstruction of the other breast to produce a symmetrical appearance; and
3. prosthesis and treatment of physical complications of mastectomy, including lymphademas (swelling of the lymph vessels or lymph nodes).

Limitations

Surgical Expense Benefits *are not* payable for:

1. Dental work or treatment, except as specifically provided;
2. Elective cosmetic or plastic surgery procedure such as rhinoplasty or breast augmentation. Breast reduction (reduction mammoplasty) may be considered an eligible expense in certain cases which are determined to be "medically necessary. Examples of medical necessity include severe skin disorder (such as rash or ulceration under the breast) and/or severe musculoskeletal symptoms (such as back pain or shoulder disfiguration) which generally requires that no less than 550 grams of tissue be removed from each breast;
3. Sterilization reversal procedures; or
4. Cosmetic or reconstructive surgery which is not necessary for prompt repair of an accidental bodily injury, which occurs while the patient is eligible.

Charges by an assistant surgeon will be considered as a covered expense provided his assistance is considered medically necessary. The Plan will consider 20% percent of the reasonable and customary amount of the surgical procedure for the services of an Assistant Surgeon.

Surgical Expense Benefits are also subject to all General Plan Exclusions and Limitations.

Second Surgical Opinion Benefits

When you or your Dependent wishes to secure a second opinion regarding the medical necessity or an in-patient surgical procedure of a non-emergency nature, the Plan will pay the physician's fee and related expenses provided:

1. You or your Dependent is examined by a board-certified specialist; and
2. The specialist submits a written report of his findings and recommendation; and
3. The specialist physician who renders the second surgical opinion does not also perform the recommended surgical procedure.

Second Surgical Opinion Benefits are subject to all General Plan Exclusions and Limitations.

Diagnostic X-Ray and Lab Benefits

When you or your Dependent incurs out-patient expense for examination by X-ray or laboratory testing to aid in diagnosis of non-occupational sickness or accidental bodily injury, the Plan will pay those expenses up to the reasonable and customary amount charged in the area and as described in this section.

Diagnostic Benefits are payable for examination and testing in a physician's office, clinic or hospital out-patient department. (Colonoscopy screenings are payable when recommended by your physician, every three years.)

Limitations

Diagnostic X-Ray and Lab Benefits *are not* payable for:

1. Testing or examination not recommended as medically necessary to diagnose sickness or injury (e.g., pre-martial or employment examinations, research studies, camp or school admission);
2. X-ray or testing related to dental care or treatment;
3. Eye examination for prescribing corrective lenses, including contact lenses; or
4. Testing or examination performed while the Eligible Person is hospital confined (covered under the Hospital Benefits).

Diagnostic X-ray and Lab Benefits are also subject to all General Plan Exclusions and Limitations.

Fertility Benefits

Fertility benefits are available only through Progyny. **To access benefits, contact Progyny at (833) 233-1401.**

Fertility benefits include:

1. Artificial Insemination (IUI);
2. Fertility-related bloodwork and testing;
3. IVF (in vitro fertilization with fresh or frozen oocytes);
4. PGT-A (PGS, or pre-implantation genetic screening) to assess embryo viability;
5. PGT-M (PGD, or pre-implantation genetic diagnosis);
6. Frozen embryo transfer (FET);
7. Frozen oocyte transfer (includes fertilization of previously frozen oocytes and transfer);
8. Purchase of donor tissue (eggs and sperm);
9. Preservation of embryo, egg, and/or sperm for up to one year; and
10. Fertility medications (via Progyny Rx only and subject to prior authorization).

Employees and Spouses will be entitled to two "Smart Cycles" per lifetime. Each item listed above is considered a part of a Smart Cycle, applying a formula determined by Progyny. Thus, the benefit allows, for example, multiple IVF attempts. Benefits will be paid by the Plan at 80% of the contracted rate and will be subject to the annual deductible and out-of-pocket maximum.

To learn more about this benefit, visit:

https://progyny.com/smart-benefits/smart-cycle
or call Progyny at (833) 233-1401

Pregnancy Expense Benefits

When you or your Dependent Spouse incurs expenses for hospital confinement or treatment by a physician due to pregnancy, including normal childbirth, Cesarean section or miscarriage, the plan will pay those expenses on the same basis as any sickness or injury, up to the reasonable and customary amount charged in the area and as described in this section. Obstetrical procedures are eligible under the Surgical Expense Benefits of the Plan.

Benefits for pregnancy are effective immediately for expenses incurred on or after the Eligible person's individual effective date of coverage. Pregnancy is not considered a pre-existing condition.

Limitations

Pregnancy Expense Benefits *are not* payable for pregnancy expenses incurred by a Dependent child.

Pregnancy Expense Benefits are subject to all the limitations which apply to individual benefits payable for any sickness or injury, including the General Plan Exclusions and Limitations.

Statement of Rights Under the Newborn's and Mother's Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket cost so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization of prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Fund Office.

Newborn Dependent Child Benefits

When a female Employee or the Dependent wife of a male Employee delivers a child or children while eligible under the Plan, benefits are payable for the newborn, up to the reasonable and customary amount charged in the area and as described in this section.

Crib Care

Benefits for the care of each newborn Dependent child are payable under the Hospital Expense Benefits in the same manner as hospital room and board and miscellaneous charges. Crib care is payable during the period the mother of the child is hospital confined as a result of giving birth to the child.

Newborn Examination

Benefits for medical examination and care of a newborn Dependent, while hospital confined, by a physician specializing in pediatrics are payable for the day of birth or the next following day.

Newborn Circumcision

Benefits for circumcision of a newborn Dependent male child by a physician are payable in the same manner as Surgical Expense Benefits.

Birth Coverage

Benefits for special care and treatment medically required by a newborn Dependent child as a result of:

1. Sickness contracted or injury suffered; or
2. Congenital defect; or
3. Premature birth.

Benefits are payable in the same manner as any other disability, up to the reasonable and customary amount charged in the area.

Limitations

Crib care, Newborn Examination and Newborn Circumcision Benefits *are not* payable for expenses incurred:

1. After the mother of the child is no longer hospital confined as a result of giving birth to such child unless the child requires extended confinement;
2. During a period of confinement for the mother which is longer than that for a normal delivery.

Newborn Dependent Child Benefits are not payable for expenses incurred by the newborn child or children of an Eligible Person's Dependent child.

Newborn Dependent Child Benefits are also subject to all General Plan Exclusions and Limitations.

Covered Expenses

The following hospital, medical and other expenses are covered by the Comprehensive Major Medical Benefits:

1. Daily hospital charges forward or semi-private room and general nursing services;
2. Daily hospital charges for treatment at an intensive or coronary care unit;
3. Other medically necessary services and supplies furnished by the hospital;
4. The services of a legally qualified physician;
5. The services of a graduate registered nurse (R.N.) or legally licensed physiotherapist, provided those services are not rendered by someone who ordinarily resides in your home or by a member of your family or your spouse's family;
6. Diagnostic laboratory and x-ray examinations, x-ray or radium therapy treatment;
7. Casts, splints, trusses, braces and crutches and artificial limbs and eyes replacing limbs or eyes which are lost while a person is eligible for these benefits;
8. Whole blood or blood plasma, including the cost of their administration, other than those charges for "elective" testing and donation. Autologous transfusion procedures will be considered if medically necessary due to surgery and only those pints used as a result of the surgery will be considered an eligible expense;
9. Anesthetics and oxygen, including their administration, or rental of equipment;
10. Rental, up to the purchase price, of durable medical equipment (such as wheel chair, hospital bed, or braces) based on at least one purchase estimate for such equipment;
11. Medically necessary professional local ambulance service to and from a hospital or between hospitals if necessary for more highly specialized care;
12. Drugs and medicines which require a physician's prescription and are legally obtained from a licensed pharmacist that are not vitamins, minerals, food supplements or substitutes;

13. Speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) as a result of a disease or injury;
14. Home health care services for part-time intermediate skilled nursing by a graduate registered nurse (RN), provided those services are not rendered by someone who ordinarily resides in your home or by a member of your family or your spouse's family. The Plan will only consider four hours per day up to a total of 60 visits in a calendar year. Home Health Care must replace a needed hospital stay, must be for the care or treatment of a sick or injured person, and must be furnished by a facility, organization or association that meets the Plan's definition of a Home Health Care Agency;
15. Respiratory and physiotherapists when required due to physical impairment caused by illness or injury;
16. Cardiac rehabilitation (not to exceed six weeks unless medically necessary) following a heart attack or surgery;
17. Hospice care services (of an approved hospice program) provided to an eligible person who is terminally ill if the medical prognosis indicates a life expectancy of six months or less. Benefits for hospice care are provided for the period beginning on the date the attending physician certifies that an eligible person is terminally ill and ends six months after it began or on the date of the eligible person's death, whichever is sooner. Benefits may be extended to a maximum of 12 months (from the date it began) if the physician certifies that the eligible person is still terminally ill;
18. The replacement or adjustment of artificial limbs, eyes, braces or durable medical equipment, when medically necessary, or in the case of an eligible dependent child, due to growth;
19. All treatment and supplies related to temporomandibular joint dysfunction (TMJ), including surgery, appliances and adjustment of occlusion, up to a lifetime benefit of one thousand five hundred dollars ($1,500.00) per individual;
20. Elective sterilization for member or spouse;
21. Pre-natal vitamins;
22. Birth control pills, patches, IUD's, Depo-Provera injections, and Norplant methods of Birth Control;
23. Any services, or treatment received that are not available in the PPO Network, will be considered for payment at the In-Network rate.
24. Up to two pairs of custom shoe inserts (including foot orthotics) per calendar year for the same diagnosis when prescribed by a Physician.
25. Sleep studies once every five years if prescribed by a Physician.
26. Up to three pairs of surgical stockings per year when prescribed by a Physician.

Some dental work and oral surgery procedures may be considered covered expenses under Comprehensive Major Medical Benefits. Dental services rendered by a physician, dentist, or dental surgeon for treatment of fractured jaws and repair or replacement of natural teeth due to accidental injury is considered covered expense if you or your dependent was eligible when the accident occurred and if the services are provided within two years of the accident.

Comprehensive Major Medical Benefits recognize only medically necessary hospital charges related to these and other dental procedures as covered expense.

Limitations

Comprehensive Major Medical Benefits *are not* payable for:

1. Eye refraction (for fitting glasses only), eyeglasses or dental prosthetic appliances or charges for the fitting of any of these applications, unless such appliances are required due to accidental injury:

2. Cosmetic or reconstructive surgery which is not necessary for the prompt repair of an accidental bodily injury, which occurs while the patient is eligible;

3. Dental care or treatment except as specifically provided;
4. Rest cures or custodial care;
5. Ambulance service or transportation between cities, such as by air ambulance, railroad or bus;
6. Maintenance, cleaning, service, or repairs of durable medical equipment;
7. Vision training or orthoptics or aniseikonia;
8. Testing or examination not recommended as medically necessary to diagnose sickness or injury (e.g., pre-marital or employment examination or research studies); or
9. Experimental or investigational procedures.
10. Vitamins or supplements, other than pre-natal vitamins.

The Comprehensive Major Medical Benefits are also subject to all General Plan Exclusions and Limitations.

All benefits are subject to additional exclusions and limitations for some conditions. Refer to the Treatment with Special Limitations Section for additional information.

SECTION II – OTHER BENEFITS

Weekly Accident and Sickness Benefits (Loss of Time)

If you become totally disabled from non-occupational accidental bodily injury or sickness, the Plan will pay the Weekly Benefit shown in the Schedule of Benefits. Benefits begin with the date of disability specified in the Schedule of Benefits and continue while you remain totally disabled, subject to the maximum period of benefits during one period of disability shown in the Schedule of Benefits.

Active Employees Only

Application for Loss of Time Benefits

For the Fund to consider Loss of Time, you must submit a fully completed claim form.

1. Both you and the physician must complete the form.
2. The Fund must receive a "Return to Work Notice" completed by your physician.

Period of Disability

All disability absences will be considered as having occurred during a single period of disability unless evidence acceptable to the Trustees is furnished that:

1. The cause of the latest disability absence cannot be connected with the causes of any prior disability absences, and the latest disability absence occurs after return to active work for at least one day; or
2. The causes of the latest disability absence can be connected with the causes of a prior disability, but the two were separated by a return to active work for at least two weeks.

Limitations

If you are otherwise an Active Employee under the Plan but are currently enrolled in COBRA Continuation Coverage, you may be eligible for Loss of Time benefits. Contact the Fund Office for details.

No benefits are payable under this benefit provision for any period or day of disability for which the Employee is not under the regular care and attendance of a physician. A Chiropractor is not considered a physician for the purposes of disability benefits.

No benefits are payable under this benefit provision for any period on or after the date an Employee retires, even if such Employee would normally be considered eligible based on Employer contributions for hours worked before retirement.

The benefits provided under this provision are not assignable. Weekly Accident and Sickness Benefits are also subject to all General Plan Exclusions and Limitations.

Benefits paid under this Section are not eligible for and do not contribute to the Co-payment Limit which allows for one hundred percent (100%) payment under the Major Medical Expense Benefits.

Chiropractic Expense Benefits

When you or your Dependents are treated by a Chiropractor in connection with the detection, treatment and correction of structural imbalance, subluxation or misalignment of the vertebral column for the purposes of alleviating pressure or spinal nerves, benefits for all related services, supplies and procedures will be paid as described in this section.

Chiropractic Services

After satisfying the calendar year deductible, chiropractic treatment charges are payable at 80% for In-Network providers and 70% for Non-Network providers. Covered services include all services provided by a Chiropractic Professional, including but not limited to office visits, manipulations, adjustments and diagnostic x-ray or laboratory services. The benefit maximum is $2,100 per calendar year.

Limitations

This Plan *does not* provide benefits for:

1. Orthotics are not covered when prescribed by a Chiropractor;
2. Diet or hair analysis;
3. Nutritional or food supplements and/or vitamins;
4. Pillows, supports or similar devices;
5. More than one treatment per day;
6. Booklets;
7. Services rendered or recommended by a Naprapath, or
8. Services or conditions other than those indicated above.

Expenses related to chiropractic treatment, other than the Chiropractic Services specified above ***are not eligible*** under the Major Medical Expense Benefits (chiropractic charges do not apply towards the maximum out of pocket expense.

A chiropractor is not generally considered a "physician" for the purpose of the Loss of Time Benefit. Benefits for or related to treatment by a Chiropractor are subject to all General Plan Exclusions and Limitations.

Benefits paid under this Section are not eligible for and do not contribute to the Co-Payment Limit which allows for one hundred (100%) percent payment under the Comprehensive Major Medical Expense Benefit.

Clinical Trials

The Plan will cover the patient costs for a covered person enrolled in an approved clinical trial. An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition that is:

1. Federally funded or approved;
2. Conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. A drug trial that is exempt from having such an investigational new drug application.

A "life-threatening condition" is any disease from which the likelihood of death is probable unless the course of the disease is interrupted. "Routine patient costs" include all services and supplies that are typically covered by the Plan for persons not enrolled in clinical trials. Routine patient costs do NOT include:

1. The investigational item, device or service itself;
2. Services that are provided solely to satisfy data collection and analysis needs, or
3. Services that are clearly inconsistent with the widely accepted and established standards of care.

Mental and Nervous Disorder Benefits

When you or your Dependent requires treatment for a mental or nervous disorder, the Plan will pay those reasonable expenses incurred up to the maximums shown in the Schedule of Benefits and as described in this Section. The Plan will cover both individual and group treatment.

Out-Patient Treatment

Out-Patient treatment for Mental and Nervous Disorder Benefits are considered if performed by a provider acting within the scope of their license. Treatment for Mental and Nervous Disorder Benefits are paid under the Comprehensive Major Medical Expense Benefits, and are paid at 80% for In-Network providers, and 70% for Non-Network providers.

The Plan will cover family and marriage counseling at the regular coinsurance, deductibles, and out-of-pocket limits. However, family and marriage "coaching" will remain excluded.

In-Patient Treatment

In-Patient treatment for Mental and Nervous Disorder Benefits is considered if performed by a provider acting within the scope of their license. Treatment for Mental and Nervous Disorder Benefits are paid under the Comprehensive Major Medical Expense Benefit at 80% for In-Network providers and 70% for Non-Network providers.

Limitations

Benefits for treatment of Mental and Nervous Disorders are subject to the same terms, conditions and limitations governing individual benefits for any other illness or injury under this Plan.

Alcoholism and Substance Abuse Benefits

When you or your Dependent spouse requires treatment for alcoholism or the abuse of other drugs or intoxicants, benefit payments by the Plan are subject to the rules described in this section in addition to the conditions governing individual benefits.

Co-Payment

Alcoholism and Substance Abuse Benefits do not pay covered expenses in full, so you will share in the cost of your treatment. After satisfying any applicable deductible, the Plan pays covered expenses for in-patient or out-patient rehabilitation programs as outlined in the Schedule of Benefits including:

1. Hospital room, board and miscellaneous charges.
2. Group or individual rehabilitation counseling rendered to a hospital in-patient.
3. Prescription drugs and out-patient laboratory testing, if any.
4. Out-patient group or individual rehabilitation.

Covered Expenses

Only expenses considered eligible under the Major Medical Expense Benefits are covered under this Section. Recognized facilities may include non-hospital facilities specializing in substance abuse treatment as well as normal hospital in-patient facilities. If possible, contact the Claims Office before undergoing treatment to verify approval of a particular program.

Limitations

Benefits for treatment of alcoholism and substance abuse ***are not*** payable for:

1. Treatment programs, which are not conducted by a state-licensed or nationally accredited facility.

Benefits for treatment of alcoholism and substance abuse are subject to the same terms, conditions and limitations governing individual benefits for any other illness or injury under this Plan.

Preventive Care Benefit

The Plan offers coverage for preventive care that complies with the requirements of the Affordable Care Act. A list of covered services and supplies is provided below. The list is based on the United States Preventive Services Taskforce (USPSTF) recommendations that have A or B-level recommendations, the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA) Bright Futures program for children, and the HRSA-sponsored Women's Preventive Services Initiative (WPSI) and is subject to change as these organizations revises their guidance.

All covered preventive services provided by an in-network provider will be paid at 100%. Non-network services will be subject to the non-network deductible and non-network coinsurance.

Note that common adult immunizations, including flu shots and the COVID-19 vaccine, are on the list. This Plan will also continue to cover all routine physical physicals, as set forth later in this SPD.

** Preventive services by the IBEW Local 364 Health & Wellness Center are also still covered in full **

IMMUNIZATIONS	
Covered Immunization	**Frequency**
Diphtheria, tetanus, and pertussis (DTAP)	As recommended by the Advisory Committee on Immunization Practices (ACIP) and that have been adopted by the Director of the Centers for Disease Control and Prevention, including: • Recommended Immunization Schedule for Persons Aged 0 Through 6 Years • Recommended Immunization Schedule for Persons Aged 7 Through 18 Years • Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind • Recommended Adult Immunization Schedule. Travel and work-related immunizations are excluded.
Hepatitis A (HepA)	
Hepatitis B (HepB)	
Human papillomavirus (HPV)	
Influenza (seasonal)	
Influenza type B (Hib)	
Measles, mumps & rubella (MMR)	
Meningococcal (MCV)	
Pneumococcal (PCV/PPSV)	
Polio (IPV)	
Rotavirus (RV)	
Varicella	
Zoster (shingles)	

ADULTS (19 OR OVER UNLESS SPECIFIED)	
Covered Service or Supply	**Frequency**
Abdominal aortic aneurysm ultrasound screening (men age 65-75 who smoke(d))	one per lifetime
Alcohol misuse counseling	one visit per lifetime
Blood pressure screening (age 18+)	one per calendar year
Cholesterol abnormality screening (men age 35+, or age 20+ if increased risk; women age 45+, or age 20+ if increased risk)	one per calendar year
Colorectal cancer screening (adults age 50-75), including colorectal exams, flexible sigmoidoscopies, barium enemas, and colonoscopies. Colonoscopy coverage includes medically indicated sedation or anesthesia, pathology, and medically appropriate pre-screening specialist consultation. Cologuard also covered under this benefit.	Within the age and frequency guidelines established by the American Cancer Society (age 50 if at average risk)
Depression screening	one per lifetime
Diabetes screening (adults with blood pressure greater than 135/80)	one per calendar year
Diet counseling (adults at increased risk for diet-related chronic disease)	one per lifetime
Hepatitis C screening	once per calendar year
HIV screening	as prescribed by patient's physician
Lung cancer screening with low-dose CT for ages 55+ with history of smoking	once per calendar year
Obesity screening, and if patient is obese (BMI 30 or higher), up to 26 face-to-face counseling sessions (CPT G0447) with doctor (M.D./D.O.) or behavior therapist (Masters' or better) specializing in weight loss	one course of treatment per year
Sexually transmitted infections counseling (adults at increased risk)	one per lifetime
Syphilis screening (persons at increased risk)	one per calendar year
Tobacco use counseling (age 18+)	two 90-day attempts per calendar year, consisting of four 10-minute counseling sessions
Tuberculosis screening for adults at high risk	one per calendar year

PHARMACY PRODUCTS FOR ADULTS	
Covered Service or Supply	**Frequency**
Aspirin to prevent cardiovascular disease (men age 45-79; women age 55-79), when prescribed by physician	as prescribed by patient's physician – generics only
Bowel prep for covered colonoscopies	generics and OTCs only
Statin drugs (low to moderate dosages)	as prescribed by patient's physician – generics only
Tobacco cessation medications (age 18+)	all physician-prescribed medications (including OTCs) for two 90-day attempts per year

PREVENTIVE SERVICES FOR WOMEN	
Covered Service or Supply	**Frequency**
BRCA genetic screening and counseling (women with a family history of BRCA 1 or BRCA 2 risk factors)	one per lifetime
Breast cancer counseling (women age 35 and older at high risk)	as prescribed by patient's physician
Breastfeeding support, supplies (including rental of breast pump), and counseling	lactation counseling by doctors, nurses, and credentialed lactation specialists; breast pumps and supplies as needed
Cervical cancer screening	one per calendar year
Chlamydial infection screening (women age 24 or younger or at increased risk)	one per calendar year
Contraception (non-oral) – FDA-approved contraceptive methods for women (IUDs, Depo Provera, etc.) prescribed by a physician, and surgical sterilizations	as prescribed by patient's physician
Contraceptive counseling – Patient education and counseling	as prescribed by patient's physician
Domestic and interpersonal violence screening and counseling	one per calendar year
Gonorrhea screening (women at increased risk)	one per calendar year
HPV DNA testing	every 3 years starting at age 30
Mammograms	one per calendar year
Osteoporosis screening (women age 60; and post-menopausal women with increased risk of osteoporotic fractures)	one per lifetime
Preeclampsia screening and monitoring for pregnant women (should be included in global OB fee)	as prescribed by patient's physician
Prenatal care, meaning routine doctor visits. (Delivery, prenatal lab, ultrasounds, and high-risk pregnancy care services are covered under the regular major medical provisions of the Plan for female employees, retirees, and spouses ONLY—not for dependent children of any age.)	as prescribed by patient's physician
Prenatal screening for gestational diabetes, anemia, bacteriuria, HIV and other infections, Hepatitis B, Rh incompatibility, perinatal depression and syphilis	one per pregnancy
Well-woman preventive visits to obtain recommended preventive services that are age and developmentally appropriate	one per calendar year

PHARMACY PRODUCTS FOR WOMEN	
Covered Service or Supply	**Frequency**
Aspirin for pregnant women at high risk for preeclampsia	as prescribed by patient's physician – generics only
Breast cancer chemoprevention drugs (women age 35 and over at high risk)	as prescribed by patient's physician – generics only
Folic acid supplements (women capable of pregnancy)	0.4 to 0.8 mg (400 – 800 µg) per day
Oral contraceptives – FDA-approved drugs and devices that require a prescription. 100% coverage for oral contraceptives (birth control pills) that are generic (or brand without a generic equivalent)	as prescribed by patient's physician

CHILDREN (NEWBORN THROUGH AGE 18, AS APPLICABLE)	
Covered Service or Supply	**Frequency**
Alcohol/drug assessment	as recommended by the American Academy of Pediatrics and Bright Futures
Anticipatory guidance	
Autism screening	
Behavioral assessment	
Cervical dysplasia screening	
Developmental screening	
Dyslipidemia screening	
Health history	
Hemoglobin screening	
Lead screening	
Measurements, including height, weight, BMI, blood pressure, etc.	
Metabolic screening	
Oral health risk assessment	
Physician examination	
Sensory (vision and hearing) screening	
Sexually transmitted disease screening and counseling (adolescents)	
Tuberculin (TB) test	
Depression screening (children age 12-18)	one per lifetime
HIV screening (children age 11 or older at increased risk)	one per lifetime
Newborn screenings for hemoglobinopathies, hearing loss, hypothyroidism, phenylketonuria (PKU), and heritable disorders (as recommended by the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children)	one per lifetime
Obesity screening and counseling (children age 6+)	one per lifetime
Sexually transmitted disease counseling (adolescents)	as determined by patient's physician
Skin cancer behavioral counseling	one per lifetime
Tobacco use intervention (education and brief counseling to prevent initiation of tobacco use in school-aged children and adolescents)	one per lifetime
Vision screening (children 3-5 years)	one per lifetime

PHARMACY PRODUCTS FOR CHILDREN	
Covered Service or Supply	**Frequency**
Iron supplements (children age 6-12 months at increased risk for anemia)	as prescribed by patient's physician – generics only
Oral fluoride (children 6 months+ if water source deficient in fluoride)	as prescribed through age 5 – generics only
Prophylactic medication for gonorrhea	one per lifetime

Well Child Care Benefits

Routine Physical Examinations and Checkups

When your Eligible Dependent child incurs expenses for a Routine Physical Examination, performed by a physician, the Plan will pay those reasonable expenses up to the amounts shown in the Schedule of Benefits Section and as described in that Section. Eligible expenses include the physician's office, clinic or hospital out-patient department charges.

Limitations

Well Child Care Benefits are not payable for testing or examination related to accidental bodily injury or sickness. Well Child Care Benefits are subject to all General Plan Exclusions and Limitations.

Once the maximum benefit for Well Child Care or Routine Examinations has been exhausted, there is no further coverage for these services.

Routine Physical Examination Benefit (Employee and Spouse Only)

When you or your Dependent spouse incurs eligible expenses for a routine physical examination performed by a physician, the Plan will pay those reasonable expenses up to the amounts shown in the Schedule of Benefits.

Eligible expenses include the physician's professional fees, immunizations and diagnostic x-ray or laboratory charges. The examination may be performed in a physician's office, clinic or hospital out-patient department.

The Plan provides for one hundred percent (100%) coverage of all Mammograms, regardless of whether they are performed for preventative or diagnostic purposes. There is no dollar limitation of payment for this procedure if performed as part of a routine examination, or with a qualified diagnosis. Benefits are paid at 100% of the **approved charges** regardless of the purpose of the examination.

Limitations

Routine Physical Examination Benefits are not payable for:

1. Testing or examination related to accidental bodily injury, sickness or pregnancy (including resulting child birth or complications);
2. Testing or examination related to or as a condition of employment or to the issuance of any insurance policy;
3. Expense incurred by a Dependent other than the Employee's spouse.

Routine Physical Examination Benefits are also subject to all General Plan Exclusions and Limitations. Benefits paid under this Section are not eligible for and do not contribute to the Co-Payment Limit which allows for 100% payment under the Comprehensive Major Medical Expense Benefit. Benefits are also not payable under any other benefit.

Prescription Drug Benefits

The Plan will pay for Prescription Drugs, in generic or brand form, when prescribed by a physician, and after applicable co-payments have been satisfied. Generally, when a Brand Drug with a Generic equivalent is prescribed, you must use the Generic Drug. If you decline to do so, you must pay the cost difference between the Generic and Brand Drugs, in addition to the Co-Payment. If you have a medical requirement for a Brand Drug that has a Generic equivalent, your physician may submit a Letter of Medical Necessity for Sav-Rx's clinical review; Sav-Rx will then determine if an exception may be made.

The Prescription Drug program includes topical contraceptives such as birth control patches and the birth control injection, Depo-Provera in addition to oral contraceptives, or birth control pills.

NOTE: This Plan does not provide benefits for prescriptions obtained at Wal-Mart pharmacies.

Specialty Drugs

The Plan has partnered with Sav-Rx to provide two programs to manage specialty medication.

Sav-Rx Specialty Drug Program

The Specialty Drug Program includes a prior authorization process which helps to manage high-cost drug therapies by ensuring that these medications are being prescribed for an appropriate patient and condition at an acceptable dose and quantity.

Aspects of the Specialty Drug Program:

- Require Prior Authorization for all Specialty Drugs
- Specialty Prescriptions dispensed up to 30 Days' Supply, unless part of the Sav-Rx HIA 90 program (described below) and approved through Sav-Rx Clinical.
- Sav-Rx Specialty Pharmacy or Specialty Pharmacy partner may be required for certain Specialty Drugs

Additionally, Sav-Rx offers a voluntary program that allows you to receive certain brand specialty medications delivered to you with no out-of-pocket cost. If your medication is eligible for the program, Sav-Rx will contact you about the program. If you choose to participate, you must have a 15-minute teleconference with a pharmacist. Your medication will then be delivered to your home, at no cost to you.

High Impact Advocacy Program

The High Impact Advocacy Program will reduce or eliminate out-of-pocket expenses for you, while also reducing the Plan's cost. The Program will only affect Participants taking certain high-cost specialty medications; Sav-Rx will contact you if your medication is covered under this Program.

Prescriptions for specialty drugs through the High Impact Advocacy Program must be filled through the Sav-Rx Specialty Pharmacy. Sav-Rx will also facilitate your enrollment in any manufacturer coupon program.

Medications may be added to or removed from the High Impact Advocacy Program list at any time; should one of your medications be affected, Sav-Rx will contact you.

For Class C Employees

The Plan Provides a combination Medicare Part D and supplemental benefit program. The only difference is that Class C Employees and their Medicare-eligible Spouses will each have two I.D. cards, both of which must be show at the pharmacy.

Hearing Care Benefits

When you or your Dependent incurs expenses for hearing care, the Plan will pay those expenses up to the amount shown in the Schedule of Benefits and as described in this Section.

Eligibility

Benefits are payable while the patient is eligible under the Plan. The benefit is available to all eligible members and their Dependents.

The Deductible Amount

Eligible expenses incurred for hearing care will be applied to the deductible amount normally required under the Plan, in whole or in any combination with other eligible expenses.

Co-Payment

Hearing Care Benefits are paid at 80% for In-Network providers and 70% for Non-Network providers for covered expenses for eligible hearing care treatment expenses.

The Maximum Amount

All payments under Hearing Care Benefits are limited to the maximum amount shown in the Schedule of Benefits. The maximum amount applies to you and each of your Dependents separately. The maximum amount cannot be reinstated and is not renewed if eligibility is lost and then regained at a later date.

Covered Expenses

Hearing Care Benefits are divided into three main parts: a physical examination by a special physician (Otologist or Otorhinolaryngolist); a test of hearing ability and condition by a special physician or a licensed audiologist; and the purchase of a hearing aid, if required.

Fitting and purchase of a hearing aid includes the reasonable charges for the manufacturing of ear molds by a special physician or licensed audiologist; and the purchase of a hearing aid, including hearing aid rental and audiologist consultation fees during an evaluation period (whether or not a hearing aid is found to be satisfactory and is purchased).

Limitations

Hearing Care Benefits are not payable for:

1. Examination or testing by other than an otologist, otorhinolaryngolist or licensed audiologist;
2. Services or supplies provided by an audiologist, which are not prescribed by a specialist physician;
3. Charges for hygienic cleaning of the hearing aid;
4. Batteries and their installation;
5. Charges for repair due to accidental damage or for replacement of a lost hearing aid.

Hearing Care Benefits are also subject to all General Plan Exclusions and Limitations. Benefits paid under this Section are not eligible for and do not contribute to the Co-Payment Limit, which allows for one hundred (100%) percent payment under the Comprehensive Major Medical Expense Benefit.

Organ Transplants

Limitations

Organ Transplant Benefits *are not* payable for:

1. Expense incurred by any person other than an Eligible Person as determined by the Eligibility Rules, including but not limited to a living tissue or organ donor, and
2. Organ transplants other than those approved by Medicare, and
3. Treatment employing experimental or investigative medical or surgical procedures.

"Experimental or Investigative" means the use of any treatment, procedure, facility, equipment, drugs, devices or supplies, or if performed under controlled conditions in order to discover an unknown effect and not yet recognized as acceptable general medical practice and any such items requiring federal or governmental agency approval for which such approval has not been granted at the time the service was provided. The Trustees have the sole authority to determine whether the treatment shall be considered "experimental or investigational" for the purposes of this Plan. Organ Transplant Benefits are also subject to all General Plan Exclusions and Limitations.

Flexible Benefit Account - Spousal Insurance Reimbursement

In an effort to reduce the overall Fund expenses, the Trustees have elected to implement a new benefit. This benefit, has been created to encourage enrollment of participant's spouses and or dependents in other health care or insurance coverage that may be available through your spouse's employer. Each year the Trustees of the Fund will review the possible savings the Fund may have realized in the prior year and determine whether this benefit will be continued.

If your spouse does enroll in coverage offered through his or her employer, the Fund will continue to provide coverage on yourself as the primary carrier and will provide secondary coverage for your spouse. Primary coverage for your dependent children will be based upon the "birthday rule" as described in your Summary Plan Description.

If acceptable proof of other insurance is provided to the Fund Office, participants will receive up to three hundred dollars ($300.00) per month, with a maximum of three thousand six hundred dollars ($3,600) annually as reimbursement for the cost of the other insurance coverage. Acceptable proof of the other insurance coverage will be required each month. Acceptable proof can be a copy of your spouse's paycheck reflecting the cost of health care coverage or a letter from your spouse's employer identifying the cost of coverage.

Flexible Benefit Account (FBA)

This benefit allows reimbursement of eligible expenses, up to a maximum of $250 per family, per calendar year (January through December).

Eligible Expenses incurred related to Medical, Dental, or Vision care, may be eligible for reimbursement from the FBA. (Please see the list of covered service) You must be eligible, based on the Plan's regular eligibility provisions, on the date that services are rendered. All claims submitted must include the following:

- An itemized bill for the services rendered.
- Proof of payment (receipts) for services rendered, or…
- Proof of a denial from your Insurance Carrier (Explanation of Benefits – EOB) for services rendered by a Health Care, Dental, or Vision Provider.

Eligible and Non-Eligible Health Care Expenses

The following list identifies some of the common medical, dental and health related expenses that the **Internal Revenue Service** considers to be deductible expenses. These expenses are eligible for reimbursement through your Flexible Benefit Account (FBA) provided that you have not been reimbursed for them through any other benefits plan. **You must be eligible on the date of purchase/service.**

Examples of Eligible Health Care Expenses (*Reimbursement for Co-Payments):

Acupuncture	Guide dog and its upkeep
Alcoholism and drug addiction treatments*	Hair transplant (medically necessary)
Ambulance*	Hearing aids and batteries
Artificial limbs and teeth*	Hospital services-including meals and lodging, clinic costs
Birth control pills*	HMO (Health Maintenance Organization) co-payments
Braces	Insulin*
Braille books and magazines (to the extent prices exceed prices for regular books and magazines)	Iron Lung
Car (Special medical equipment within)	Laboratory fees*
Contact lenses including saline solution and enzyme cleaner	Lead-based paint removal to prevent lead poisoning
Crutches*	Legal fees to allow treatment for mental illness
Dental Treatment	Lip-reading lessons
Diathermy	Lodging for medical care
Electrolysis or hair removal (medically necessary)	Medical information plan (amount paid to plan that keeps your medical information)
Eye examination	Mentally retarded, special home
Eyeglasses	Nurses' expenses and board
False Teeth	Nursing care*
Fees for health club (medically necessary)	Skilled Nursing home (if for medical reasons)*
Fees for health club (medically necessary)	Operations and related treatments*
Fees to doctors, hospitals, etc. for: Anesthesiologist* Chiropractor* Christian Science practitioners Clinic charges* Dentist Dermatologist* General Practitioner* Gynecologist*	Orthopedic shoes
	Over-the-counter drugs- see specific list attached
	Oxygen equipment*
	Prescribed drugs and medicine*
	Radial Keratotomy*
	Rental of medical equipment*
	Sanitarium
	Smoking cessation programs
	Special schooling for physically or mentally handicapped

Internist*	family member
Midwife*	Sterilization*
Neurologist*	Telephone (for the deaf)
Obstetrician*	Television equipment which displays the audio part of TV
Ophthalmologist	Programs for the deaf
Optometrist	Therapy (for medical treatment)*
Osteopath, licensed*	Transplants*
Physical Therapist*	Travel costs to obtain medical care and prescriptions (Must
Podiatrist*	be submitted via paper claim)
Practical Nurse*	Vitamins (that require a prescription for purchase)
Psychiatrist*	Weight loss programs (physician approved)
Psychoanalyst (medical care only)*	Wheel chair*
Psychologist (medical care only)*	Whirlpool baths
Sex therapist (medical care only)*	Wigs to cover baldness due to medical reasons
Surgeon*	X-rays*

Over-the-Counter (OTC) Drugs

OTC drugs include many drugs that used to be prescription drugs, such as Claritin and Advil, as well as items like cold or cough medicine, pain relievers, allergy medications, and antacids. OTC items that are merely beneficial to the general health of an individual, such as vitamins, toiletries, (such as toothpaste, mouthwash, etc.), dietary and nutritional supplements, and cosmetics (such as face cream) are not allowable. You may find additional information regarding coverage of OTC at the IRS website located at: www.IRS.gov/newsroom.

As with all other FBA expenses, you will need to save your receipts for these items and send them in when you submit your FBA claim reimbursement form. The Fund requires proper substantiation for each item purchased to show that they are being used to "alleviate or treat personal injuries or sickness" for you and/or your dependent(s).

Remember, adequate substantiation for these claims must include the name of the drug or medicine, the date it was purchased, and the charge for the item. If the name of the drug is not listed on the receipt, you must write the name of the drug on your claim form. Here is a partial list of eligible and in-eligible OTC drugs:

Eligible Over-the-Counter Reimbursable Medical Expenses

Allergy Relief, such as oral medications, nasal sprays, and patches
Analgesics, such as Fever and Pain Reducers like Aspirin, Tylenol, Ibuprofen
Antacids and Heartburn Relief, such as Alka-Seltzer, Mylanta, and Milk of Magnesia
Antibiotic Ointments
Anti-itch and hydrocortisone creams
Arthritis pain relieving creams
Athlete's Foot Treatment, such as nail and foot anti-fungal creams
Blood Pressure monitor and related equipment
Cholesterol test equipment
Cold Medicines, such as tablets, syrups, drops, lozenges
Diabetes, such as glucose monitor and related equipment
Eye Care, such as contacts, saline solution, and lubricant eye drops
Eye Patches
Feminine Care relating to treatment of vaginal infections
First Aid, such as heat wraps, compresses, bandages, tape, gauze dressing, adhesive pads, band aids, and pain relieving creams
Incontinence Products, such as Depends and Serenity pads
Joint Support Bandages and Hosiery, such as knee supports, elbow supports

Laxatives
Motion Sickness, such as Dramamine, patches, bracelets
Shampoo Treatment relating to treatment of psoriasis, lice
Smoking Cessation Relief, such as patches, gum
Stomach & Digestive Relief, such as Pepto-Bismol, Imodium, Colace, Lactaid
Tooth and Mouth Pain Relief, such as Orajel, Anbesol
Urinary Pain Relief
Vaporizers and Humidifiers
Wart Removal Medication

Non-Eligible Over-the-Counter Medical Expenses

Vitamin (for the general health of an individual)
Toiletries, such as toothpaste, mouthwash, etc.
Dietary and Nutritional Supplements
Cosmetics, such as face cream, etc.

Examples of Non-Eligible Health Care Expenses

Any illegal treatment	Diaper service
Cosmetic services and procedures (unless necessary to Restore normal functioning)	Health and beauty aids
Food for weight loss programs	Karate or Kick boxing classes
Medications specifically used for cosmetic purposes	Over-the-counter drugs (including health & beauty aids, vitamins, and nutritional supplements) for general well being.
Cost of remedial reading classes for non-disabled child	Teeth Whitening
Dancing or ballet, even when recommended by doctor	Funeral Expenses
Hospital benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax	Nursing Care for a healthy baby
Travel your doctor told you to take for a rest or change	Spouse's Insurance Premiums

SECTION III - DENTAL CARE BENEFITS

Introduction

When you or your Dependent incurs expense for dental care, the Plan will pay those expenses up to the reasonable and customary amount charged in the area up to a maximum amount as shown in the Schedule of Benefits and as described in this Section. The Plan also requires co-payments for eligible types of care so you will share the cost of your treatment. Co-payment levels are specified for each group of eligible expenses.

Dental Preferred Provider Network

This plan utilizes a Dental Preferred Provider Network through Blue Cross and Blue Shield of Illinois (BCBSIL), called Dental Network of America (DNoA). Since BCBSIL negotiates reduced fees with these participating providers, your out-of-pocket expenses (and the Fund expenses) will be lower if you utilize the services of a participating provider. This network still allows all participants to choose any licensed dentist for their dental care however, to find a participating dentist and maximize your savings, visit the Dental Network of America (DNoA) website at www.dnoa.com or call 866-LABOR-L-U (522-6758) between 8:00 a.m. - 6:00 p.m. CDT. It is important to note that you may also seek services with dentists who are not in the Dental PPO Network, but the savings may be substantially less to the participant and the Fund.

Predetermination of Benefits

You are not required to have the dentist submit an estimate of charges before work begins. However, the Trustees recommend that the dentist give the Claims Office a description of the procedures to be performed and the estimated fees before treatment starts if the total charges will be over $100. This will let you and your dentist know if the treatment plan is considered reasonable and what benefits will be paid.

Alternate Methods of Treatment

If an alternate method of treating a dental condition is used, the amount included as a covered dental expense will be the reasonable and customary charge for the service that is commonly used nationwide in the treatment of that condition and that is recognized by the dental profession to be appropriate in accordance with accepted nationwide standards of dental practice.

If you and your dentist choose a more expensive alternative dental treatment, benefits will be payable only for amounts that would have been paid had the procedures been performed according to the above guidelines.

The Maximum Amount

All payments under Dental Care Benefits are limited to the maximum amount shown in the Schedule of Benefits for the type of care involved. The maximum amount applies to you and each of your eligible Dependents separately.

Covered Expenses

Dental Care Benefits through Dental Networks of America (DNoA) are divided into four main parts: preventative expenses; diagnostic expenses; restorative expenses (such as most fillings and extractions) and prosthodontics expenses (such as bridge work and dentures). The percentage payable by the Plan is determined separately for each type of treatment group.

1. Preventative Expense. The Plan pays 100% of the reasonable expense for the following dental care:
    a. Oral Examinations, twice per calendar year;
    b. Preventative treatment consisting of:
        - Oral prophylaxis (cleaning and scaling of teeth) but not more than twice in a calendar year;
        - Topical sodium and stannous fluoride treatment or sealants are available only to eligible persons under age 19, but not more than one treatment per tooth in a calendar year; and

- Bitewing x-rays, not more than twice in a calendar year;

c. Space Maintainers for replacement of deciduous prematurely lost teeth for an eligible person under age 19.

2. Diagnostic Expense. The Plan pays sixty-five percent (65%) of the reasonable and customary expenses, once the annual deductible has been satisfied, for x-rays, consisting of:
   a. Full mouth x-rays, once in a 36 consecutive-month period.
   b. Emergency palliative treatment.
3. Restorative Expenses. The Plan pays sixty-five percent (65%) of the reasonable and customary expenses for the following dental care once the annual deductible has been satisfied:
   a. Extractions not related to orthodontics including impacted teeth;
   b. Oral surgery, including medically necessary administration of local or general anesthetics, including nitrous oxide;
   c. Fillings, other than gold;
   d. Periodontal treatment (diseases of gums);
   e. Endodontic treatment (pulp infection and root canal therapy);
   f. Injections of antibiotic drugs;
   g. Repair or cementing of crowns, in-lays, on-lays, bridgework or dentures, or relining or rebasing of dentures more than six months after their installation; once each 36 months;
   h. On-lays or crown restorations to restore diseased or accidentally broken teeth, but only when the teeth cannot be restored with an amalgam, silicate, plastic or other material; and
   i. Scaling and root planing are covered every two years.
4. Prosthodontics Expenses. The Plan pays sixty-five percent (65%) of the reasonable expense for the following dental care, once the annual deductible has been satisfied:
   a. Initial installation of complete or partial bridgework fixed or removable;
   b. Initial installation of gold fillings or crowns as abutments, provided that amalgam, silicate, plastic or other materials will not adequately restore the teeth;
   c. Implantology of individual teeth or dentures.
   d. Replacement of previously existing gold restorations provided that:
      - Amalgam, silicate, plastic or other materials will not adequately restore the tooth, and
      - The previous restoration was installed five (5) or more years prior to this replacement.
   e. Replacement of previously existing complete or partial removable dentures or fixed bridgework provided that:
      - replacement is required due to the extraction of one (1) or more natural teeth while eligible for Dental Care Benefits; and
      - the previous denture or bridgework was installed three or more years prior to its replacement.
5. Orthodontic Expense. When an eligible person under 19 years of age undergoes Orthodontic Treatment, the Plan pays ninety-five percent (95%) of the reasonable and customary expense for the following services and supplies during the first 24 months of treatment after appliances are placed, once the annual deductible has been satisfied:
   a. diagnostic procedures, including cephalometric x-rays;
   b. surgical therapy, including repositioning of the jaw or facial bones or teeth to correct malocclusion; and
   c. appliance therapy (braces), including related periodic oral exams, surgery and extractions.

Expense Incurred

Expense Incurred means the date a dental service or treatment is performed, except for the following services or treatments:

1. Dentures or bridgework – the date the impressions are taken.
2. Crowns, in-lays, on-lays – the date the teeth are first prepared.
3. Root canal therapy – the date the pulp chamber is opened.

The Maximum Amount

All payments under Dental Care Benefits are limited to the maximum amount shown in the Schedule Benefits for the type of care involved. The maximum amount applies to you and each of your eligible Dependents separately.

The maximum amount for all other Covered Expenses applies to payments for treatment each calendar year and so is renewed each January 1st. Benefits not used in a prior year cannot be carried forward to increase the maximum amount for the next calendar year.

Treatment in Progress When Eligibility Terminates

The Plan will generally not pay for services or supplies furnished after the date you or your Dependent's eligibility terminates, even if the Claims Office has predetermined the payments for a treatment plan submitted before the termination date.

The Plan will pay for services or supplies related to the following covered expenses if the treatment is rendered and delivered to the patient within ninety (90) days after the termination date and the following conditions are met:

1. A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while the patient was covered under the Plan;
2. A crown if the dentist prepared the tooth for the crown while the patient was covered under the Plan; and
3. Root canal therapy if the dentist opened the tooth while the patient was covered under the Plan.

Limitations

Dental Care Benefits ***are not*** payable for:

1. Any service rendered, supply ordered or treatment plan begun before coverage became effective;
2. Treatment other than by a licensed dentist or licensed physician, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the dentist;
3. Services or supplies that are primarily cosmetic in nature, including charges for personalization or characterization of dentures;
4. Replacement of a lost, missing or stolen prosthetic device;
5. Services rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer or governmental agency;
6. Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature;
7. Any duplicate appliance or prosthetic device within the first 24 months after the appliance is placed;
8. Athletic mouth guards;
9. A plaque control program (a series of instruction on the care of the teeth);
10. Periodontal splinting;

11. Services which are provided under other sections of this Plan;
12. Myofunction therapy (correction of harmful habits);
13. Sealants, beyond age 19;
14. Expenses for services other than those specifically indicated as covered;
15. Veneers;
16. The replacement of any prosthetic appliance, crown, in-lay or on-lay restoration or fixed bridge within three years of the date of the last placement of such item, unless that replacement is required as a result of accidental bodily injury sustained while the patient is eligible under this Plan;
17. Expenses for services other than those specifically indicated as covered;
18. Treatment for TMJ (such treatment is covered under the Comprehensive Major Medical Benefit. This medical benefit is a limited benefit); and
19. Treatment which started while the patient was not eligible for this Plan's Dental Benefits.

Limitations

Dental Care Benefits for Orthodontic Treatment *are not* payable for:

1. A Dependent other than a Dependent child;
2. Any orthodontic treatment program that began on or after the Dependent child's 19th birthday;
3. Any orthodontic treatment procedures performed after the first 24 months that appliances are placed.
4. Dental Care Benefits are subject to all General Plan Exclusions and Limitations.

SECTION IV - VISION CARE BENEFITS

When you or your Dependent incurs expenses for vision care, the Plan will pay those expenses up to the maximum amount shown in the Schedule of Benefits and as described in this Section. There is **no deductible** required by the Plan before Vision Care Benefits become payable.

The Maximum Amount

Payments under the Vision Care Benefits are limited to the individual maximum as shown in the Schedule of Benefits.

Covered Expense

Services or supplies must be provided by an Optician, Optometrist, or Ophthalmologist to be considered Covered Expenses. Typical services are shown below.

1. Vision Examination
2. Vision analysis may be done. Vision analysis includes:
    a. complete case history;
    b. measuring and recording of visual acuity, corrected and uncorrected; distance and near, with new prescription if required.
    c. examination of fundus, media, crystalline lens, optic disc and pupil reflex for pathology, anomalies or injury, corneal curvature measurements, retinoscopy;
    d. fusion determination, distance and near, subjective determination, distance and near, and stereopsis determination, distance and near;
    e. color discrimination and amplitude or accommodation;
    f. analysis of findings, lens prescription (if needed); and
3. Contact Lenses or Lenses and Frames. Related services and supplies include:
    a. professional advice on frame selection;
    b. facial measurement, and preparation of specifications for optical laboratory and verifying and fitting of prescription glasses or contact lenses;
    c. re-evaluation and progress report after fitting new prescription and subsequent servicing.
4. Lasik Surgery
    a. limited to the maximum benefit as shown in the schedule of benefits, and is limited to once per lifetime per eye.

Limitations

Vision Care Benefits *are not* payable for:

1. Examinations or materials more frequently than specifically provided;
2. Lenses, frames or contact lenses which are lost or broken except at the normal intervals when benefits are available;
3. Special procedures such as orthoptics, vision training or aniseikonia;
4. Sun glasses or tinted glasses;
5. Services or supplies not listed as covered vision expenses;
6. Services, treatment or supplies, related to medical or surgical treatment of the eyes;

7. Services, treatment or supplies which are rendered or finished before the date a person becomes initially eligible or after the date a person's eligibility terminates;
8. Both normal glasses with frames and/or contact lenses more frequently than specifically provided;
9. Contact lenses or lenses except the first pair immediately required after cataract surgery;

Vision Care Benefits *are* payable for one set of contact lenses or glasses per calendar year, ***but not both.***

Vision Care Benefits are also subject to all General Plan Exclusions and Limitations.

SECTION V - DEATH AND DISMEMBERMENT BENEFITS (EMPLOYEES ONLY)

Death Benefits

If you die from any cause, a Death Benefit is payable in the amount specified in the Schedule of Benefits. The Fund Office must be provided with acceptable proof of death on forms provided by the Trustees.

Beneficiary Designation

You must file a written designation of Beneficiary with the Fund Office on a properly completed form. If you have not made an irrevocable designation of Beneficiary, you may name a new Beneficiary without your prior Beneficiary's consent, by filing a new form with the Fund Office. The change of Beneficiary will be effective retroactively to the date you sign the form, whether or not you are living when the Fund Office receives it. The Plan is not responsible for any payments made before the change of Beneficiary form is received. If you do not designate a Beneficiary or if your Beneficiary does not outlive you, the Death Benefit will be paid to the living in the following order:

1. Spouse;
2. Children, including legally adopted children;
3. Parents;
4. Brothers and sisters; or
5. Executor or administrator of the Employee's estate.

If two or more persons are entitled to the Death Benefit, they will share equally.

Notice of Claim

Written notice of the death of an Employee whose coverage has been continued under this provision must be given to the Fund Office within 12 months of the date of death. If written notice is not given within such 12 month period, the Plan will not be liable for any person on account of that death.

Accidental Death and Dismemberment Benefits

If you lose a limb or an eye or if you die from a bodily injury, the Plan will pay benefits up to the Principal Sum in the Schedule of Benefits provided:

1. The injury was caused solely by an accident occurring while you are eligible in the Plan;
2. The loss is directly related to the accident and is independent of all other causes; and
3. The loss occurs within 90 days after the accident.

The amount of Benefit payable is based on the type of loss. The entire Principal Sum ($15,000) will be paid for the following losses:

Life or
Both hands, or
Both feet, or
Both eyes, or
One hand and one foot, or
One hand and one eye, or
One foot and one eye.

One-half the Principal Sum ($7,500) will be paid for the following losses:

One hand, or
One foot, or
One eye.

One-fourth the Principal Sum ($3,750) will be paid for loss of the thumb and index finger of the same hand.

"Loss" with reference to a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" with reference to an eye means the irrecoverable loss of the entire sight thereof. "Loss" with reference to the thumb and index finger means severance of two or more phalanges of both the thumb and index finger.

Payment of Benefits

Benefits payable for Accidental Death under this section will be paid to the Beneficiary or Beneficiaries as determined for death by normal causes. Benefits payable for Dismemberment under this section will be payable to you. Accidental Death and Dismemberment Benefits are paid in a lump sum. If two or more persons are entitled to the Death Benefit, they will share equally.

Limitations

Accidental Death and Dismemberment Benefits will be paid only for the greatest of the above losses if more than one loss results from any one accident.

Accidental Death and Dismemberment Benefits *are not* payable for any loss:

1. Which is not permanent;
2. Which occurs more than 90 days after the injury;
3. Which results from:
   a. Alcohol, drug or substance abuse, or
   b. Self-destruction or injury and/or attempted self-destruction or injury,

   unless due to an underlying physical or mental condition;
4. Which results from your participation in a riot or in the commission of a felony;
5. Which results from an act of declared or undeclared war or armed aggression;
6. Which is incurred while you are in training or on active duty in the armed forces, National Guard or Reserves of any state or country;
7. For which any governmental body or its agencies are liable,
8. Which results from mental or bodily infirmity, including ptomaines, bacterial infections or disease;
9. Which results from medical or surgical treatment.

Accidental Death and Dismemberment Benefits are not payable for any loss you sustain while in any aircraft:

1. Which results from injuries you receive while the aircraft is engaged in racing, endurance testing, acrobatic or stunt flying;
2. Other than while riding as a passenger in a commercial aircraft on a regularly scheduled flight.

Accidental Death and Dismemberment Benefits are also subject to all General Plan Exclusions and Limitations.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and general limitations apply to all benefits provided by the Fund unless specifically waived by a particular benefit section.

Routine Care and Elective Procedures

Benefits under this Plan are for the treatment of sickness or accidental bodily injury when rendered by hospitals and physicians. Routine care, cosmetic surgery, diet medication or supplements, which are not medically necessary to correct a condition which threatens the health of an Eligible person are not eligible for Benefits from this Plan. The Trustees reserve the right to have an Eligible Person examined by a physician of their own choice and at their own expense to make their determination regarding any benefit payable or eligibility rule of this Plan.

Treatment designed to merely improve bodily functions is not considered medically necessary or an eligible expense for benefits.

Medical Necessity

Benefits under this Plan are payable only for services and supplies which are considered by the Trustees to be medically necessary in view of the patient's condition and diagnosis; this determination of medical necessity applies equally to medical/surgical benefits and mental or nervous disorder and substance abuse benefits. For example, non-emergency hospital admission and confinement over a weekend will be presumed not medically necessary and not an eligible expense incurred. Hospital admission for surgery which is generally performed on an out-patient basis will not be considered eligible for benefits unless such admission is medically necessary due, for example, to a co-existent medical condition.

Work Related Disabilities

Payment will not be made by the Plan for expenses incurred because of disease, defect or accidental injury which occurs during, or arises out of, any occupation for wage or profit. If the Eligible Person's claim under Workers' Compensation or any Occupational Disease Law is rejected, the illness or injury will not be considered work-related and payment will be made.

1. A claim under Workers' Compensation will be considered to have been rejected under the following circumstances:
    a. when, after a hearing in the Illinois Industrial Commission (or a corresponding agency in another state), there has been a final administrative determination denying the claim and no lawsuit seeking court review of the decision has been filed; or
    b. when a decision has been rendered by the Illinois Industrial Commission (or corresponding agency in another state), a party has sought court review of the decision and a final court determination has been made rejecting the claim.

Organ Transplants

Payment will be limited to the usual, customary and reasonable fee schedule incurred as a result of any type of organ transplants, such as, but not limited to the liver, lung, heart, kidney or cornea.

Reasonable and Customary Charges

Payment will not be made by this Plan for any expense incurred or charge made, which the Trustees determine is not reasonable or customary as defined herein.

Treatment Without Charge

Payment will not be made for confinement in any hospital or treatment by a physician when the hospital or physician makes no charge that the Eligible Person is legally required to pay or would not be charged in the absence of these benefits.

Illegal Occupation or Act or Commission of Felony

Any condition, disability, or expense resulting from or sustained as a result of being engaged in: 1) an illegal act or occupation which is considered to be a felony in the jurisdiction in which the act occurred, regardless of whether charged or convicted; 2) commission or attempted commission of assault, battery, criminal trespass, criminal damage to property, theft, robbery, burglary, or arson, regardless of whether charged with or convicted of a felony; or 3) participation in civil insurrection or riot; provided, however, that this exclusion shall not apply if the condition, disability or expense resulted from a medical condition.

Accidental Injuries For Which a Third Party May Be Liable

No benefits will be paid to you or your eligible dependent for expenses incurred due to an accidental injury for which a third party may be liable unless you and/or the eligible dependent sign a subrogation/repayment agreement in a form approved by the Trustees. Under the terms of this subrogation/repayment agreement you, or your dependent, must agree, that if you recover amounts from a third-party relating to your accidental injury, you will repay the Fund the benefits which had been paid, without deduction for expenses or attorneys fees.

Under the provisions of the subrogation/repayment agreement, if you or your dependent does not prosecute a claim against a third-party to recover for injuries, then you or your dependent must agree to authorize the Fund, at its option, to bring a claim in the name of you or your dependent against the third-party, including the filing of a lawsuit in court. You or your dependent must agree to cooperate fully with the Fund in any action which the Fund may take. You and your dependent must not do anything, or sign anything, after a loss for which the Fund paid benefits which impairs the Fund's right to recover the benefits paid.

If you or an eligible dependent accept a settlement or receive an award, future medical expenses for any injury or illness that had been caused by the third party are not eligible expenses under this Plan.

Liability for Accidental Injuries

Benefits under this Plan are considered secondary and excess coverage, including but not limited to, any automobile insurance or individual common carrier's liability (such as bus or commercial airline). No payment shall be made until proof is submitted to and judged acceptable by the Trustees that a proper claim has been made for other coverage. Normal Plan benefits shall be paid if other coverage has been denied or shall be coordinated with other coverage payments, if any.

General Limitations

Benefits of this Plan ***do not cover*** any loss caused by, incurred for, or resulting from:

1. Declared or undeclared war, or any act thereof, or military or naval services of any country;
2. Services, treatment or supplies received from a dental or medical department maintained by a mutual benefit association of this or another employee benefit plan or labor union;
3. Services, treatment or supplies, which are payable or furnished under any policy of insurance or other medical benefit plan or service plan for which the Trustees shall, directly or indirectly, have paid for all or a portion of the cost;
4. Services or treatment rendered or supplies furnished primarily for cosmetic purposes;
    a. Necessary for the prompt repair of an accidental bodily injury or sickness or disease; and
    b. Performed within two years of a covered event;
5. Expenses incurred for services performed or supplies furnished by other than a physician;
6. Services, treatment, or supplies rendered or furnished:
    a. Before the individual concerned became an Eligible Person; or
    b. Without the recommendation and approval of a legally qualified physician;
7. Physical therapy, supplies or prosthesis for sexual dysfunction or inadequacies;

8. Implantation within the human body of artificial mechanical devices designed to replace human organs other than pacemakers or similar such devices which merely assist rather than replace the function of the organ;
9. Ambulance service or transportation between cities or states (such as by ambulance, air ambulance, railroad or bus) unless judged by the Trustees as essential for treatment of a life-threatening illness or injury;
10. Growth hormones;
11. Expenses incurred for the purpose of reversing tubal ligations, vasectomies or other sterilization procedures;
12. Special home construction to accommodate a disabled person;
13. Education, special education, job training or work hardening whether or not given in a facility that also provides medical or psychiatric treatment beyond the first medically necessary visit. Special education or like services, regardless of: the type of education, the purpose of the education, their recommendation of the attending physician or the qualification of the individual rendering the educational services;
14. Rest cures or custodial care;
15. Speech therapy, other than charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) while eligible in the Plan and as the result of a disease or accidental injury. Speech therapy to improve speech in the absence of disease or accidental injury (such as for a learning disability or speech delay) is considered special education and is not covered;
16. Supplies or equipment for personal hygiene, comfort or convenience;
17. Services, treatment or care rendered by a member of the Eligible Member's family;
18. Treatment or services for or in connection with child, career, social adjustment, pastoral, or financial counseling;
19. Treatment or services for primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, or carbon dioxide therapy;
20. Charges incurred for travel, whether or not recommended by a physician;
21. Fertility or infertility benefits except as provided by Progyny as described on page 34;
22. Expenses for services related to sex transformations or sexual dysfunctions or inadequacies (including impotency), other than diagnosis and treatment of organic impotency;
23. Voluntary acceptance of extraordinary risks such as speed contests or fighting;
24. Programs or prescription medications for the purpose of smoking cessation (must be submitted through the prescription drug program);
25. Pre-natal vitamins (submitted through the prescription drug program);
26. Charges incurred for any abortion procedure performed on a dependent child except where the pregnancy is the result of rape as evidenced by a Police Report;
27. Any condition, disability, or expense incurred resulting from Court Ordered Treatment of any kind;
28. Acupuncture;
29. Supplies or equipment for cleaning or maintaining a CPAP machine;
30. Genetic testing; and
31. Gene therapy.

General Plan Provisions

Physical or Dental Examination and Autopsy

The Trustees at their own expense have the right and opportunity to examine the person or any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during pendency of claim under the Plan, and to make an autopsy in case of death, where it is not forbidden by law.

Free Choice of Physician

The covered person has free choice of any physician and the physician-patient relationship will be maintained.

Workers' Compensation Not Affected

The Plan is not in lieu of and does not affect any requirement for coverage of Workers' Compensation insurance.

Time Limits for Filing Claims

The Fund will furnish to the claimant, on request, the forms approved by the Trustees for filing proof of loss covered under this Plan. The Trustees may accept other written forms as proofs of loss, if in their sole judgment, the written proofs contain complete and credible information as to the occurrence, character and extent of the loss for which the claim is made.

Written proof of expense incurred due to hospital confinement or due to total disability must be furnished to the Fund within 90 days after the termination of the period for which the claim is made. Written proof of other covered expense incurred must be furnished within 90 days of the date the expense is incurred. Failure to furnish notice or proof of loss within the time period provided in the Plan will not invalidate or reduce any claim:

- if it was not reasonably possible to give proof within that time; and
- if proof is furnished as soon as reasonably possible; and
- no later than 24 months from the time proof is otherwise required (except this time limit will not apply to a claimant who is legally incapacitated).

Benefits payable under the Plan for any loss other than Weekly Accident and Sickness Benefits will be paid as they accrue and upon receipt of due written proof of loss. Subject to due written proof of loss, Weekly Accident and Sickness Benefits will be paid at the times set forth in the applicable benefit provision.

Circumstances That May Result in Loss of Eligibility of Benefits

Throughout this booklet the Trustees have tried to bring to your attention those circumstances, which might lead to a loss of eligibility and to describe any limitations, exclusions, or restrictions applicable to specified benefits.

The Trustees urge you to familiarize yourself with this information, especially as it relates to the requirements, which must be met in order to maintain your eligibility for benefits.

REMEMBER: You must work the required number of hours or make timely self-payments in order to maintain your eligibility.

If at any time you are uncertain about how a specific circumstance might affect your eligibility or benefit coverage, please contact the Fund Office and, if possible, try to do so before any circumstance arises.

Claims Review and Appeal Procedures

Claim Appeal

If you are not satisfied with the action taken on your claim, you have the right to appeal. The procedures for the appeal are set forth below.

In reviewing your claim every effort will be made by the Trustees to handle interpretations of the Plan and claims disputes in a consistent and equitable manner. The Trustees have full discretionary authority to determine eligibility for benefits under the Plan and to interpret the Plan, all Plan documents, Plan rules, and procedures,

and the terms of the Trust Agreement. Their decisions and interpretations will be given the maximum deference permitted by law for the exercise of such full discretionary authority and will be binding upon all persons involved.

Your Right to Request Review of an Adverse Benefit Determination

Most questions or concerns about decisions the Claims Administrator makes on claims or requests for benefits can be resolved through a phone call to the Claims Administrator.

In addition, the Employee Retirement Income Security Act of 1974, as amended (ERISA) claims procedure regulations protect you by providing you the opportunity to request review of an adverse benefit determination.

An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in your employer's health plan. You may request review of an adverse benefit determination on a pre-service claim, an urgent care claim, or a post-service claim.

Types of Claims Covered

For purposes of the procedures set forth below, the following terms are used to define health claims:

- **Urgent Health Claims:** claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;
- **Pre-Service Health Claims:** for example, pre-certification of a hospital stay or predetermination of dental coverage;
- **Post-Service Health Claims:** for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician, and
- **Concurrent Claims:** claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by Plan amendment or Plan termination.
- **Rescission of Coverage:** retroactive cancellation of coverage.

Initial Submission of Claims

Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, medical claims should be submitted to BCBSIL, prescription drug claims should be submitted to SavRx, and dental and all other claims for benefits (including eligibility claims) should be submitted to the fund office.

Notice That Additional Information is Needed to Claim

- After the claim is submitted, the Fund deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:
  - For Urgent Health Claims – 24 hours after receiving improper claim.
  - For Pre-Service Health Claims – 5 days after receiving improper claim.
- After receipt of notice from the Fund that the claim is incomplete, the Claimant's deadline to supply the Fund the information requested to complete claim is:
  - For Urgent Health Claims – 48 hours after receiving notice.
  - For Pre-Service Health Claims – 45 days after receiving notice.
  - For Post-Service Health Claims – 45 days after receiving notice.
  - For Disability Claims – 45 days after receiving notice.

Avoiding Conflicts of Interest

The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

Initial Decision on a Claim

- Additional Evidence:
  - The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and
  - Before the Fund can issue an initial benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.
- The Fund deadline for making an initial decision on a claim is:
  - For Urgent Health Claims – As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim; or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.
  - For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension is permitted if the Plan needs more information and it has provided notice of same to the Claimant during the initial 15 day period. Fund deadline for responding is tolled while awaiting requested information from the Claimant.
  - For Post-Service Health Claims – 30 days after receiving the initial claim. A 15-day extension is permitted if the Plan needs more information and has provided notice of same to the Claimant during the initial 30 day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.
  - For Disability Claims – 45 days after receiving the initial claim. A 30-day extension is permitted if the Plan needs more information and has provided proper notice of same to the Claimant. An additional 30-day extension is permitted if the Plan needs more information and has provided notice of same to the Claimant during the first 30-day extension. Fund deadline for responding is tolled while awaiting additional information from Claimant.

Adverse Benefit Determination.

Notice of an adverse benefit determination will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- the internal rule or similar guideline relied upon in denying the claim;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the claimant for which the timeframe for completion of the internal appeal would jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function;

- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal; and
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272.

Internal Appeals

- **Adverse Benefit Determinations**

  A Claimant may appeal any Adverse Benefit Determination received under Section 7.6. An Adverse Benefit Determination means any of the following:

  - a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;
  - a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
  - failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
  - rescission of coverage.

- **Submission of Internal Appeals.**

  An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the Claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal appeal.

  The Plan will continue to provide coverage for an ongoing course of treatment pending the outcome of an internal appeal.

  The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals should be submitted as follows:

  NECA-IBEW Local No. 364 Welfare Fund
  6525 Centurion Drive
  Lansing, MI 48917-9275
  Attn: Board of Trustees

- **Time for Submitting Internal Appeals.**

  A Claimant must appeal a benefit denial within the following time limits:

  - For Urgent Health Claims – 180 days after receiving denial.
  - For Pre-Service Health Claims – 180 days after receiving denial.
  - For Post-Service Health Claims – 180 days after receiving denial. In addition, for those claims administered by BCBS, the second appeal to Trustees must be made within 30 days of the BCBS appeal denial.
  - For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.
  - For Disability Claims – 180 days after receiving denial.

ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED ON INTERNAL APPEAL, ON EXTERNAL REVIEW, OR IN A COURT OF LAW.

- **Notice of Decision on Internal Appeal.**

  The notice of a decision on appeal will include:

  - the specific reasons for the denial;
  - the specific Plan provision or provisions on which the decision was based;
  - a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
  - the internal rule or similar guideline relied upon in denying the claim;
  - if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
  - information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable),
  - a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
  - a description of the external review process, including information regarding how to initiate the external review process;
  - a statement of the Claimant's right to bring a civil action after a further denial on appeal or external appeal, if applicable; and
  - the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration.

  The Fund deadline for deciding an appeal of a benefit denial and notifying the Claimant of its decision is:

  - For Urgent Health Claims – 72 hours after receiving appeal.
  - For Pre-Service Health Claims – The Trustees shall decide the appeal 30 days after receiving the appeal
  - For Post-Service Health Claims – The Trustees shall decide the appeal at a Board Meeting.
  - For Concurrent Claims – Prior to termination of previously approved course of treatment.
  - For Disability Claims – The Trustees shall decide the appeal at a Board Meeting.*

** Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third Board Meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than five days after the decision is made.*

External Appeals

If you appeal to the Board of Trustees, but the review process still results in an adverse benefit determination (denial), you may, in certain cases, request an additional review by an independent review organization (IRO). An external review is available for claims denied based on clinical or scientific judgments, such as decisions based on medical necessity. It does not apply to claim denials related to a person's eligibility for coverage or specific Plan exclusions.

A request for an external appeal review must be filed with the Plan within four months of the date the claimant receives a notice that his/her internal appeal has been denied. If the deadline falls on a Saturday, Sunday, or federal holiday, the time limit will be extended to the next working day.

Within five business days following receipt of a request for an external appeal, the Fund will complete a preliminary review to determine whether the claim is eligible for an external appeal. Within one business day

after completing the preliminary review, the Fund will send a notice to the claimant. That notice will contain ONE of these three responses:

- The notice will advise that the claim is eligible for an external appeal and the appeal will be processed as described below. OR:
- The notice will advise that the claim is eligible for an external appeal but some information or forms are missing. If anything required for an external appeal is missing, the notice will describe the information or materials needed to make the request complete and the Fund will allow the claimant to complete the request for an external appeal. This must be done within the four-month filing period described above, but the claimant will have no less than 48 hours from receipt of the notice. OR:
- If the claim is NOT eligible for an external appeal, the notice will advise the claimant of the reason(s) for that ineligibility and will give the claimant contact information for the Employee Benefits Security Administration of the Department of Labor (toll-free number 866-444-EBSA (3272)).

The Fund will assign an independent review organization (called an "IRO") to process the external appeal. The IRO must be accredited by URAC or a similar nationally recognized accrediting organization. External appeals will be assigned to an IRO on a rotating basis to ensure independence and impartiality. The assigned IRO will notify the claimant in writing that his/her external appeal will be processed. This notice will include a statement that the claimant may submit in writing to the assigned IRO, within ten business days of the date of receipt of the notice, additional information for the IRO to consider when conducting the external review. The IRO is permitted to, but is not required to, accept and consider additional information submitted after ten business days.

Within five business days after the claim has been assigned to an IRO, the Fund will provide to the assigned IRO the documents and any information considered in making the claim determination or the decision on the internal appeal. Failure by the Fund to timely provide such documents and information will not delay the processing of the external appeal.

Upon receipt of any information submitted by the claimant, the assigned IRO will, within one business day, forward that information to the Fund. Upon receipt of any such information, the Fund may reconsider its prior denial, although reconsideration by the Fund will not delay the processing of the external appeal. Within one business day after making such a decision, the Fund will provide written notice of its decision to the claimant and to the assigned IRO. The assigned IRO will then terminate the external appeal.

The IRO will review all of the information and documents that were timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Fund's internal appeals process. In reaching a decision, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the claimant's medical records, the recommendation of the attending health care professional, reports from other appropriate health care professionals, appropriate practice guidelines, applicable clinical review criteria and other documents submitted by the Fund. The IRO's decision will be consistent with the terms of the Fund's plan of benefits, unless those terms are inconsistent with applicable law.

The assigned IRO will provide written notice of the final external appeal decision within 45 days after the IRO receives the request for the external appeal. The IRO will deliver the notice of final external appeal decision to the claimant and the Fund. The IRO's written decision will be binding on both the claimant and the Fund, except to the extent that other remedies may be available under federal law. The IRO's decision will also advise that judicial review may be available to the claimant. If the IRO's decision reverses the Fund's benefit determination, the Fund will immediately provide coverage or payment of the claim.

An "expedited" external appeal is available if a claim has been denied and if:

- The claim was denied based on clinical or scientific judgments (see the first criterion for standard (non-expedited) external appeals for examples), and
- The denial of the claim involves a medical condition of the claimant for which the time required to complete an internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or

- The claimant filed an internal appeal, which was denied, and the time required to complete a standard (non-expedited) external appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function.

A claimant must request an expedited external appeal. The Fund will not evaluate the claimant's circumstances to see if he/she satisfies these criteria unless the claimant, in writing, specifically requests an expedited external appeal. Immediately upon receipt of such a request, the Fund will determine whether the request meets either of the criteria stated above and will also evaluate if the claim meets the requirements a standard (non-expedited) external appeal, except that the claimant need not have filed an internal appeal. The Fund will immediately evaluate the claimant's request and will provide the claimant a notice advising that:

- The claim is eligible for an expedited external appeal and the appeal will be processed as described below, OR
- The claim is eligible for an external appeal, but some information or forms are missing. If anything required for an external appeal is missing, the notice will describe the information or materials needed to make the request complete, and the Fund will allow the claimant to complete the request for an external appeal. This must be done within the four-month filing period for an external appeal, but the claimant will have no less than 48 hours from receipt of the notice.
- If the claim is NOT eligible for an expedited external appeal, the notice will advise the claimant of the reason(s) for that ineligibility and will give the claimant contact information for the Employee Benefits Security Administration of the Department of Labor (toll-free number 866-444-EBSA (3272)).

Upon a determination that a claim is eligible for expedited external appeal, the Fund will immediately assign an IRO to process the appeal, following the general procedures applicable to a standard external review, except that the Fund will transmit all necessary documents and information regarding the claim to the assigned IRO, and will identify the appeal as an expedited appeal. The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external appeal. The IRO will notify the claimant and the Fund of the final external appeal decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external appeal. If the IRO's decision is not given in writing then, within 48 hours after the date of the oral notice of the decision, the IRO will provide written confirmation of the decision to the claimant and the Fund.

An external review is also available with respect to adverse benefit decisions that involve coverage for Emergency Medical Services received at Non-Network facilities, services received from out-of-network providers at in-network facilities, air ambulance services, services provided by out-of-network providers believed to be in-network providers, and services provided to Continuing Care Patients (all as determined above) in order to determine compliance with the surprise billing and cost-sharing protections under the No Surprises provisions found in the Consolidated Appropriations Act of 2021.

Discretion of Trustees.

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

Limitations of Actions.

For adverse benefit denials not subject to external review, no action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal. For adverse benefit denials subject to external review, a request for external review must be made within the time limitations provided in this Section. In the event a Claimant does not abide by these time limitations, he/she waives his/her right to any further review of an adverse determination, including waiving his/her right to have the determination reviewed in a court of law.

How Benefits Are Reduced

Coordination of Benefits With Other Group Plans

To alleviate the problem of excess coverage, which needlessly increases the costs of protection, all the Plan benefits will be coordinated with the following coverage:

1. Individual, group, blanket, franchise, general liability, common carrier insurance coverage; or
2. Hospital or medical service organizations, group practice, and other prepayment coverage; or
3. Any coverage under any labor-management trusted plans, union welfare plans, employer organization plans or Employee benefit organization plans; or
4. Any coverage under governmental programs or any coverage required or provided by any statute.

Benefits will be reduced under certain circumstances when an individual is covered under this Plan and under one or more other plans, but it is intended that the individual will be fully reimbursed for allowable expenses under the various plans to the extent combined benefits equal one hundred (100%) percent of the total allowable expenses.

Benefit Determination

As stated above, the Plan will coordinate benefits with all group programs providing coverage to the Employee or his dependent for all claims.

1. When the other group plan does not have a provision for Coordination of Benefits, they must be considered the primary carrier and must make benefit payment first before this Fund will consider payment.
2. When the other group plan does have a provision for Coordination of Benefits, the order of benefit payments will be determined as follows:

The eligible person must claim benefits due from the "primary" plan determined by these rules for its share of eligible expenses, including benefits or services available from prepayment coverage programs such as Health Maintenance Organizations. When this Plan is "secondary" according to the established order of benefit determination, the term "benefits payable under another Plan" will include the benefits that would have been paid if the eligible person made a proper claim on that Plan or used its services. This Plan's liability and its benefit payments will not increase simply because the eligible person elects not to use the "primary" coverage.

Claim for a Covered Employee

The covered employee must first submit all charges to the group with the earliest effective date. After the charges have been considered, copies of all charges and payment statements should then be submitted to the secondary plan for consideration.

When Claim is on the Dependent Spouse

1. The other plan, (the plan covering the spouse as Employee), will, without exception, pay benefits first when the claim is on the spouse.
2. This Plan, (which covers the spouse as a dependent), will pay second and will coordinate with the other plan.

When Claim is for a Dependent Child

The Trustees have adopted, in principle, the coordination provision known as the "birthday rule". The "birthday rule" provides that:

In claims involving children, the order of benefit payments will be as follows:

1. The plan covering the parent whose birthday occurs earliest in the calendar year will pay first.
2. The plan covering the parent whose birthday occurs later in the calendar year, and having a provision for Coordination of Benefits, will pay second.

Special Note: If an Employee covered under this Plan has two types of group coverage, the plan with the earliest effective date must pay first. The Plan covering the Employee for the shortest period of time will consider the balance due upon receipt of:

1. A copy of itemized bills; and
2. A copy of the payment statement.

If there is a divorce and/or remarriage, the financial and medical responsibility is generally stipulated by court decree. If the decree does not stipulate the responsibility, or if one of the parents has remarried, there are special rules applied. Members are required to submit legal documents that are requested by the Fund Office so that the order of benefit determination can be established. Contact the Fund Office for further information.

Coordination of Benefits with Medicare

When you or your Dependent becomes eligible for Medicare (officially known as Title XVII of the Social Security Amendments of 1954, amended effective July 1, 1973, and as thereafter may be amended) in addition to this Plan, the Trustees require that you enroll in Medicare Part A (hospital) and Part B (medical). This applies whether you are eligible due to attained age or to a qualifying disability.

Effect on Benefits

When a person is eligible in this Plan and in Medicare, Medicare generally is required to pay first. Benefits payable by this Plan may be reduced by the amount Medicare pays, but only if the total of this Plan's normal benefits and Medicare's payment will be more than one hundred percent (100%) of eligible expenses.

You or your Dependent will be considered to be currently eligible and covered by Medicare as soon as you would be eligible to enroll whether or not you actually enroll as you should.

Limitations

To comply with Federal regulations, the provision will not apply to an Employee who is still eligible in this Plan due to Employer contributions or to the spouse of such an Employee.

Medicare will always be required to pay first when eligible expenses are incurred by:

1. Persons eligible due to self-payments of contributions to this Plan; or
2. Retired Employees and their Dependents; or
3. Employees eligible for Medicare on the basis of permanent kidney failure, after the first eighteen (18) months of treatment.

Subrogation

The Trustees of the Welfare Fund may elect to use their right of Subrogation if you or an eligible Dependent are paid benefits by the Plan due to accidental injuries or sickness for which someone else may be liable. Subrogation means that the Trustees can regain, by legal action if necessary, benefits paid in your behalf by the Fund from the person who caused the injury or that person's insurance company. The Trustees believe that subrogation will result in savings for the Fund for the benefit of all Eligible Persons because the cost of treatment for such accidental injuries will be the responsibility of the insurance company of the person who caused or contributed to the accident.

If the Trustees enter into a Subrogation Agreement with you, your claims and benefit payments will normally continue to be paid in the same way as they were previously. However, you or your Dependent will have certain responsibilities to the Welfare Fund as claimant. An Eligible Person who receives benefits from the Fund under these circumstances must sign and deliver all related papers and forms to the Fund and must do whatever else is necessary to help the Fund administer this subrogation clause. An Eligible Person must not do anything or sign any document, which may impair the Fund's right to recover the benefits paid relative to the loss.

If you or an Eligible Dependent becomes ill or is injured and a third party is responsible, you may be able to recover expenses from a responsible third party, Worker's Compensation coverage, the insurer, or a group plan. If it happens, the Trustees have the right to require you to repay any applicable benefits you received from this Plan. The Trustees may, at their own discretion pursue a claim against any third party, including the filing of a claim in court. If you or an Eligible Dependent accept a settlement or receive an award, future medical expenses for any injury or illness caused by the responsible third party are not eligible expenses under this Plan.

STATEMENT OF PARTICIPANT'S RIGHTS

Information Required by the Employee Retirement Income Security Act (ERISA)

Introduction

You have probably heard about ERISA. ERISA stands for the Employee Retirement Income Security Act, which was signed into law in 1974.

This federal law establishes certain minimum standards for the operation of employee benefit plans including the NECA-IBEW Local No. 364 Health and Welfare Fund. The Trustees of your Fund, in consultation with their professional advisors, have reviewed these standards carefully and have taken the steps necessary to assure full compliance with ERISA.

ERISA requires that Plan participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits, and the procedures to follow when filing a claim for benefits. This information has already been presented in the preceding pages of this Summary Plan Description.

ERISA also requires that participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan. This information follows:

READ THIS SECTION CAREFULLY. Only by doing so can you be sure that you have the information you need to protect your rights and your best interests under this Plan.

Your Rights as a Participant

As a participant in the Fund:

1. You will automatically receive a Summary Plan Description (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.
2. If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA.
3. Each year you will automatically receive a summary of the Plan's latest annual financial report. A copy of the full report is also available upon written request.
4. You may examine, without charge, all documents relating to this Plan. These documents include: the legal Plan Document, collective bargaining agreements, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as annual reports and Plan descriptions. Such documents may be examined at the Fund Office (or at other required locations such as work sites or union halls) during normal business hours.

To assure that your request is handled promptly and that you have given the information you want, the Trustees have adopted certain procedures which you should follow:

- Your request should be in writing;
- It should specify what materials you wish to look at; and
- It should be received at the Fund Office at least three days before you want to review the materials at the Fund Office.

Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you want available at any work site or union location at which 50 or more participants report to work. Allow ten days for delivery.

5. You may obtain copies of any Plan document upon written request to the Trustees, addressed to the Fund Office. ERISA provides that the Trustees may make a reasonable charge for the actual cost of reproducing any documents you request.

You are entitled to know, however, what the charge will be in advance. Just ask the Fund Office.

6. No one may take any action which would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.
7. In accordance with Section 503 of ERISA and related regulations, the Trustees have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim.
8. These procedures appear in the Appeal section of this booklet. Basically, they provide that:
   - If your claim for a welfare benefit is denied in whole or in part, you will receive a written explanation of the reason(s) for the denial.
   - Then, if you are still not satisfied with the action on your claim, you have the right to have the Plan review and reconsider your claim in accordance with the Plan's claims review procedures.
   - These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented on your behalf.
9. In addition to creating rights for Plan participants, ERISA also defines the obligations of people involved in operating employee benefit plans.

   These persons are known as "fiduciaries". They have the duty to operate your Plan with reasonable care and with your best interests in mind as a participant under the Plan.

   Be assured that the Trustees of this Plan will do their best to know what is required of them as "fiduciaries" and to take whatever actions are necessary to assure full compliance with all state and federal laws applicable to the Plan.
10. Under ERISA, you may make certain actions to enforce the rights listed above.

    - For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court.

      Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that:

      - the request was actually received, and
      - the material was mailed to the right address, or
      - the failure to send the material was not due to circumstances beyond the Trustees' control.

      If you are still not able to get the information you want, you may wish to take legal action. The Court may require the Trustees to provide the materials promptly and/or pay you a fine until you actually receive the materials (unless the delay was caused by reasons beyond the Trustees' control).
    - Although the Trustees will make every effort to settle any disputed claims with participants fairly and promptly, in accordance with the Fund's rules, there is always the possibility that differences can not be resolved to everyone's satisfaction.

      For this reason, you may file suit in a state or federal court if you feel that you have been improperly denied a benefit. Before exercising this right, however, you will normally find it advisable to exhaust all the claim review procedures available under your Plan and then proceed only upon the advice of your attorney.
    - If it should happen that Plan fiduciaries misuse the Plan's money or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

      The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

      If you lose, the court may order you to pay these costs and fees. For example, if the court finds your claim is frivolous, you may be required to pay court costs and legal fees.

We hope this Summary Plan Description has provided you with most important information about your Plan and your rights under ERISA.

If you have any questions about your Plan, you should contact the Trustees by writing to: IBEW Local Number 364 Health and Welfare Fund, 6525 Centurion Drive, Lansing, Michigan, 48917-9275 or telephone the Fund Office: (517) 321-7502 or (877) 364-4239.

If you have any questions about this Statement or about your rights under ERISA which have not been answered in this Summary Plan Description or by the Fund Office, you should contact the nearest Area Office of the U.S. Department of Labor. The Fund Office will be glad to furnish the address.

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Participants will be notified of any plan changes.

OTHER IMPORTANT INFORMATION

The Trustees Interpret the Plan

Under the Trust Agreement creating the Welfare Fund, and the terms of this Plan, the Board of Trustees has the sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan and any administrative rules adopted by the Trustees. The Trustees have full discretionary authority to interpret and construe the Plan, all Plan Documents, the Trust Agreement, and all Plan rules and procedures. The Trustees interpretation will be given the maximum deference permitted by law for the exercise of such full discretionary authority. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to the Plan, and the Welfare Plan provides, that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Any interpretation of the Plan's provisions rests with the Board of Trustees. **No employer or union**, nor any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board nor can an employer or union act as an agent of the Board of Trustees.

However, the Board of Trustees has authorized the Administrative Manager and the Fund Office staff to handle routine requests from participants regarding eligibility rules, benefits, and claims procedures. But, if there are any questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for a final determination.

The Plan Can Be Changed

The Trustees have the legal right to change the Plan, subject to any collective bargaining agreement that applies to it.

Although the Trustees hope to maintain the present level of benefits and to improve upon them if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. To do so may require Plan changes from time to time.

Changes in the Plan may also be required in order to preserve the Fund's tax exempt status under Internal Revenue Service rules and regulations. These rules and regulations may change and as a result, Trustees may find it necessary to change Plan provisions so that the Trust does not lose its tax exempt status.

Your Plan is Tax Exempt

Your Welfare Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the employers contributions to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefits paid on your behalf are not taxable as personal income. Also, investment earnings on Plan assets are excluded as taxable income of the Trust since they are specifically set aside for the purpose of providing benefits to participants.

Obviously, such tax exemption works to the benefit of both employer and employee. In effect, it means that money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses.

The Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Plan "Qualified" as a tax exempt Trust under Internal Revenue Service rules.

Right to Receive and Release Necessary Information

To determine the applicability of and to implement the terms of this Plan or the similar terms of any other plan, the Fund may, without consent or notice to any covered person, release to or obtain from any insurance company or other organization or individual, any information, with respect to any covered person, which the Fund deems

to be necessary for such purposes. Any covered person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with its provision have been made under any other plans, the Fund shall have the right, exercisably alone and at its sole discretion, to pay any organization making such other payments any amounts it shall determine to be warranted.

If any Plan benefits become payable to the estate of an eligible person or to an eligible person or Beneficiary who is a minor or otherwise not competent to give a valid release, the Plan may pay up to $1,000 in benefits to that person's relative by blood or connection by marriage who the Trustees find is equally entitled thereto.

Any payment made by the plan in good faith under this provision shall fully discharge the Plan to the extent of such payment.

Right of Recovery

Whenever payments have been made by the Fund with respect to allowable expenses in excess of the maximum amount of payment necessary at the time to satisfy its provisions, the Fund shall have the right to recover such payments, to the extent of such excess, from among one or more of the following the Fund shall determine:

1. Any individual to whom or from whom such payments were made; or
2. Any insurance company, hospital, physician or any other organization.

The Fund may also recover such excess payments by reducing future benefit payments, if any, which become due a Participant, Dependent or Beneficiary.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which are prescribed herein effective at the time of payment. If no such designation or provision is then effective, the indemnity will be payable to the estate of the Employee. Any other accrued indemnities unpaid at the Employee's death may, at the option of the Trustees, be paid either to the beneficiary or to the estate.

Subject to any written direction of the Employee, all or a portion of any indemnities provided by the Fund for services rendered by a hospital, nursing, medical, surgical, dental or vision service may, at the Trustees' option, and unless the Employee requests otherwise in writing no later than the time for filing proof of loss, be paid directly to the hospital or provider of services.

Name of the Plan

The Plan is the NECA-IBEW Local No. 364 Health and Welfare Fund.

Type of Plan

This Plan provides Health Care Benefits for expense due to hospitalization, surgery, medical treatment, vision or dental care. This Plan also provides benefits for Death, Accidental Dismemberment and Weekly Accident and Sickness (Loss of Time).

Type of Plan Administration

The Plan is administered and maintained by the Board of Trustees. The Trustees have selected a professional employee benefits administrative firm as the Administrative Manager of the Plan. The Administrative Manager is responsible for carrying out the Trustees' policy decisions, record keeping, accounting and paying most benefits subject to the Plan Document.

Name and Address of Administrative Manager

The Administrative Manager selected by the Trustees is:

James E. Schreiber, Administrative Manager
TIC Midwest
6525 Centurion Drive
Lansing, MI 48917-9275

Telephone: (517) 321-7502
Toll Free: (877) 364-4239
Facsimile: (517) 321-7508

Name and Address of Claims Administrator

The Claims Administrator selected by the Trustees is:

TIC Midwest
6525 Centurion Drive
Lansing, MI 48917-9275

Telephone: (517) 321-7502
Toll Free: (877) 364-4239
Facsimile: (517) 321-7508

Name and Address of Investment Consultant

The Investment Consultant selected by the Trustees is:

Ted Disabato
Meketa Investment Group, Inc.
525 W. Monroe Street, Suite 560
Chicago, IL 60661

Telephone: (312) 474-0900
Facsimile: (312) 474-0904 FAX

Name and Title of Each Trustee

Union Trustees	**Management Trustees**
David Cargill, Chairman	John Robinson, Secretary
Bradley Vos	John Larson
Alan Golden	Jim Lee

Name and Address of Local Union Office

NECA-IBEW Local No. 364
6820 Mill Road
Rockford, IL 61108

(815) 398-6282
(815) 398-1203 FAX

Robin Perez
Benefits Coordinator

Parties to the Collective Bargaining Agreement

The Fund is established and maintained under the terms of a collective bargaining agreement. This agreement sets forth the conditions under which participating Employers are required to contribute to your Fund.

The parties to the collective bargaining agreement are:

Local Union Number 364,
International Brotherhood of Electrical Workers

and

Northern Illinois Chapter,
National Electrical Contractors Associations, Inc.

And those Employers which execute an individual collective bargaining or non bargaining participation agreement with the Local Union. Upon written request to the Administrative Manager, Participants and Beneficiaries may obtain information as to the address of a particular Employer and whether that Employer is required to pay contributions to this Plan.

Internal Revenue Service Employer and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Board of Trustees is 41-1677804 and the Plan Number is 501.

Agent for Service of Legal Process

James Neuman
Baum Sigman Auerbach & Neuman, Ltd.
200 West Adams Street, Suite 1825
Chicago, IL 60606-5231

(312) 236-4316
(312) 236-0241 FAX

Service of legal process may also be made upon any Plan Trustee.

Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules in the Eligibility Section of this Document. Circumstances which may cause you to lose eligibility are explained in the Eligibility Rules in the Eligibility Section of this Document.

Sources of Trust Fund Income

Sources of Trust Fund income include Employer contributions, Employee self-payment of contributions and investment earnings. All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining or non-bargaining participation agreements between the Union and an Employer Association or those Employers who are not members of or represented by an Association but who execute an individual collective bargaining agreement with the Local Union.

The agreements specify the amount of contribution, due date of Employer contributions, type of work for which contributions are payable and the geographic area covered by the labor contract.

Method of Funding Benefits

Benefits payable under this Plan are self-funded and paid directly from the accumulated assets of the Trust Fund. A portion of Fund assets are also allocated for reserves to meet future liabilities and to carry out the objectives of the Plan.

Fiscal Year of the Plan

The financial records of this Plan are based on a fiscal year which begins October 1 and ends September 30.

The Plan May be Terminated

Although the Trustees do not foresee that the Plan will be terminated, the Trust Agreement provides that termination may occur when:

1. The Trustees determine that the Trust Fund assets are not adequate to carry out the purpose for which the Welfare Fund is intended; or
2. There is no longer a collective bargaining agreement or other written agreement in effect that requires Employer contributions to be made to the Trust Fund and negotiations for extension thereof have ceased.

The Trustees are obligated to use the Trust Assets for payment of expenses incurred up to the date of termination and expenses related to the termination as their first priority. Remaining assets, if any, must be used to continue Plan benefits after the Plan termination date for those persons eligible when the Plan was terminated.

Upon written request, you may examine the agreement at the Administration Office or other specified locations. Or you may request of a copy of the agreement which will be provided for a reasonable charge.

Grandfathered Status

Effective January 1, 2021 this Plan is no longer a grandfathered plan under the provisions of the Affordable Care Act.