NECA – LOCAL NO. 145 IBEW WELFARE PLAN

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

RESTATED EFFECTIVE
October 1, 2022

TABLE OF CONTENTS

IMPORTANT INFORMATION

Name of Plan	NECA – Local No. 145 IBEW Welfare Plan
Name and Address of Plan Sponsor/ Plan Administrator	Board of Trustees NECA – Local No. 145 IBEW Welfare Plan 1700 52nd Avenue, Ste. B Moline, Illinois 61265
"EIN" Number	42-6062181
Plan Number	501
Agent for Service of Legal Process	Service of legal process may be made on the Plan Administrator
Plan Counsel	Cavanagh & O'Hara, LLP
Plan Consultant/Benefits Administrator	RJLee & Associates, a company of Accel Holding Inc. 1700 52nd Ave., Ste. B Moline, Illinois 61265
Claims Administrator	Midwest Association of Health & Welfare Funds 1700 52nd Ave., Ste. B Moline, Illinois 61265
Plan Year (fiscal)	October 1st
Type of Plan	Self-Funded employee welfare benefit plan (with reinsurance) which provides the benefits briefly described in this booklet.
Funding	Contributions made by Employers and Covered Persons
Board of Trustees and Benefits Office	1700 52nd Avenue, Ste. B Moline, Illinois 61265 309-764-8080

This Plan is construed and administered in accordance with ERISA. The Plan Administrator has the discretionary authority to interpret the terms of this Plan and to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems necessary.

GRANDFATHERED PLAN NOTICE

This group health plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Office at 1700 52nd Avenue, Suite B, Moline, IL 61265 or (309) 764-8080.

You may also contact the U.S. Department of Health and Human Services at http://www.hhs.gov/ or the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers. The Department of Labor website (in the Regulations and Guidance/Grandfathered Health Plans section) has a table summarizing which protections do and do not apply to grandfathered health plans.

PLAN DOCUMENT

This Plan Document is effective October 1, 2022, unless otherwise noted. This is a self-funded employee welfare benefit plan coming within the purview of the Employee Retirement Security Act of 1974 ("ERISA"). The Plan is funded with Employer and/or Employee contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

WHEREAS, Quad Cities Chapter of the National Electrical Contractors Association (NECA) (the "Association") and Local No. 145 International Brotherhood of Electrical Workers (the "Union"), jointly established a Collective Bargaining Agreement and Agreement and Declaration of Trust on November 15, 1961, for the purpose of establishing a plan to provide health and certain other benefits for its Members who are beneficiaries of the Plan; and

WHEREAS, it is necessary to amend and restate the Plan document to conform to law and regulation changes, including the privacy rules of HIPAA and the Patient Protection and Affordable Care Act;

NOW, THEREFORE, the Trustees hereby amend and restate the NECA - Local No. 145 IBEW Welfare Plan, hereinafter referred to as the "Plan", and this document thereinafter referred to as the "Plan Document." This Plan Document shall also constitute the Summary Plan Description ("SPD").

PURPOSE

The purpose of this Plan Document/SPD is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of covered medical, dental, and certain other expenses, including Weekly Income benefits, as well as the Health Reimbursement Account benefits.

Benefits of this Plan shall be payable for expenses incurred on and after the effective date of this Plan Document, except as specified.

The Plan Document/SPD and the Schedule of Benefits describe all of the benefits that are provided by the Plan. Please refer to the SPD and the Schedule of Benefits for information about specific benefits and amount of coverage provided to you by the Plan.

This Plan Document/SPD supersedes all other prior Plan Documents and SPDs and issued Amendments, and shall be the sole document used in determining benefits for which Covered Persons are Eligible. It may be amended from time to time by the Board of Trustees to reflect changes in benefits or Eligibility requirements. This Plan is not in lieu of and does not affect any requirements for coverage by Worker's Compensation. Any change to this Plan so made shall be binding on each Covered Person, and on any other individual or individuals referred to in this Plan Document/SPD.

Wherever used in this Plan Document/SPD, masculine pronouns shall include both masculine and feminine genders, and the singular shall include the plural unless the context indicates otherwise.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems necessary.

The decision of the Board of Trustees on any disputes arising under this Plan, including (but not limited to) questions of construction, interpretation, and administration shall be final, conclusive, and binding on all persons having an interest in or under the Plan. Any determination made by the Board of Trustees shall be given maximum deference permitted by law in the event the determination is subject to judicial review, and shall not be overturned by a court of law unless it is arbitrary and capricious.

BALANCE BILLING

In the event that a Claim submitted by a Network or non-Network provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such Claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over non-Network providers that engage in balance billing practices.

In addition, with respect to services rendered by a Network provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network.

Effective October 1, 2022, the federal No Surprises Act limits providers from balance billing in circumstances involving emergency services, services by an out of network provider at a network provider/facility or for air ambulance services. There are also other circumstances that may result in out of network claims being considered as in network claims. See Section 16 of this Plan Document/SPD entitled "No Surprises Act Services" for more information.

The Covered Person is responsible for any applicable payment of Co-Insurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

FAMILY MEDICAL CENTER & HEALTHCARE CLINIC

The Board of Trustees for the NECA – Local No. 145 IBEW Welfare Plan is pleased to announce the Plan has contracted with Everside Health, LLC to provide primary care services at the NECA Local No. 145 IBEW Family Medical Center, LLC.

The Family Medical Center, managed by Activate Healthcare, LLC, is located at 4624 Progress Drive, Suite A, Davenport, Iowa 52807. It will provide great benefits for all covered participants, spouses and dependents.

The services provided by the Family Medical Center are as follows:

- Preventive care – Annual wellness exams, preventive screenings such as hypertension, metabolic health, diabetes, and more.
- Primary care – Infections, cold & flu, digestive issues, sprains & strains, rashes, and minor procedures such as mole and wart removal and minor wound treatment.
- Condition management – Diabetes, high blood pressure, high cholesterol, asthma, arthritis, coronary heart disease, COPD, sleep apnea, and more.
- Chiropractic care –

The services provided at the Family Medical Center are being provided as a benefit to the covered participants, spouses, and dependents of the Plan who are age 3 and older. However, participants, spouses, and dependents of the Plan are not required to use the Family Medical Center's services. Participants, spouses, and dependents of the Plan can choose to utilize these services or to continue seeing a primary care physician.

Should you choose to utilize the services at the Family Medical Center, the services will be provided at:

- No out-of-pocket costs for medical visits for you and your covered family members.
- No-cost for generic drugs when prescribed by the on-site clinician and dispensed at the clinic.
- No-cost for commonly ordered labs if performed at the clinic.

The services provided by the Family Medical Center will be performed by following providers:

- Dr. Karl Treiber, Doctor of Osteopathic Medicine
- Lindsey Lange, FNP-C
- Dr. Tiffany Themas, DC, RN, BSN

Virtual Care appointments by phone and video using any computer or mobile device. Set up a new account by visiting members.eversidehealth.com or by downloading the free app by searching for Everside Health on the Apple App Store or Google Play Store.

A participant must have worked in covered employment and the hours must be reported by a contributing employer. A form for the Family Medical Center is required to be completed and returned to the Benefits Office. This benefit does not affect your eligibility for Health and Welfare Fund and does not constitute insurance.

SECTION 1 – DEFINITIONS

ACCIDENT or ACCIDENTAL. An unforeseen or unexplained sudden occurrence by chance, without intent or volition.

ACTIVE WORK and ACTIVELY AT WORK. Active, full-time performance by a Participant of all customary duties of his occupation at any location of business to which the Employer normally requires the Participant to travel. A Participant shall be deemed "Actively at Work" on each day of a regular paid vacation, and on a regular non-working day on which he is not disabled, provided he was "Actively at Work" on the last preceding working day.

ADVERSE BENEFIT DETERMINATION. Any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage, even if the rescission does not impact a current Claim for benefits;
4. A termination of benefits;
5. 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 Claimant's eligibility to participate in the Plan;
6. 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 or
7. A 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.

An Explanation of Benefits shall serve as an Adverse Benefit Determination.

AFFORDABLE CARE ACT ("ACA"). The Affordable Care Act or ACA is the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act or ACA to refer to the health care reform law.

AIR AMBULANCE. Air Ambulance means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

ALLOWABLE EXPENSES. Those Medically Necessary charges for services which are a covered benefit of this Plan, and which will be considered for reimbursement up to the Maximum Allowable Charge allowance for each service for non-PPO services or Indemnity plans, or to the Preferred Provider Organization ("PPO") allowable amount for each service for PPO services, after Deductible amounts have been fulfilled, Co-Insurance applied, and limitations and exclusions applied. The Maximum Allowable Charge is based on the PPO fee schedule.

Notwithstanding the foregoing, if a Participant or Dependent receives Non-PPO Provider Emergency Services, Non-PPO Services at a PPO provider, and Services from Non-PPO Air Ambulance Providers, then the Allowable Charge shall mean the amount that the Plan is required to pay under the *No Surprises Act,* as further described in the Section 16 on "No Surprises Act Services and Protections."

ALTERNATE CARE. Medical Care or treatment that is provided in lieu of the benefits specified in this Plan because it may be provided in a less comprehensive setting or because it is less expensive. Alternate Care must be: (1) recommended by the case manager for a Covered Person, (2) Medically Necessary, and (3) approved by the Trustees.

If the Trustees determine that Medical Care or treatment is Alternate Care for a Covered Person in one instance, they shall not be obligated to determine that the same Medical Care or treatment is Alternate Care for other Covered Persons under this Plan in any other instance.

AMBULATORY SURGICAL CENTER. A specialized facility:

1. Where coverage of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or
2. Where coverage of such facility is not mandated by law, meets all of the following requirements:
   a. It is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing surgical procedures;
   b. It is operated under the supervision of a licensed doctor of medicine ("M.D.") or doctor of osteopathy ("D.O.") who is devoting full time to such supervision, and it permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital in the area;
   c. It requires in all cases other than those requiring only local infiltration anesthetics that a licensed anesthesiologist (M.D., D.O.) administer the anesthetics and remain present throughout the surgical procedure;
   d. It provides at least two (2) operating rooms and at least one (1) post-anesthesia recovery room, is equipped to perform diagnostic x-ray and laboratory examinations, and has available to handle foreseeable Emergencies trained personnel and necessary equipment, including but not limited to, a defibrillator, a tracheotomy set, and a blood bank or other blood supply;
   e. It provides the full-time services of one or more Registered Nurses ("R.N.s") for patient care in the operating rooms and in the post-anesthesia recovery room;
   f. It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require postoperative confinement; and
   g. It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, laboratory tests, and/or x-rays, an operative report and a discharge summary.

AMENDMENT. A formal document that changes the provisions of this Plan, duly signed by the authorized person or persons as designated by the Trustees.

ANCILLARY SERVICES. Subject to rulemaking by the Secretary of the U.S. Department of Health and Human Services and with respect to services furnished by an out-of-network provider at an in-network Health Care Facility, the term "Ancillary Services" means the following:

- Items and services related to 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;
- Item and services provided by other specialty practitioners, as specified through rulemaking by the federal government; 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.

ASSOCIATION. Quad Cities Chapter of the National Electrical Contractors Association (NECA). Association may also include the Midwest Insulation Contractors Association of Eastern Iowa and Western Illinois and Vicinity.

ATTENDING PHYSICIAN (HOSPICE CARE). The Physician who: (1) is treating the Terminally Ill Covered Person, and (2) recommends admittance to a Hospice Care program.

AUTHORIZED REPRESENTATIVE. An Authorized Representative is an individual who has been designated by a Covered Person to file a claim for a Covered Person or to receive information from the Plan Administrator with respect to any Claim for benefits that entails notification of the Administrator's action on the Claim as required under Section 29, below. An Authorized Representative shall be named by the Covered Person by completing and submitting the Plan's Appointment of Personal/Authorized Representative Designation Form to the Plan Administrator.

A health care professional with knowledge of your medical condition may act as an Authorized Representative in connection with an Urgent Care Claim (defined herein) without having to complete the Appointment of Personal/Authorized Representative Designation Form.

The Appointment of Personal/Authorized Representative Designation Form must, however, be completed for all other claims.

BENEFIT DETERMINATION. Action of the Plan Administrator to grant or deny a Claim for benefits. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems necessary.

BENEFIT SERVICE ADMINISTRATOR. The individual or business entity, if any, appointed and retained by the Trustees to supervise the administration, consideration, investigation and settlement of Claims, maintain records, submit reports, and perform other such ministerial functions as may be set forth in a written administration agreement. If no Benefit Service Administrator is appointed or retained (as a result of the termination or expiration of the administrative agreement or other reason) or, if the term Benefit Service Administrator is used in connection with a duty not expressly assigned to and assumed by an appointed and retained Benefit Service Administrator in writing, the term will mean the Trustees. Both the ultimate responsibility for the administration of this Plan and the authority to interpret the Plan shall remain with the Trustees.

BENEFITS OFFICE. The Welfare Plan's administrative office.

BIOLOGICALLY BASED MENTAL ILLNESS. A mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the Illness. This includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

BIRTHING CENTER. Any health facility, place, or institution which is not a Hospital or in a Hospital, and where births are planned to occur away from the mother's usual residence following normal, uncomplicated pregnancy.

BRAND NAME PRESCRIPTION DRUG or BRAND NAME DRUG. Pharmaceutical products manufactured and sold under the name assigned by the developer/manufacturer.

BUSINESS ASSOCIATE. A person or entity who:

1. On behalf of a covered entity, performs or assists in the performance of a function or activity involving the use or disclosure of Protected Health Information ("PHI") (e.g. Claims processing, data analysis, utilization review or quality assurance); or
2. Provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the covered entity involving disclosure of PHI from

the covered entity (or another Business Associate or the covered entity).

CALENDAR QUARTER. The periods designated as follows:

1. January - March
2. April - June
3. July – September
4. October - December

CALENDAR YEAR. A twelve (12) month period of time beginning on the first day of January, and ending on the last day of the following December.

CHEMICAL DEPENDENCY/SUBSTANCE ABUSE FACILITY. A legally constituted and operated institution established to provide medical treatment for patients who require Inpatient or Outpatient care for Substance Abuse, but who do not currently require continuous Hospital services. The facility must provide 24-hour nursing service under the supervision of a full-time Registered Nurse (R.N.) and permanent facilities for Inpatient Medical Care on the premises. Daily medical records must be maintained on all patients. A Chemical Dependency Facility does not include any institution or part thereof used principally as a rest facility, a facility for the aged, a Hospital, Skilled Nursing Facility/Extended Care Facility, or one providing primarily Custodial Care. Inpatient services include Partial Hospitalization/day treatment, and services at a Residential Treatment Facility. Such Chemical Dependency/Substance Abuse Facility must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or Commission on Accreditation of Rehabilitation Facilities or a Medicare approved provider, and able to provide medication assisted therapy if providing opioid use disorder care. If it is not in-network, it must be an institution qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare.

CHILD or CHILDREN. In addition to a Participant's own blood descendant of the first degree or lawfully adopted Child, a stepchild, a Child placed with a covered Participant in anticipation of adoption, a covered Participant's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any "eligible foster child" who is defined as an individual placed with the Participant by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction, or any other Child for whom the Participant has obtained legal guardianship. See Section 2, "Dependent Eligibility," for additional information.

CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP"). The CHIP Program or any provision or section thereof which is herein specifically referred to, as such act, provision, or section may be amended from time to time.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 ("CHIPRA"). CHIPRA or any provision or section thereof, which is herein specifically referred to.

CLAIM. Any request for a plan benefit or benefits, made by a Covered Person or by a representative of a Covered Person that complies with a Plan's reasonable procedure for making benefit Claims.

CLAIMS ADMINISTRATOR. The organization responsible for adjudicating Claims. The Claims Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Claims Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

CLEAN CLAIM. A Claim that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a Claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment

which prevents timely as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include Claims under investigation for fraud and/or abuse, Claims under review for Medical Necessity, fees under review for Maximum and Allowable Charges, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document. A provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, and additional elements of which the provider has knowledge. The Plan Administrator and/or Claims Administrator may require attachments or other information in addition to these standard forms to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements, and must be complete, legible, and accurate. A Claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CO-INSURANCE. The percentage of Covered Expenses that is paid for by a Covered Person.

COLLECTIVE BARGAINING AGREEMENT. The labor agreement between the Union(s) and the Association(s), or any amendments thereof, or a labor agreement between the Union and any other employers.

CONCURRENT CARE CLAIM. A Claim for extension of the duration or number of treatments provided pursuant to a previously-approved benefit Claim.

CONTRACTOR. Any entity who, due to a Collective Bargaining Agreement, makes contributions to the NECA – Local No. 145 IBEW Welfare Plan on behalf of its Employees.

CONTRIBUTING EMPLOYER or EMPLOYER. An Employer who is bound by a Collective Bargaining Agreement or other agreement with the Union to contribute to the Plan.

CONTRIBUTION RATE. The amount contributed to the Plan per Hour worked as specified from time to time in the Agreements between the Union and Contractors' Association covering work performed under said Agreements.

COORDINATION OF BENEFITS. The mechanism used in group health insurance to designate the order in which the multiple carriers are to pay benefits and to prevent duplicate payment.

CO-PAY. The predetermined amount paid by the Covered Person on a per-item or per-service basis.

COVERED EXPENSE(S). A service or supply provided in accordance with the terms of this Plan, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option. All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as set forth elsewhere in this document.

COVERED PERSON. A Participant or his Dependent who has enrolled for coverage under this Plan. Covered Person also means an individual who has Plan coverage under the Plan's Continuation of Benefits provisions.

COVERED WORK. Employment of an Employee by an Employer under a written agreement requiring contributions to the Plan for such work.

CREDITABLE COVERAGE. Those coverages required to be included as such under Section 701(c) of ERISA, excluding those coverages that are permitted to be excluded under 701(c) of ERISA.

Solely for purposes of illustration and not in limitation of the foregoing, Creditable Coverage generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental, and church plans) that are not followed by a significant break in coverage, and excludes coverage for liability, limited scope dental or vision benefits, specified disease, and/or other supplemental-type benefits.

CUSTODIAL CARE. Care consisting of services and supplies provided to an individual in or out of an institution primarily to assist him in activities of daily living whether or not he is disabled and no matter by whom recommended or furnished.

Board, room and skilled nursing services are not, however, considered Custodial Care if: (1) provided during confinement in an institution for which coverage is available under this Plan, and (2) combined with other necessary therapeutic services under accepted medical standards which can reasonably be expected to substantially improve the individual's medical condition.

DEDUCTIBLE. The dollar amount that is applied to Covered Expenses before the charges are considered at the Co-Insurance rate.

DENTAL SERVICE. A professional Dental Service which is included in the list of Dental Services under covered medical or dental expenses and is rendered by a Dentist in the necessary treatment of Accidental Injury, dental disease or defect. It also shall mean the scaling and cleaning of teeth by a licensed dental hygienist or dental assistant if performed under the supervision and direction of a Dentist, and a charge is made for such service by the Dentist; and laboratory services for preparation of dental restoration and dental Prosthetic Devices if the Dentist includes the cost of such services or devices in the charges for these services.

DEPENDENT. An individual who meets the Eligibility requirements described under Section 2 of this Plan to become a Covered Person eligible to receive Dependent Benefits.

DEPENDENT BENEFITS. The coverage provided under this Plan Document with respect to a Covered Person who is a Dependent of a Participant.

DOLLAR BANK. An account established for each Member to record the amount of contributions made to the Plan on his behalf.

DOLLAR BANK ALLOCATION RATE. The Contribution Rate per Hour.

DURABLE MEDICAL EQUIPMENT ("DME"). Covered medical equipment designed for repeated use. It must be primarily and customarily used to serve a medical purpose, not being useful to a person in the absence of an Illness or Injury.

EFFECTIVE DATE. The day an individual becomes an Covered Person under the Plan.

ELIGIBLE or ELIGIBILITY. Being entitled to the benefits under the provisions of the Plan by virtue of having fulfilled the Eligibility requirements shown in Section 2.

ELIGIBLE EXPENSE. The Maximum Allowable Charge for each service for non-PPO providers or Indemnity plans, or to the PPO Allowable Expense for any service or supply which is Medically Necessary for the care of a patient's Illness or Injury, which is ordered by a Physician, and which is commonly and customarily recognized as appropriate in the treatment of the patient's diagnosed Illness or Injury. The service or supply cannot be educational or Experimental in nature, or provided primarily for the purpose of medical or other research. In the case of a Hospital Confinement, the length of confinement and Hospital services and supplies will be considered reasonably necessary only to the extent they are determined to be related to the treatment of the condition involved and not allocable to scholastic, educational or vocational training of the patient. The Maximum Allowable Charge is based on the PPO fee schedule.

EMERGENCY MEDICAL CONDITION, MEDICAL EMERGENCY OR EMERGENCY. A medical condition, including mental health

condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

EMERGENCY SERVICES. Emergency Services means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department (meaning, a Health Care Facility that is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).
- Emergency Services furnished by an out-of-network provider or at an out-of-network hospital (regardless of the department of the hospital in which such items or services are furnished) or an independent freestanding emergency department also include post stabilization services (i.e., items and services provided after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:
  - The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation; and
  - The patient or their representative is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment, the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and
  - The patient or their representative gives informed written voluntary consent to continued treatment by the out-of-network provider, acknowledging that the patient understands that continued treatment by the out-of-network provider may result in greater costs to the patient.

EMPLOYEE. An employee of an Employer for whose employment the Employer is obligated by agreement with the Union to contribute to the Plan.

EMPLOYER. Those organizations bound by the Collective Bargaining Agreement to make contributions to the NECA – Local No. 145 IBEW Welfare Plan on behalf of the Employees.

EMPLOYER CONTRIBUTION. Payments due from, or made by, Employers to the Trust pursuant to any Collective Bargaining Agreement between the Union and the Association or between the Union and/or any other Employer, or any participation agreement between the Trustees and an Employer.

ERISA. Employee Retirement Income Security Act of 1974, as amended from time to time.

ENROLLMENT DATE. The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ESSENTIAL HEALTH BENEFIT(S). Under Section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered

within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of Utah as permitted by the Departments of Labor, Treasury, and Health and Human Services.

EXPERIMENTAL/INVESTIGATIONAL, and/or INVESTIGATIVE. Any drugs, medical supplies, medical devices, medical equipment, medical or surgical procedures, treatments, or services that, at the time the determination is made, are not:

1. Generally accepted by the medical community in the United States, meaning that the clinical efficacy (including the anticipation of the use of the benefits outweighing harm) of the drug, medical supply, device, equipment, medical surgical procedure, treatment or service has not been documented in credible published medical literature which demonstrates that the results of the treatment have been measured for a five-year period or other period generally regarded as valid; and
2. Reasonably expected to:
   a. Result in similar or improved survival, health or function; or
   b. Alleviate symptoms of or stabilize the condition as compared to accepted alternative treatments for that condition.

Experimental/Investigational/Investigative shall also mean any drug, device, medical treatment, procedure or other similar service that meets any of the following:

1. The drug or device has not been approved by the U.S. Food and Drug Administration, and cannot be marketed for the proposed use, and/or has not been identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
2. The drug, device, medical treatment, procedure, or other similar service is subject to review and approval by the treating facility's institutional review board, or other similar body serving a similar function, for the proposed use; or
3. Reliable evidence shows that the drug, device, medical treatment, procedure, or other similar service, when applied to the circumstances of a particular patient, is the subject of on-going phase I or phase II clinical trials, or is still under the Experimental study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature, including opinions and references to or by the American Medical Association; the PDQ database of the National Cancer Institute; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, biological product, device, medical treatment, or procedure; the written informed consent used by the treating facility of another facility studying substantially the same drug, biological product, device, medical treatment, or procedure; or regulations and other official actions and publications issued by the U.S. Food and Drug Administration, the Department of Health and Human Services, the Health Care Financing Administration, the National Institutes of Health, the Council of Medical Specialty Societies, and any other association, federal program, or agency that has the authority to approve medical testing or treatment.

The Plan Administrator has the discretionary authority to make determinations concerning which drugs, services, supplies, care, and/or treatments shall be considered experimental/investigational and/or investigative.

EXPLANATION OF BENEFITS ("EOB"). A statement that is sent to a Covered Person that shows how a Claim was processed. It provides a brief description of the services, the dollar amount of the services, how much was applied to the Deductible (if any), the amount of the payment (if any), and the balanced owed which is the patient's responsibility. It also provides an explanation of any ineligible amounts.

EXTENDED CARE FACILITY. (See SKILLED NURSING FACILITY/EXTENDED CARE FACILITY).

FAMILY MEMBER. A Participant or his Dependent. Under any benefit section, a "covered Family Member," as of any given time, is a Family Member for whom coverage is then in force under the section.

FAMILY UNIT. The Participant and his qualified Dependents, and a former Participant and his qualified Dependents having Plan coverage under the Plan's Continuation of Benefits provisions.

GENDER and NUMBER. Except as the context may specifically require otherwise, use of the masculine gender shall be understood to include both masculine and feminine genders, use of words in the Plan may include the plural or the plural may be used in the singular.

GENETIC INFORMATION. Information about genes, gene products and inherited characteristics that may derive from an individual or Family Member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

GENERIC PRESCRIPTION DRUG or GENERIC DRUG. Pharmaceutical products manufactured and sold under their common chemical or official names. The generic equivalent of a Brand Name Drug must meet the same standards for safety, purity, strength, and effectiveness as the Brand Name Drug. Both Generic Drugs and Brand Name Drugs have the identical chemical composition and therapeutic effect.

GINA. The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233) which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

HEALTH CARE FACILITY. Health Care Facility (for non-emergency services) means each of following:

- A Hospital (as defined in section 1861(e) of the Social Security Act);
- A Hospital outpatient department;
- A critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

HEALTH COVERAGE. The term Health Coverage means benefits consisting of Medical Care (provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as Medical Care) under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended.

HOME HEALTH CARE. A Home Health Care Agency program for continued care and treatment of the Family Member which is established and approved in writing by such Family Member's Physician following termination of a Hospital

Confinement or Skilled Nursing Facility/Extended Care Facility confinement as a resident Inpatient, and which is for the same or related condition for which the Covered Person was confined. The Physician must certify that the proper treatment of the Illness or Injury would require continued confinement as a resident inpatient in a Hospital or Extended Care Facility in the absence of the services and supplies provided as part of the Home Health Care plan.

HOME HEALTH CARE AGENCY. An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) and at least one Registered Nurse (R.N.) to govern the services provided, and it must provide for full-time supervision of such services by a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) or by a Registered Nurse (R.N.).
3. It maintains a complete medical record on each patient.
4. It has a full-time administrator.

HOSPICE. A facility which provides short periods of stay for a Terminally Ill Covered Person in a home-like setting for either direct care or respite. This facility may be either freestanding or affiliated with a Hospital. It must operate as an integral part of the Hospice Care Program. If such a facility is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a Hospice, and must be accredited by the Joint Commission on Accreditation of Healthcare Organizations.

HOSPICE CARE PROGRAM. A formal program directed by a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) to help care for a Terminally Ill Covered Person. This may be through either:

1. A centrally administered, medically directed, and nurse-coordinated program which:
   a. Provides a coherent system primarily for home care,
   b. Uses a Hospice Team, and
   c. Is available 24 hours a day, seven days a week; or
2. Confinement in a Hospice.

The program must meet standards set by the National Hospice Organization. If such program is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a Hospice Care Program.

HOSPICE SERVICES. Services and supplies furnished to a Terminally Ill Covered Person by:

1. A Hospice, and/or
2. A Hospice Team

HOSPICE TEAM. A team of professionals and volunteer workers who provide care to:

1. Reduce or abate pain or other symptoms of mental or physical distress; and
2. Meet the special needs arising out of the stresses of the Terminal Illness, dying and bereavement.

The team must include at least a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.), and a Registered Nurse (R.N.).

It can include a social worker, clergyman/counselor, volunteers, clinical psychologist, physiotherapist, and occupational therapist.

HOSPITAL. An institution which is engaged primarily in providing Medical Care, Surgical Care and Behavioral Care for the treatment of sick and injured persons on an inpatient basis at the patient's expense, and which fully meets all the tests set forth in 1, 2, or 3 below:

1. It is an institution which is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Healthcare Organizations;
2. It is an institution qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; or
3. It is an institution which fully meets the following tests:

    a. Operates lawfully in the jurisdiction where it is located; and
    b. Maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified licensed doctors of medicine (M.D.s) or doctors of osteopathy (D.O.s), continuously provides on the premises twenty-four hour a day nursing service by or under the supervision of Registered Nurses (R.N.), maintains facilities for surgery, except that the requirement of facilities for surgery shall not apply to a mental institution or other institution operated primarily for physical rehabilitation following Illness and/or physical trauma or for the therapeutic treatment of the chronically ill.

Hospital also shall include a facility providing treatment for Substance Abuse which operates lawfully and is accredited as a Substance Abuse treatment facility by the Joint Commission on the Accreditation of Healthcare Organizations or is a Hospital, as defined by Medicare, which is eligible to participate in and to receive payment from Medicare. If a psychiatric or Chemical Dependency facility is not in-network, it must be a Hospital, or a psychiatric Hospital as defined by Medicare which is eligible to participate in and to receive payments from Medicare.

Hospital also shall include Birthing Centers (part of Hospital or "freestanding") which provide care either by a certified Nurse-Midwife with supervision by a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with service by nurses who have specialized training to monitor labor, delivery, and after delivery family care.

Hospital shall not include such facilities as:

1. A convalescent, nursing, or rest home, or a home for the aged;
2. A facility providing custodial or educational care; or
3. A facility which operates mainly as a school.

HOSPITAL CONFINEMENT. A 24-hour overnight stay of a Covered Person confined to a Hospital as a registered bed patient for which a charge is made. The confinement must be on the advice of a Physician and be Medically Necessary.

HOURS. Determined based on the actual Hours shown on the monthly contractor reports and on reciprocity reports received from other plans. A monthly contractor report may contain Hours worked at the end of the previous month. They, however, will be counted as Hours for the month which covers the payroll period for which the report is due from the Contractor. Hours reported on reciprocity reports will be credited on the same basis as contractor reports.

ILLNESS. A non-occupational condition in which a person is unable to function in his normal capacity due to bodily organ malfunction or any other temporary ailment, including pregnancy.

INCURRED CHARGE (DENTAL). The charge for a service or supply is considered to be incurred on the date it is furnished except:

1. Expenses for fixed bridgework, crowns, inlays, or restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved provided the person remains continuously covered during the course of treatment;
2. Expenses for full or partial dentures shall be deemed incurred on the date the final impression is taken provided the person remains continuously covered during the course of treatment;

3. Expenses for relining or rebasing of an existing partial or complete denture shall be deemed incurred on the first day of preparation of the reline or rebase of such denture provided the person remains continuously covered during the course of treatment; and
4. Expenses or charges for endodontic services shall be deemed incurred on the date the specific root canal procedure commenced provided the person remains continuously covered during the course of treatment.

INCURRED CHARGE (MEDICAL). The charge for a service or supply is considered to be incurred on the date it was furnished.

INJURY. Trauma or damage to the body by an outside force occurring while the individual is a Covered Person and which results in loss covered by the Plan.

INPATIENT. A Covered Person who is confined in a Hospital or a Skilled Nursing Facility/Extended Care Facility as a resident patient, and who is charged at least one day's room and board by the Hospital or the Skilled Nursing Facility/Extended Care Facility.

INTENSIVE CARE FACILITY. A section, ward, or wing within a Hospital which:

1. Is operated exclusively for critically ill patients; and
2. Is equipped to provide specialized professional nursing care, and special equipment and supplies.

An Intensive Care Facility shall not include any Hospital facility maintained for the purpose of providing normal, post-operative recovery treatment or service.

INTENSIVE OUTPATIENT SERVICES. Programs that have the capacity for planned, structured service provision of at least 2 hours per day and 3 days per week. The range of services offered could include group or individual psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment rehabilitation counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation" and some "day treatment."

IRC. Internal Revenue Code of 1986 as amended.

LEGAL SEPARATION AND/OR LEGALLY SEPARATED. An arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

LICENSED PRACTICAL NURSE. An individual who is licensed to perform nursing service by the state in which the person performs such service and is performing within the scope of that license.

LICENSED PUBLIC HEALTH NURSE (L.P.N.). A professional nurse who has the right to use the title Registered Graduate Nurse (R.N.), and who has extended his study in the public health field.

LIFE-THREATENING, SUDDEN and/or SERIOUS. Treatment for the sudden onset of a medical condition manifesting itself by acute symptoms that are so severe that the absence of immediate medical attention could reasonably result in:

1. Permanently placing the patient in jeopardy,
2. Causing other serious medical consequences,
3. Causing serious impairment to bodily functions, and/or
4. Causing serious and permanent dysfunction of any body organ or part.

LIFETIME. The period of time a person is actually a Covered Person commencing with the original Effective Date. It is not intended to imply or suggest benefits beyond an individual's termination date or this Plan's termination date as herein specified.

LIFETIME MAXIMUM. The amount of Covered Expenses paid for on behalf of any Covered Person during the period of time a person is actually a Covered Person under this Plan, commencing with the original Effective Date and ending with the Covered Person's termination date or this Plan's

termination date as herein specified. Lifetime Maximum amounts are enumerated in the respective Benefit Summary.

MAINTENANCE DRUG. A Prescription Drug intended for continuous use over a period of time to prevent disease, sustain life, or allow continuation of present lifestyle.

MAXIMUM AMOUNT or MAXIMUM ALLOWABLE CHARGE. The benefit payable for a specific coverage item or benefit under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

If and only if there is no negotiated rate for a given Claim, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price or manufacturer's retail pricing. These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

MEDICAL CARE. Any Medical Care, treatment, services, or supplies which are provided or ordered by a Physician, and which are necessary for diagnosing or treating an Illness or Injury.

MEDICAL NECESSITY and/or MEDICALLY NECESSARY. Services or supplies not excluded under this Plan, that have been ordered or provided by a Hospital, Physician or other provider to treat or diagnose an Illness or Injury and which are:

1. Consistent with the symptoms or diagnosis and treatment of the Illness or Injury;
2. Not primarily for the convenience of the Covered Person, Physician, or other provider;
3. The most appropriate standard or level of services in accord with accepted standards of good medical practice;
4. Not provided primarily for medical research, education, or other similar purposes;
5. Commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and
6. The most appropriate supply or level of service which can be safely provided to the Covered Person. When applied to an individual receiving inpatient care, it further means that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided on an Outpatient basis.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

MEDICAL RECORD REVIEW. The process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a service, drug, or supply was provided which is not supported by the billing. The Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

MEDICARE. The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as constituted or later amended.

MEMBER. Any individual who is covered by the terms of the Collective Bargaining Agreement between a Union and an Association.

MENTAL or NERVOUS DISORDER. Neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional disease, or disorder of any kind.

MENTAL HEALTH PARITY ACT OF 1996 (MHPA) AND MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA), COLLECTIVELY, THE MENTAL HEALTH PARITY PROVISIONS IN PART 7 OF ERISA. "The Mental Health Parity Provisions" means in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).

2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).

4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

MENTAL or NERVOUS DISORDER. Any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, or other relevant state guidelines or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

MORBID OBESITY. Weighing at least 100 pounds more than normal body weight for the person's age, sex, height, and body frame based on weight tables generally used by Physicians to determine normal body weight.

MULTI-SOURCE BRAND NAME DRUG. A Prescription Drug that is available as both a Generic Drug and a Brand Name Drug.

NAMED FIDUCIARY or FIDUCIARY. The Plan Administrator. A Fiduciary is any person who has power of control, management, or disposition over the employee benefit funds. A Fiduciary can be an agent, officer, or employee of the Plan, or a person or group having an interest in the Plan. The Named Fiduciary may allocate his responsibilities for operation and administration of this Plan to carry out the Fiduciary responsibilities under the Plan. The Named Fiduciary shall deliver to the Plan Sponsor a written instrument that
specifies the nature and extent of the responsibilities delegated, including, if appropriate, the persons who are designated to carry out Fiduciary responsibilities under the Plan.

NETWORK. The Hospitals, Physicians, and other health care providers who are members of or affiliated with the Preferred Provider network used by this Plan.

NO SURPRISES ACT SERVICES. The No Surprises Act (Public Law 116-260, Division BB) was signed into law on December 27, 2020, as part of the Consolidated Appropriations Act of 2021. The term "No Surprises Act Services" generally includes the following, to the extent covered under the Plan:

(1) out-of-network Emergency Services, (2) out-of-network Air Ambulance Services; (3) non-emergency services when performed by an out-of-network provider at an in-network facility.

NURSE-MIDWIFE. A person who is licensed or certified to practice as a Nurse-Midwife, and fulfills both these requirements:

1. A person licensed by a board of nursing as a Registered Nurse (R.N.), and
2. A person who has completed a program approved by the state for the preparation of Nurse-Midwives.

NURSE-PRACTITIONER. A person who is licensed or certified to practice as a Nurse-Practitioner, and fulfills both these requirements:

1. A person licensed by a board of nursing as a Registered Nurse (R.N.), and
2. A person who has completed a program approved by the state for the preparation of Nurse-Practitioners.

ONE PERIOD OF CONFINEMENT. All periods of confinement for the same or related cause or causes unless they are separated by a return to Active Work for a Participant or by a period of 90 days.

ORAL SURGERY. The branch of dentistry concerned with surgical procedures in and about the mouth and jaws.

ORTHODONTICS. The branch of dentistry concerned with the detection, prevention, and correction of abnormalities in the positioning of the teeth in their relationship to the jaws.

OUT-OF-NETWORK RATE. With respect to No Surprises Act Services, the term "out-of-network rate" means one of the following in order of priority:

- If the state has an All-Payer Model Agreement, the amount that the state approves under that system;
- Applicable state law;
- The amount parties negotiate; or
- The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

OUT-OF-POCKET MEDICAL EXPENSES or OUT-OF-POCKET. The cost sharing amounts for which the Covered Person is responsible. This may include the Calendar Year Deductible, Co-Insurance, and any other cost-sharing expense specified in this Plan. The Out-of-Pocket amount does not include Prescription Drug Co-Pays, ineligible expenses, charges in excess of the Maximum Allowable Charge for each service for non-PPO services or Indemnity plans, or charges in excess of Plan maximums, or any other amount as specified in the Benefit Summary. The Maximum Allowable Charge is based on the PPO fee schedule.

OUTPATIENT. A Covered Person who receives treatment at a Hospital, clinic or dispensary, but who is not confined to continuous 24-hour hospitalized care.

PALLIATIVE. An alleviating measure. To relieve (such as pain).

PARTIAL HOSPITAL CONFINEMENT. Partial hospitalization is a structured program of outpatient psychiatric services or chemical dependency services provided to patients as an alternative to inpatient psychiatric or chemical dependency care. It is more intense than the care you get in a doctor's or therapist's office. This type of treatment is provided during the day and does not require an overnight stay.

PARTIAL HOSPITALIZATION. Medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than 24 hours but more than 4 hours in a day in a licensed or certified facility or program.

PARTICIPANT. An Employee who meets the Eligibility criteria described under Section 2 of this Plan to become a Covered Person eligible for personal benefits, based on contributions made by the

Employer, Self-Contributions, or contributions made under the terms of a participation agreement.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA). The health care reform law enacted in March 2010, Public Law 111-148; together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act or ACA. (See "Affordable Care Act").

PERIODONTICS. The science of examination, diagnosis, and treatment of diseases affecting the Periodontium.

PERIODONTIUM. The tissues which surround and support the tooth, including the gingiva, cementum, periodontal membrane, and the alveolar or supporting bone.

PHYSICIAN OR SURGEON AND PRACTITIONER. A person who is licensed to practice medicine and surgery as a Doctor of Medicine, or Osteopathy, or a person who is a licensed dentist, chiropractor, podiatrist, optometrist, or licensed clinical psychologist who is practicing within the scope of his profession and/or license in the state where he practices.

In addition, the following Practitioners acting within the scope of their licenses or certifications as required in the state in which they practice:

1. Certified nurse anesthetist
2. Nurse-Practitioner
3. Nurse-Midwife
4. Certified addiction counselor
5. Certified mental health counselor
6. Social worker with a master's degree

These Practitioners must be legally licensed and/or legally authorized to provide service, care, or treatment under the laws of the state or jurisdiction in which services are rendered and must act within the scope of this license.

The Physician, Surgeon, or Practitioner cannot be the patient, the patient's Spouse, Child, brother, sister, or parent (or brother, sister, or parent by marriage).

PHYSICIAN VISIT. A personal interview between the patient and a Physician not including telephone calls or interviews, except as provided in Telehealth benefits, in which the Physician does not see the patient for treatment.

PLAN or WELFARE PLAN. This NECA-Local No. 145 IBEW Welfare Plan created by the Trust Agreement as adopted by the Trustees and as thereafter amended by the Trustees, and the assets which comprise the corpus of the Plan.

PLAN ADMINISTRATOR/PLAN SPONSOR. This Trust, organized and existing under the laws of the State of Iowa, including all subsidiaries and/or divisions which may be acquired by such trust, its predecessor organizations or successors, and any other Contractor which adopts the Plan. Benefits under this Plan for any acquired divisions or subsidiaries will be effective on the date of acquisition unless otherwise indicated.

POST-SERVICE CLAIM. All Claims that are not considered Pre-Service or Urgent Claims.

PPO ALLOWABLE AMOUNT. The allowable amount established by a Preferred Provider Organization for procedures and services charged by its members for services rendered.

PREFERRED PROVIDER ORGANIZATION ("PPO"). A select group of Hospitals, primary care Physicians, specialists, and ancillary providers who have been contracted to deliver quality care at a reduced rate. PPOs also establish allowable rates for covered procedures.

PRESCRIPTION DRUGS. Drugs which under Federal Law are only obtainable with a Physician's prescription, and which are distributed by a licensed pharmacist. If payable, Prescription Drugs are subject to the Deductible or Co-Pay specified in the Prescription Drug Benefit Summary.

PRE-SERVICE CLAIM. Any request for approval of a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining Medical Care.

PRIOR COVERAGE or PRIOR PLAN. Any plan or policy of group accident and health benefits provided by the Plan Sponsor (or its predecessor) which has been replaced by coverage under this Plan Document.

PRIVATE DUTY NURSING. A continuous bedside nursing service rendered by one nurse to one patient either in a Hospital, Skilled Nursing Facility, Hospice facility, or the patient's home, as opposed to general duty nursing which renders services to a number of patients.

PROCUREMENT COSTS. Benefits associated with obtaining an organ. This would include, but not be limited to, surgical removal of an organ from a donor, pathology, and radiology services, and services necessary to preserve the viability of the organ to be transplanted.

PROHIBITED EMPLOYMENT. The term "Prohibited Employment" will include work regularly and historically performed by electrical workers (or other craft covered by the Plan). Any employment which requires contributions to this Plan will not be considered Prohibited Employment.

PROSTHETIC APPLIANCE. Devices used as an artificial substitute to replace a missing, natural part of the body.

PROTECTED HEALTH INFORMATION ("PHI"). Individually identifiable health information that is created or received by a health care provider, health plan, or health care clearinghouse, and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for health care to an individual. Individually identifiable health information includes demographic information collected from an individual that identifies an individual (or could reasonably be used to identify an individual).

PSYCHIATRIC MEDICAL INSTITUTION FOR CHILDREN ("PMCI"). A level of care that includes individualized and intensive treatment by mental health professionals on a 24-hour basis in a residential setting, with periodic care and supervision by a Physician at least weekly. These facilities provide a therapeutic milieu for a range of treatment services such as individual, group, and family therapy. Patients who require residential care have chronic, persistent conditions that have failed intensive outpatient therapy. Licensure may differ by state, but usually licensed as residential, sub-acute, or rehabilitation. Wilderness programs, camps, and special schools do not qualify as residential treatment. Treatment must be expected to result in significant improvement. Care must not be custodial, maintenance, or long-term. Children in residence must have been diagnosed with a biologically based mental illness.

QUALIFIED BENEFICIARY. An individual entitled to COBRA continuation coverage. Individuals who may be Qualified Beneficiaries are the Spouse and Dependent Children of a covered Participant and, in certain cases, the covered Participant. Under current law, in order to be a Qualified Beneficiary, an individual must be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or a divorce from or death of the covered Participant). HIPAA changes this requirement so that a Child who is born to the covered Participant, or who is placed for adoption with the covered Participant, during a period of COBRA continuation coverage, is also a Qualified Beneficiary.

QUALIFIED MEDICAL CHILD SUPPORT ORDER. A judgment, decree, or order (including a settlement agreement approved by a Court) issued by a court of competent jurisdiction requiring that a medical child support order recognize a Participant's or Spouse's Child as an alternate recipient. Such order must be qualified by the Plan as outlined in Section 4.

QUALIFYING PAYMENT. Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

RECOGNIZED AMOUNT. Recognized Amount means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

For Air Ambulance Services furnished by out-of-network provider, the Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

REGISTERED NURSE (R.N.). A professional person who is licensed to perform nursing service by the state in which the person performs such service and is performing within the scope of that license.

REMISSION. A halt in the progression of a Terminal Illness, or an actual reduction in the extent to which the Illness has already progressed.

RESIDENTIAL TREATMENT FACILITY. A facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Covered Persons diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

RETIREE DOLLAR BANK. A Dollar Bank to allow additional accumulation of funds to assist Retirees age 61 and older, or a person of any age who is retired and is receiving a disability pension through the N.E.C.A. Local No. 145 I.B.E.W. Pension Plan, to offset the cost of maintaining coverage under this Welfare Plan.

RETIRED EMPLOYEE or RETIREE. Person who meets the Eligibility requirements of Section 2 and thereby is Eligible for Retired Employee Benefits.

SELF-CONTRIBUTIONS. Payments made to the Plan by a Participant or Retired Employee or Dependent for the purpose of continuation of Eligibility for Plan benefits, subject to the provisions of Section 2.

SELF-CONTRIBUTION ASSISTANCE FUND. A fund established to provide assistance to active Plan Participants who are required to make Self-Contributions to continue coverage under the Plan. Not available to Retirees, Participants under a participation agreement, Participants under a Collective Bargaining Agreement that does not provide for their participation in the Self-Contribution Assistance Fund, or Qualified Beneficiaries for COBRA continuation benefits.

SELF-CONTRIBUTION ASSISTANCE FUND ALLOCATION RATE. The balance of the Contribution Rate after subtracting the Dollar Bank Allocation Rate.

SEMI-PRIVATE ROOM. A Hospital room shared by two or more patients.

SINGLE SOURCE BRAND NAME DRUG. A Prescription Drug that is only available as a Brand Name Drug.

SKILLED NURSING FACILITY/EXTENDED CARE FACILITY. An institution, or distinct part thereof, which is licensed pursuant to state and local laws, and is operated primarily for the purpose of providing extended care or skilled nursing care and treatment for individuals convalescing from any Injury or Illness, and:

1. Is an approved and a participating Skilled Nursing Facility/Extended Care Facility of Medicare;
2. Has organized facilities for medical treatment and provides 24-hour nursing services under the full-time supervision of a Physician or Registered Graduate Nurse (RN);

3. Maintains daily clinical records on each patient and has available the services of a Physician under an established agreement;
4. Provides appropriate methods for dispensing and administering drugs and medicine;
5. Has transfer arrangements with one or more Hospitals, a utilization review plan in effect, and operational policies developed with the advice of, and reviewed by, a professional group, including at least one Physician; and
6. Excludes any institution that is other than incidentally a rest home, a home for the aged, or a place for the treatment of a Mental or Nervous Disorder or Substance Abuse.

SPOUSE. The person to whom the Employee or Retiree is lawfully married under the laws of the state in which the marriage took place regardless of the Employee's or Retiree's state of residence.

SUBSTANCE ABUSE AND/OR SUBSTANCE USE DISORDER. Any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or application sources. The fact that a disorder is listed in any of the above publications does not mean the treatment of the disorder is covered by the Plan.

SUBSTANCE ABUSE FACILITY. A legally constituted and operated institution established to provide medical treatment for patients who require Inpatient care for Substance Abuse, but do not currently require continuous Hospital services. The facility must provide 24-hour nursing service under the supervision of a full-time Registered Nurse (R.N.) and permanent facilities for Inpatient Medical Care on the premises. Daily medical records must be maintained on all patients. A Chemical Dependency Facility does not include any institution or part thereof used principally as a rest facility, a facility for the aged, a Hospital, Skilled Nursing Facility/Extended Care Facility, or one providing primarily Custodial Care or educational training.

SUPERVISING PHYSICIAN (HOSPICE CARE). The Physician directing the Hospice Care Program.

TERMINALLY ILL COVERED PERSON. A member of the Family Unit whose life expectancy is approximately six (6) months or less as certified by the Physician.

TOTAL DISABILITY or TOTALLY DISABLED. The Participant is unable, as a result of Illness or Injury, to perform the normal duties of his occupation and is not performing work of any kind for wage or profit. For purposes of the Weekly Income benefit, consideration shall be given to the lack of availability of light duty work within the trade in determining Eligibility for benefits.

TRUST. Any trust established by the parent organizations as a funding vehicle for the benefits provided by this Plan.

TRUST AGREEMENT. The document, and all amendments to and modifications thereof, executed by the Union and Employer Trustees, creating the Plan.

TRUSTEE(S). The person, firm, corporation, or other entity appointed by the parent organizations to manage the Trust.

UNION or LOCAL NO. 145 IBEW. Local Union No. 145 the International Brotherhood of Electrical Workers. Union may also mean Heat and Frost Insulators & Allied Workers Local No. 81.

URGENT CARE CLAIM. Any Claim for Medical Care or treatment with respect to which the application of time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function; or

2. In the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

VISIT. Each attendance of a Physician or medical practitioner, including a Registered Nurse (R.N.), to the Covered Person regardless of the type of professional services rendered during such attendance, whether it be termed a consultation, treatment, or given some other name.

WAITING PERIOD. The time between the first day a Member attains Initial Eligibility and the first day of coverage under the Plan.

WELL-BABY CARE. Medical Care customarily furnished to a Dependent Child who is neither injured nor sick. Well-Baby Care shall be deemed to be not incidental to the treatment of an Illness, regardless of whether such Child is suffering from an Illness when Medical Care is furnished. Hospital Confinement of a Child after its birth or until such Child's mother is discharged from the Hospital, whichever is longer, shall be deemed to be Well-Baby Care unless the Plan receives evidence satisfactory to it that a different period of Confinement is customary in the Hospital in which such Child is confined.

SECTION 2 - ELIGIBILITY

INITIAL ELIGIBILITY AND RE-ELIGIBILITY

Initial Eligibility is based on working 780 hours in a maximum of 9 consecutive months. An individual may opt out of coverage, but all contributions on his behalf made by Contributing Employers will revert to the Plan.

QUARTERLY ELIGIBILITY

Quarterly (Continuing) Eligibility is based on 390 hours per quarter.

Coverage under the Plan will commence with the first day of the Calendar Quarter following 9 consecutive months during which the individual has a total of 780 Hours of employment for which a Contractor has directly or indirectly (through reciprocity reports) made payments to the Plan. These rules also apply to those who choose regular quarterly Eligibility rather than accelerated Eligibility as outlined below, and those who elect accelerated Eligibility but fail to make required Self-Contributions if Contractor contributions are not sufficient to maintain Eligibility.

A Member working outside the jurisdiction of the Agreements between Local Union No. 145 IBEW and Quad-Cities National Electrical Contractors Association covering work performed under said Agreements (the "Agreement") in a jurisdiction where the local health and welfare plan has entered into a reciprocity agreement with this Plan may direct that local plan to forward an accounting of his Hours and contributions made on his behalf under the reciprocity agreement to this Plan. Hours forwarded from such a plan shall be credited to the Member's account for determining whether the Member has met the Eligibility requirements. Because this Plan's Benefits Office has no control over when a reciprocating plan sends Hours and contributions, it is the responsibility of the Member to verify submission of Hours/contributions by the reciprocating plan and receipt of Hours/contributions by this Plan.

In the event contributions received by the Plan are less on a per hour basis than the Dollar Bank Allocation Rate during the 9 or fewer consecutive month period in which the Member works 780 Hours, the Member must self-contribute the difference between the amount received by the Plan from Contractor contributions (directly or through reciprocity) and the cost of coverage as determined by the Trustees to continue coverage beyond the first Calendar Quarter of coverage. Such Self-Contributions must be received in full by the Plan before the twenty-fifth (25^{th}) day of the month preceding the quarter of coverage.

In no event will a Member become a Participant in the Plan until the Trustees have received Contractor reports, reciprocity reports or adequate proof in the opinion of the Trustees showing 780 Hours worked in a 9 or fewer consecutive month period.

Contributions are credited for coverage as follows:

Dollars earned January-March	buy	Coverage for July-September
Dollars earned April-June	buy	Coverage for October-December
Dollars earned July-September	buy	Coverage for January-March
Dollars earned October-December	buy	Coverage for April-June

ACCELERATED ELIGIBILITY

1. If a Member elects accelerated Eligibility, coverage under the Plan will commence with the 1st day of the 2nd month following a period during which the Member has earned contributions for a total of 130 Hours of employment for which a Contractor has directly or indirectly (through reciprocity reports) made payments to the Plan. The 130 Hours must be worked in a maximum of 3 consecutive months. For example:

135 Hours worked in March	Coverage effective May 1st
75 Hours worked in March and 75 Hours worked in April	Coverage effective June 1st
25 Hours worked in March 20 Hours worked in April 65 Hours worked in May 10 Hours worked in June	Not yet eligible
20 Hours worked in March 20 Hours worked in April 75 Hours worked in May 50 Hours worked in June	Coverage effective August 1st

A Member working outside the jurisdiction of the Agreement in a jurisdiction where the local health and welfare plan has entered into a reciprocity agreement with this Plan may direct that local plan to forward an accounting of his Hours and contributions made on his behalf under the reciprocity agreement to this Plan. Hours forwarded from such a plan shall be credited to the Member's account for determining whether the Member has met the Eligibility requirement of 130 Hours in 3 consecutive months. Because this Plan's Benefits Office has no control over when a reciprocating plan sends Hours/contributions, it is the responsibility of the Member to verify submission of Hours/contributions by the reciprocating plan and receipt of Hours/contributions by this Plan.

After initial Eligibility is attained, in the event contributions received by the Plan are less on a per hour basis than the amount necessary to continue coverage for the subsequent coverage period, the Member must self-contribute the difference between the amount received by the Plan from Contractor contributions (directly or through reciprocity) and the cost of coverage as determined by the Trustees to continue participation beyond the period for which adequate contributions have been received.

IN THE EVENT THE MEMBER DOES NOT MAKE SUFFICIENT SELF-CONTRIBUTIONS TO CONTINUE COVERAGE, HE MUST MEET THE REQUIREMENTS FOR RE-ELIGIBILITY AS OUTLINED UNDER THE RULES FOR QUARTERLY ELIGIBILITY ABOVE.

Self-Contributions must be received by the 25th day of the month for which Eligibility is requested. For example:

Joe has been covered under the Plan since his initial Eligibility date of May 1st based upon his having contributions made on his behalf for 130 Hours worked during the previous March. In April, Joe only worked 120 Hours, resulting in insufficient contributions made on his behalf to maintain coverage for June. Joe will receive notification from the Benefits Office that he must make the necessary Self-Contribution by May 25th or coverage will be terminated effective June 1st. If Joe's coverage is terminated, he will be

Eligible for continuation under the Plan's Continuation of Coverage under COBRA provisions. He then can attain Eligibility again only under the quarterly Eligibility rules outlined above. Accelerated Eligibility no longer is an option.

Contributions worked for Hours in excess of 130 per month will be maintained separately to enable the Member to attain regular quarterly Eligibility which must be achieved within 60 months of initial Eligibility either through Contractor contributions or through a combination of Contractor contributions, Self-Contributions and reciprocal contributions.

2. An additional option for accelerated Eligibility is available. In the event the Plan receives contributions for a Member for 780 Hours at the end of the first or second month of the Calendar Quarter, he may choose to become covered on the first day of the second or third month of the quarter respectively. The rules outlined above concerning separate banking to attain quarterly coverage and Self-Contributions to maintain coverage apply.

EXPEDITED INITIAL EDIBILITY FOR NEWLY ORGANIZED EMPLOYEES

A "newly organized employee," who provides evidence of continuous health insurance coverage, will become eligible for immediate coverage, at the election of the newly organized employee, either on (i) the first day the newly organized employee works in employment covered by a Collective Bargaining Agreement that requires contributions to the Fund or (ii) the first day of the month following the month in which the newly organized employee commenced employment; provided that, the Fund receives a lump sum payment equal to 780 hours multiplied by the applicable Contribution Rate at the time of such election.

The payment of the 780 hours required for Initial Eligibility shall result in the newly organized employee being eligible for two (2) Quarters of eligibility. Eligibility after the initial two (2) Quarters of eligibility shall be based on contributions received by the Fund for hours worked by the newly organized employee. If coverage starts mid-Quarter, then the Fund will pro-rate the payment of 780 hours to minimally provide six (6) months of coverage and the newly organized employee may continue eligibility as permitted by the Plan (e.g., through Dollar Bank, self pays, etc.) to maintain eligibility for the following applicable full eligibility Quarter.

A newly organized employee who earns Initial Eligibility as described in this section, shall forfeit eligibility and, if applicable, all dollars in their Dollar Bank or Retiree Dollar Bank, as of the last day of the month in which such employee engages in Prohibited Employment for a Non-Contributing Employer or through self-employment.

If a newly organized employee loses eligibility for coverage as a result of engaging in Prohibited Employment and later returns to work for a Contributing Employer, then the newly organized employee will have to start over and satisfy the Fund's initial eligibility requirements. Additionally, a newly organized employee who engages in Prohibited Employment shall not be eligible to receive any assistance from the Self-Contribution Assistance Fund.

For purposes of this provision, a "newly organized employee" is an employee who (i) was previously employed by an employer that did not have a collective bargaining agreement with the Union, (ii) becomes employed by a Contributing Employer, and (iii) is identified by the Union as a "newly organized employee." The Board of Trustees shall make the determination whether an employee is considered a "newly organized employee."

For purposes of this provision, a "Non-Contributing Employer" is defined as any employer that performs work in the electrical construction industry that is covered by an area-wide construction industry collective bargaining agreement but does not make contributions to this Plan. Public employers are not considered to be Non-Contributing Employers.

For purposes of this provision, "Prohibited Employment" has the same meaning as set forth in the section below entitled "Prohibited Employment."

PARTICIPATION AGREEMENTS

The Board of Trustees may, from time to time, enter into Participation Agreements with related entities such as Contractors, the Union, and the apprenticeship program, which allow participation in this Plan under the terms of the agreements. The Board of Trustees establishes the rules governing Participation Agreements.

LOSS OF ELIGIBILITY

A Participant must meet re-Eligibility requirements under quarterly Eligibility rules if:

1. A Participant who has attained initial Eligibility is maintaining Eligibility on a quarterly rather than a monthly basis and who does not receive coverage under the Plan for 2 consecutive Calendar Quarters; or
2. A Participant is maintaining Eligibility in accordance with rules for accelerated Eligibility, and does not receive coverage under the Plan for one month; or
3. A Participant worked and/or received credit for Hours due to disability for no more than 390 Hours during 4 consecutive Calendar Quarters, unless the Participant demonstrates continued disability due to Illness or Injury in which case the 390 hours may be extended to a total of 8 consecutive Calendar Quarters. Medical evidence of continued disability will be required by the Board of Trustees to extend coverage beyond the normal 4 consecutive Calendar Quarters.

RE-ELIGIBILITY

If a Participant loses Eligibility due to any of the provisions above, he must become re-Eligible in order to again become covered by the Plan. For a Participant who becomes re-Eligible, coverage will commence with the first day of the Calendar Quarter following 9 or fewer consecutive months during which he has a total of 780 Hours of employment for which a Contractor has directly or indirectly (through reciprocity reports) made payments to the Plan.

A Member working outside the jurisdiction of the Agreement in a jurisdiction where the local health and welfare plan has entered into a reciprocity agreement with this Plan may direct that local plan to forward an accounting of his Hours and contributions made on his behalf under the reciprocity agreement to this Plan. Hours/contributions forwarded by such a plan shall be credited to the Member's account for determining whether the Member has met the Eligibility requirement of 780 Hours in 9 or fewer consecutive months. Because this Plan cannot control when Hours/contributions are forwarded by another plan, it is the Member's responsibility to verify that Hours/contributions have been forwarded by the reciprocating plan and Hours/contributions have been received by this Plan.

In the event contributions received by the Plan are less on a per hour basis than the Dollar Bank Allocation Rate during the 9 or fewer consecutive month period in which the Member works 780 Hours, the Member must self-contribute the difference between the amount received by the Plan from Contractor contributions (directly or through reciprocity) and the cost of coverage as determined by the Trustees to continue participation beyond the

first Calendar Quarter of coverage. Such Self-Contributions must be received in full by the Plan by the 25th of the month preceding the quarter of coverage.

In no event will a Member become a re-Eligible Participant in the Plan until the Plan has received Contractor reports, reciprocity reports, or adequate proof in the opinion of the Trustees showing 780 Hours worked in a 9 or fewer consecutive month period.

DOLLAR BANKS

The Plan provides a Dollar Bank for Plan contributions on behalf of a Member, and to account for the cost of providing coverage to the Member. The amount allowed to be banked is determined by the Board of Trustees, and may be changed from time to time due to changes in cost of the Plan and levels of reserves.

A Retiree Dollar Bank was implemented effective July 1, 1999. The purpose of this Dollar Bank is to allow additional accumulation of funds to assist Retirees, or a person of any age who is retired and is receiving a disability pension through The N.E.C.A. Local No. 145 I.B.E.W. Pension Plan, to offset the cost of maintaining coverage under the Welfare Plan.

When the regular Dollar Bank is full, excess dollars are accumulated in the Retiree Dollar Bank until such time as that bank is full. The amount allowed to be banked is determined by the Board of Trustees, and may be changed from time to time due to changes in cost of the Plan and levels of reserves. Dollars accumulated in the Retiree Dollar Bank can be used only to pay for coverage following retirement when participant is a Retiree as defined herein or is a disabled Retiree.

An additional Dollar Bank is used for those Participants who achieve initial Eligibility under the provisions for accelerated initial Eligibility. Dollars held in this Bank are available for use only toward the attainment of normal, quarterly coverage. This must be attained within sixty months of initial Eligibility either through Contractor contributions or a combination of Contractor contributions and Self-Contributions.
The following rules apply to the Dollar Banks (not the Retiree Dollar Bank):

1. Account Adjustments. There shall be added to each Member's account the amount received by the Plan as a result of Hours worked by the Member.

   At the end of each month, for those on monthly Eligibility, the amount required to provide coverage during the second following month will be deducted from each Member's Dollar Bank.
   At the end of each Calendar Quarter, for those on quarterly Eligibility, the amount required to provide coverage during the second following Calendar Quarter will be deducted from each Member's Dollar Bank.

2. Maximum Accrual. The maximum amount of dollars which may be carried forward in the Member's Dollar Bank at the end of each month or Calendar Quarter, after deducting the amount necessary to provide coverage for the second following month or Calendar Quarter, will be the amount determined by the Trustees from time to time.

3. Participant Death. Upon the death of a participant, the Dollar Bank may be utilized for purposes of providing coverage continuation for the Participant's Spouse and/or Eligible Dependents.

4. No Cash Payments/Forfeiture. There will be no cash payments to a Member from his Dollar Banks. The amount credited to a Member's Dollar Bank may be used only to provide coverage under the Plan. Any amount remaining in a terminated Member's following 24 consecutive months (hours worked) during which the Member does not receive contributions under the Plan will be forfeited. This time period is waived for Retirees if they elect to freeze their Dollar Banks while covered under their Spouses' plans.

THE DOLLAR BANK IS SUBJECT TO IMMEDIATE **FORFEITURE** IF A PARTICIPANT WORKS IN PROHIBITED EMPLOYMENT. SEE BELOW.

COVERAGE

A Member will receive coverage under this Plan if he has a sufficient amount in his Dollar Bank to provide the coverage, or if he makes a Self-Contribution to cover the difference between the balance of his Dollar Bank plus any Self-Contribution Assistance Fund allocation and the cost of coverage. Eligibility for coverage during the second following Calendar Quarter shall be determined by the end of each Calendar Quarter after adjustments have been made to each Member's Dollar Bank.

If, at the end of a Calendar Quarter, a Member's Dollar Bank contains sufficient amounts to cover the cost of such coverage, he will receive such coverage during the 2nd following Calendar Quarter. If his Dollar Bank does not contain a sufficient amount, he may make a self-contribution as provided below equal to the difference between the amount in his Dollar Bank plus any allocation from the Self-Contribution Assistance Fund and the cost of coverage as approved by the Trustees to continue such coverage.

If a Participant loses Eligibility and elects COBRA Continuation coverage benefits for 3 or more consecutive quarters, he must become re-Eligible under the Eligibility rules.

PROHIBITED EMPLOYMENT

Participants who engage in **Prohibited Employment** for a **Non-Contributing Employer** will forfeit the dollars in their Dollar Bank or Retiree Dollar Bank and will lose their eligibility for coverage on one of the following applicable dates:

(i) The last day of the month in which the participant engages in **Prohibited Employment** for a **Non-Contributing Employer** (if the Participant gives the Fund notice of such employment), or

(ii) After the Fund provides thirty (30) days advance written notice to the Participant (if the Participant fails to provide notice).

If a Participant loses eligibility for coverage as a result of engaging in **Prohibited Employment** for a **Non-Contributing Employer** and later returns to work for a contributing employer, then the Participant will have to start over and satisfy the Fund's initial eligibility requirements.

Additionally, Participants who engage in **Prohibited Employment** for a **Non-Contributing Employer** shall not be eligible to receive any assistance from the Self-Contribution Assistance Fund.

A Retiree who engages in **Prohibited Employment** for a **Non-Contributing Employer** shall lose eligibility for coverage and shall not receive any assistance from the Retiree Supplement Fund.

For purposes of this provision, a **Non-Contributing Employer** is defined as an employer that does not make contributions to this Plan and which directly performs work in the electrical building and construction industry (or other type of work in the building and construction industry that is covered by the Plan). Public employers (i.e., federal, state, and local governments) and employers that do not directly perform work in the applicable building construction industry are not considered to be **Non-Contributing Employers**. A **Non-Contributing Employer** includes **self-employment** or **work performed as an employee**.

For purposes of this provision, **Prohibited Employment** is defined as work that regularly and historically is performed by electrical workers (or other craft covered by the Plan). Any employment that requires contributions to this Plan is not considered **Prohibited Employment**.

If requested by the Plan or if a Participant/Retiree disputes the Plan's determination that he/she is engaged in **Prohibited Employment** for a **Non-Contributing Employer**, then he/she must provide the Plan with a copy of wage, payroll, or other employment records, including but not limited to his Social Security Administration earnings records, as requested by the Plan or to dispute the Plan's determination.

Failure to provide payroll records shall permit the Plan to presume/determine that the Participant/Retiree is working in **Prohibited Employment** for a **Non-Contributing Employer**, subject to the Participant/Retiree having the right to overcome such presumption by establishing to the satisfaction of the Trustees that his/her work was not **Prohibited Employment** for a **Non-Contributing Employer.**

SELF-CONTRIBUTION

The Benefits Office will determine at the end of each Calendar Quarter those Participants who:

1. Are Eligible to participate and receive coverage under the Plan during the 2nd succeeding month or Calendar Quarter;
2. Would be Eligible for coverage during the 2nd succeeding month or Calendar Quarter if they make a Self-Contribution to the Plan; and
3. Will not be Eligible for participation during the 2nd succeeding month or Calendar Quarter.

The Benefits Office shall send a notice to each such Participant setting forth:

1. The balance of the Member's Dollar Banks;
2. The amount of any allocation from the Self-Contribution Assistance Fund for those Members Eligible for such allocation;
3. The established cost of coverage; and
4. The amount of self-contribution which will be necessary to continue the individual's coverage under the Plan.

Such notice shall be mailed to Members Eligible to make self-contributions. Such individuals shall have until the 25th day of the month following the end of the month after which coverage would be terminated (in the case of monthly Participants) or the 25th day of the 3rd month following the Calendar Quarter (in the case of quarterly Participants) to make a self-contribution to continue participation in the Plan for the 2nd succeeding month or Calendar Quarter. For example, if coverage was paid through May 31st, the Participant who has monthly coverage would have until May 25th to self-contribute to maintain coverage for June. An individual on Quarterly coverage which would terminate June 30th would have until June 25th to self-contribute for the July-September quarter. If the 25th day of the month falls on a Saturday or Sunday, the Participant will have until 4:30 p.m. on

the following Monday to make the payment (Tuesday, if Monday is a legal holiday). If payment is not received by the due date, coverage will be terminated and notification of the individual's right to Continuation of Coverage under COBRA will be mailed to him along with a termination notice.

ELIGIBILITY TO MAKE SELF-CONTRIBUTIONS

A Participant who has a balance in his Dollar Bank is eligible to make a self-contribution for the amount needed to maintain coverage. If, however, an individual's Dollar Bank balance falls to zero, he is eligible to make a self-contribution only if he meets the requirements established for eligibility for the Self-Contribution Assistance Fund. If these requirements are not met, the individual will be terminated from the Plan and offered COBRA.

SELF-CONTRIBUTION ASSISTANCE FUND

The Self-Contribution Assistance Fund ("SCAF") is established to assist those Members who are covered by a Collective Bargaining Agreement under which contributions are made to the SCAF ("SCAF Participant"), who do not have a sufficient balance in their Dollar Bank to maintain coverage, and who must make Self-Contributions in order to maintain coverage under the Plan. The SCAF is available only to Participants who are (i) on normal quarterly Eligibility, (ii) have at least 390 hours reported to the Fund in a six consecutive calendar quarter look-back period, and (iii) meet the other requirements set forth below. The SCAF is established to provide assistance to those Participants in the Plan who are actively seeking full-time employment in the electrical industry through Local No. 145 IBEW, or who are unable to work due to disability. They also may be actively seeking full-time employment in the electrical industry through another IBEW local having a reciprocal agreement with the NECA-Local No. 145 IBEW Welfare Plan. The SCAF may also be made available to Participants who are or have recently been disabled and receiving Weekly Income benefits.

For purposes of determining whether a SCAF Participant has satisfied the 390 hour in a six calendar quarter requirement specified above after the conclusion of service in the uniformed services, the time period during which a Participant was performing service in the uniformed services as defined by USERRA up to twenty-four (24) months shall be regarded as a "grace period." Accordingly, upon receipt of an application after the conclusion of uniformed services, the Fund will determine whether the SCAF Participant had 390 hours in a six calendar quarter period that occurred either before and/or after the SCAF Participant's USERRA uniformed service. A SCAF Participant who qualifies for this "grace period" must satisfy the other requirements for SCAF set forth in this section.

Normal SCAF support is a maximum of 75% of the cost of coverage.

The Board of Trustees shall determine whether a Participant is seeking full-time employment in the electrical industry, or meets the requirements for assistance due to disability based on all information available to them.

The basis for determining "actively seeking full time employment" shall be the referral procedure currently in force with the Local No. 145 IBEW. Individuals who are "actively seeking full time employment" in the jurisdiction of Local No. 145 IBEW will be allowed 2 turndowns without penalty. They will be completely ineligible for SCAF support if there is a 3rd turndown. The Trustees shall rely on information provided by the Union Hall in determining SCAF eligibility. If the Participant is found ineligible for SCAF support for one quarter, he may become eligible for SCAF support for the next succeeding quarter if he again signs the book, and does not have turndowns as described above.

All funds allocated to the SCAF during a Calendar Quarter plus any amounts in the SCAF but used in the previous Calendar Quarter shall be available for allocation to individuals who qualify for SCAF assistance and

who must make a Self-Contribution to the Plan in order to maintain coverage under the Plan. In no event shall such assistance exceed the percentage of the total cost of coverage established by the Trustees from time to time.

In the event that funds available in the SCAF are not sufficient to provide the full amount of the percentage of the cost of coverage as established by the Trustees for all individuals who are entitled to assistance, a formula shall be employed to allocate the available funds. If a SCAF Participant has worked the following Hours during the Calendar Quarter, he shall receive the indicated number of SCAF Units:

Hours	Units
Fewer than 50	7
50 but fewer than 100	6
100 but fewer than 150	5
150 but fewer than 200	4
200 but fewer than 250	3
250 but fewer than 300	2
300 but fewer than 350	1
350 or more	0

The Benefits Office shall total the number of units assigned and divide the available funds by that number of units. The amount thus determined shall be rounded down to the first ten cent increment which shall be the unit value for that Calendar Quarter. Each SCAF Participant shall receive an allocation of the SCAF equal to the number of units allocated to him multiplied by the unit value determined for that quarter provided, however, that the amount of the allocation to an individual Participant shall in no case exceed the percentage established by the Board of Trustees for the Plan from time to time. This allocation shall be taken into account in determining the amount of Self-Contributions received for continuing participation and coverage under the Plan.

In the event a SCAF Participant receives an allocation from the SCAF but does not make the necessary Self-Contribution to continue participation, the allocation from the SCAF shall be terminated and reverted to the SCAF.

If the amount of the allocation from the SCAF plus the balance of the SCAF Participant's Dollar Bank exceeds the cost of coverage, the allocation shall be reduced to that amount required when added to the SCAF Participant's Dollar Bank to provide coverage.

To be eligible to receive the SCAF, a Participant must complete and return the SCAF Election Form.

RECIPROCITY CREDIT

1. **CREDIT.** Contractor contributions to the Plan for a Participant under a reciprocity agreement shall be credited to his Dollar Bank unless all Dollar Banks have reached their maximum allowable amount.

2. **TIMELINESS OF RECIPROCITY REPORTS.** If the Benefits Office does not receive reciprocity reports in a timely manner to enable it to take these Hours into account when preparing calculations for the purpose of determining whether a Participant must self-contribute to continue participation, the Benefits Office shall not consider reciprocity dollars in such calculations. If such calculations indicate the Participant must self-contribute to continue participation, he must do so or he will not be eligible for coverage. Provided the Participant timely self-contributes and a reciprocity report is later received, the Benefits Office will credit the Participant for late contributions.

The Benefits Office has no control over when a reciprocating fund transmits Hours/contributions. Therefore, it is the responsibility of the Participant to verify that such Hours/contributions have been remitted to the Benefits Office and that the Benefits Office has received them.

If the hourly contribution rate received through reciprocity is less than the hourly contribution rate required by this Fund, then the Participant shall receive full credit in his/her Dollar Bank and HRA at this Fund's hourly contribution rate. In other words, contributions received through reciprocity will be credited to a Participant on an "hour for hour" basis.

DISABILITY

A Participant shall receive credit for 20 Hours per week for up to 26 weeks for any period during which he is disabled as defined under the Disability Benefit provided by the Plan.

RETIREMENT

Upon retirement, a Participant may continue to use the unused credit in his Dollar Bank to provide coverage under the provisions of the Plan relating to coverage for retired Members. Upon becoming a Retiree or a disabled Retiree, a Retiree may also use any funds accrued in his Retiree Dollar Bank.

A Participant is eligible to continue on this Plan as a Retiree if he receives a benefit under any IBEW pension benefit plan, or if he was covered under the terms of a Participation Agreement for at least 5 years prior to retiring.

RETIREE ELIGIBILITY

A Participant may be Eligible to maintain coverage under the Plan as a Retiree provided required contributions for coverage as established by the Trustees are submitted to the Plan on a timely basis. This Plan also will accept reciprocal contributions to offset the cost of coverage if a Retiree is working for a reciprocating local outside the jurisdiction of Local No. 145 IBEW (or other Collective Bargaining Agreement that requires contributions to this Fund).

Participants may retire as early as age 55 (earlier for disabled Participants under certain circumstances). Upon retirement, the Participant must elect one of the options below:

1. Continue coverage as a Retiree and draw down any remaining balances in his Dollar Banks or;
2. Terminate participation in the Plan or;
3. Make Self-Contributions at current Retiree rates to maintain participation in the Plan once Dollar Banks are exhausted or;
4. Freeze Dollar Bank and Retiree Dollar Bank and terminate coverage in this Plan effective as of the retirement date for the Participant; provided, however, to be eligible for this option the Participant must have a balance in either Dollar Banks, be eligible to use either one and have current medical coverage through a working Spouse's health plan or the Participant must have his own current medical coverage through another employer at the time of retirement.

If a Participant elects to freeze his Dollar Bank and Retiree Dollar Bank, that Retiree must either have medical coverage under a working Spouse's health plan or the Participant must have his own current medical coverage

through another employer at the time of retirement. In such situations, the Retiree and his Spouse will be allowed upon written request at the time of retirement to terminate coverage under this Plan temporarily until such time as his Spouse ceases to be covered under Spouse's health plan or the Participant ceases to be covered through his employer plan. At such time, the Retiree and Spouse may again be covered under this Plan provided written verification of loss of coverage under the Spouse's plan or loss of coverage through the Participant's employer plan is provided, including the date of such loss of coverage, and such request for reinstatement is received no later than 31 days following the loss of coverage under the Spouse's plan or the Participant's employer plan. Coverage under this Plan must begin on the first day of a calendar month.

If a Participant elects to terminate coverage in this Plan (and is not terminating coverage under option 4 above), any remaining amount in his Dollar Bank and/or Retiree Dollar Bank will be immediately forfeited upon the last date of the Participant's coverage under the Plan. If a Participant terminates his coverage at time of retirement, re-enrollment at a later date is not allowed except if the Retiree elected to freeze his Dollar Bank and Retiree Dollar Bank at the time of retirement under option 4 above.

Spouses and Eligible Dependents may remain on the Plan through election of family coverage. The Participant must have family coverage prior to retirement in order to have family coverage after retirement. A Retiree cannot add a Spouse or Dependent following his retirement.

If the Participant dies while covered under the Spouse's plan, the Spouse may return to this Plan under the following conditions:

1. The Spouse is not eligible for retiree coverage under her Plan;
2. The Spouse takes retiree coverage under her plan until the limiting age for retiree coverage under that plan (i.e., Medicare eligible retirees are dropped from the employer's plan);
3. The Spouse has not remarried and otherwise meets the requirements as an Eligible Dependent for this Plan; or
4. If the Spouse is disabled, she has exhausted COBRA continuation coverage under her plan.

After a Participant reaches age 65 and is eligible for Medicare (or, in the case of early retirement due to disability, he becomes eligible for Medicare and he is receiving a Disability Pension from the Pension Fund), he may continue participation in the Plan as a Retiree and pay a Medicare Retiree contribution rate.

Spouses and Eligible Dependents may continue on the Plan under Family coverage as long as the Participant is active on the Plan. If the Participant dies, his Spouse and Eligible Dependents may continue on the Plan as long as they (i) complete the Election Form and return it on the due date specified, (ii) continue to meet Eligibility requirements and (iii) make required contributions.

This Plan provides coverage for Retirees at the discretion of the Board of Trustees and may be eliminated at any time if they deem necessary.

RETIREE SUPPLEMENT FUND

The Retiree Supplement Fund was established to assist Eligible Retirees and Surviving Spouses with the cost of maintaining coverage through this Plan or assist with payment of other costs eligible for reimbursement through the Health Reimbursement Account program following retirement. The Retiree Supplemental Fund is established to assist those Participants (and Surviving Spouses, as applicable) who are covered by a Collective

Bargaining Agreement under which contributions are made to the Retiree Supplement Fund. To be Eligible, a Participant must:

1. Be retired under the N.E.C.A. Local No. 145 I.B.E.W. Pension Plan (or other applicable retirement plan that covers Employees participating in this Plan);
2. Be covered under the Welfare Plan, and have been active on the Plan for the 5 years immediately preceding retirement; or
3. Be the surviving Spouse of a Participant who met the criteria listed above.

In addition, the surviving Spouse of a Participant who was active in the Plan at the time of his death shall be eligible for a benefit at such time the Participant would have reached the age to be eligible for a Pension benefit.

Trustees expressly reserve the right to modify or terminate this benefit if it is in the best interests of the Plan.

The Trustees determine annually whether a dollar allocation will be made to eligible Retirees or Surviving Spouses. The amount varies from year-to-year based upon the balance in the Retiree Supplement Fund. A Retiree's or Surviving Spouse's allocation is based upon pension credits earned at the time of retirement, including past service credits. An allocation is not guaranteed to occur annually; the allocation is based upon an annual review.

ELIGIBILITY DATE

A Participant hired on or after the effective date of this Plan becomes Eligible for personal benefits after completing the required Waiting Period. Coverage will be effective as described under the Initial Eligibility provisions earlier in this Section.

DEPENDENT ELIGIBILITY

Eligible Dependents can be enrolled during the Plan's Open Enrollment or in circumstances permitted under Special Enrollment. See, Section 5 of this Plan.

Eligible Dependents include:

1. Participant's Spouse (unless Legally Separated). Coverage will end the day that you become legally separated or divorced.
2. Participant's Child from birth (including routine nursery charges) to the end of the month in which he attains age 26.
3. Participant's unmarried Child of any age who is deemed to be mentally, physically, or developmentally disabled, incapable of self-support, is unmarried, resides with parents who are covered by this plan, receives at least 50% of support from parents, was covered by the plan prior to his 26th birthday, and is not eligible for coverage under any state or federal health plan. Trustees will require proof of disability from a licensed physician or psychologist.

A "Child" is the Participant's:

1. Natural born Child or legally adopted child. An adopted Child shall be considered a "Child" from the moment the Child is placed in the custody of the parents for adoption (proof may be required).
2. Stepchild.

3. Foster child who is placed with the Participant by an authorized placement agency, or by judgment, decree or other order of any court of competent jurisdiction (proof may be required).
4. Any Child for whom the Participant is a legal guardian or serves in a limited guardianship capacity.
5. Any Child for whom the Participant is required, by Qualified Medical Child Support Order, to provide coverage.

If both parents of a Child are covered for personal benefits under the NECA – Local No. 145 IBEW Welfare Plan, the Plan will coordinate benefits as if the Child were covered by two separate Plans. The Participant with the earliest date of birth in the year will be primary.

Failure to provide information requested to confirm Dependent Eligibility and/or provision of any misleading or false information may result in the immediate loss in coverage.

Any individual who is Eligible as a Participant is not a Dependent unless two active Participants are married. In such cases, the Plan will coordinate with itself as if it were two separate plans.

If two active Participants marry, the following rules apply:
1. Each Participant is covered as primary, and then secondary under each spouse's plan.
2. If they have a Child, the Child is covered under both parents, and the parent with the earliest birth date in the year will be considered primary.
3. In the case of a stepchild, court ordered coverage takes precedent over the birthday rule.

ELIGIBILITY DATE

Each Participant becomes eligible to cover his Dependents for Dependent benefits on the later of the following dates:

1. The date he is Eligible for personal benefits if he then has a Dependent (Spouse and/or Child); and
2. The date he acquired his first Eligible Dependent through marriage, birth, adoption or otherwise as stated above.

CHANGE OF ELIGIBILITY RULES

The Trustees are empowered to change or amend the foregoing Eligibility Rules of this Section at any time.

SECTION 3 - EFFECTIVE DATES

PARTICIPANT. Coverage for personal benefits becomes effective on the date he is Eligible for coverage.

DEPENDENT. Dependent benefits are noncontributory. Coverage for Dependent benefits under this Plan shall become effective on the date Eligible provided the Participant has enrolled his Dependents.

If the Participant already is enrolled for Dependent benefits, then Dependent benefits for a newly acquired Dependent will become effective on the date of acquisition.

Dependent benefits will not become effective for the Dependents of a Participant unless he is covered, or simultaneously becomes covered, for personal benefits.

If, as a result of a Qualified Medical Child Support Order, the Participant is required to provide coverage for a Dependent Child not currently enrolled in the Plan, the coverage date that has been mandated by such order may also be deemed to be the date the Participant first acquires that Dependent.

OPEN ENROLLMENT. Open Enrollment is held annually in advance of the April 1st Plan Year. Participants who have Eligible Spouses and/or Dependents who were not enrolled in the Plan when Initially Eligible, have the opportunity annually to enroll them. There is no late enrollment provision in the Plan.

During the annual Open Enrollment period, the Participant also will have the opportunity to withdraw from the HRA Program and Dental and/or Vision coverage on behalf of him and his Dependents. Refusing these coverages will not result in a reduction in the cost of coverage.

SPECIAL ENROLLMENT. If a Participant declined coverage for his Dependents under this Plan when first Eligible to enroll because his Dependents had other Health Coverage, including COBRA Continuation Coverage, and they lose the other Health Coverage, he may enroll for Dependent benefits within 31 days of the occurrence. Coverage will be effective on the first of the month following the date the enrollment form is signed.

If a Participant acquires a Dependent through marriage, he may enroll for Dependent benefits within 31 days of the marriage. Coverage will be effective on the date of the marriage.

If a Participant acquires a Dependent through legal guardianship, a foster child being placed with the Participant, birth, adoption, or placement for adoption, he may enroll for Dependent benefits within 31 days of the legal guardianship, a foster child being placed with the Participant, birth, adoption, or placement for adoption. Coverage will be effective on the date of the acquisition.

SECTION 4 - QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

This Plan will provide benefits to the Dependent Children of a Participant if a Qualified Medical Child Support Order ("QMCSO") is issued, regardless of whether the Children reside with the Participant. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice ("NMSN") which is treated by the Plan Administrator as a QMCSO. If a QMCSO is issued, the Child or Children shall become an alternate recipient or recipients of benefits under this Plan. An alternate recipient shall be treated as a normal beneficiary under this Plan, and is subject to the limitations, restrictions, provisions, and procedures as all other beneficiaries.

NATIONAL MEDICAL SUPPORT NOTICE ("NMSN")

The NMSN is intended to provide a standardized means of communication between state child support enforcement agencies, employers, and administrators of group health plans regarding the medical support obligations of non-custodial parents. The NMSN facilitates the process of enrolling children in the group health plans for which their non-custodial parents are eligible.

PROCEDURAL QMCSO REQUIREMENTS

When this Plan receives a medical child support order, it will notify the Participant and custodial parent of each Child specified in the order whether the order is or is not a QMCSO.

To be considered a QMCSO, the order must create or recognize the right of an alternate recipient (Participant's Child who is recognized under the order as having a right to be enrolled under this Plan), or assigns to the alternate recipient the right to receive benefits.

A QMCSO must contain:

1. The name and last known mailing address of the Participant, and the name and address of each Child to be covered by this Plan;
2. A reasonable description of the type of coverage to be provided by this Plan to each named Child, or the manner in which the type of coverage is to be determined;
3. The time period to which the order applies; and
4. Each Plan to which the order applies.

If the order is determined by the Plan Administrator to be a QMCSO, each named Child will be covered by this Plan. In order for the Child's coverage to become effective as of the date that the order was issued, the Benefits Office will add each named Child as a Dependent for the Participant. The Participant and the custodial parent or legal guardian are notified of such event. The custodial parent or legal guardian will receive all Plan information and copies of explanations of benefits. The Benefits Office completes the QMCSO by mailing a copy of the order back with all pertinent information.

If it is determined that the order is not a QMCSO, each named Child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within 30 days of receipt of the appeal.

This Plan will not provide any type or form of benefit or any option not otherwise provided under this Plan. All other Dependent Eligibility, Effective Date, and termination provisions will apply.

SECTION 5 - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

On August 21, 1996, Public Law 104-191 was enacted to improve portability and continuity of health insurance coverage. This Plan complies with HIPAA. This Plan cannot deny coverage based on an individual's health status. This Plan has not established Eligibility rules based on any of the following health status-related factors:

medical conditions (including physical and mental illnesses), Claim experience, receipt of health care, medical history, Genetic Information, evidence of insurability, including conditions arising out of acts of domestic violence, and disability. This does not prevent this Plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits offered provided all rules are applied on a non-discriminatory basis to all people covered.

SPECIAL ENROLLMENT THROUGH LOST COVERAGE

This group Plan is required to provide a special enrollment period for individuals who do not enroll in the Plan at their first opportunity, but subsequently lose the other source of coverage for a reason other than voluntary termination of coverage. An individual is allowed to enroll in this Plan if:

1. The Participant (or Dependent) has been covered under another group health plan or had an individual policy at the time coverage was initially offered;
2. The Participant stated in writing at the time initial enrollment was offered that other coverage was the reason for declining enrollment in the plan;
3. The individual lost coverage as a result of a certain event, such as the loss of Eligibility for coverage, expiration of COBRA continuation coverage, termination of employment, reduction in the number of Hours of employment, or Employer Contributions towards such coverage were terminated; and
4. The Participant requested such enrollment within 31 days of termination of other coverage.

The individual must complete an enrollment form within 31 days of losing the other coverage. The Effective Date for special enrollees Eligible through lost coverage will be the date of the qualifying event provided an enrollment form is completed, and the above requirements are met.

SPECIAL ENROLLMENT FOR DEPENDENTS

This group Plan is required to provide a special enrollment period when a new Dependent is acquired by marriage, legal guardianship, a foster child being placed with the Participant, birth, adoption, or placement for adoption. Qualifying for this special enrollment allows for a Participant, a Dependent or both to enroll provided application is made within 31 days of the event. If an individual seeks to enroll, coverage becomes effective:

1. In the case of marriage, the date of marriage or no later than the first day of the first month beginning after the date the request was completed;
2. For a legal guardianship, on the date on which such Child is placed in the covered Participant's home pursuant to a court order appointing the covered Participant as legal guardian for the Child;
3. In the case of a foster child being placed with the Participant, on the date on which such Child is placed with the Participant by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction;
4. In the case of a Dependent's birth, the date of such birth; or
5. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

The Plan Administrator may require documentation of dependency, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

ADDITIONAL SPECIAL ENROLLMENT RIGHTS

Participants and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Participant's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. "CHIP") coverage has terminated as a result of loss of eligibility and the Participant requests coverage under the Plan within 60 days after the termination.
2. The Participant or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Participant requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Participant and his Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request, as applicable, (including the Covered Person's enrollment form, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.

SECTION 6 - FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA")

Participants may be able to continue medical benefits under FMLA.

DEFINITIONS

The following definitions are used for purposes of describing the requirements under this Section:
"Covered Employer" means an Employer who employs 50 or more employees on each working day during each of 20 or more work weeks in the current or preceding calendar year.

"Eligible Employee" means an employee who:

- Works for a Covered Employer;
- Has worked for the Employer for at least 12 months;
- Has worked at least 1,250 Hours over the previous 12 months; and
- Works at a location where at least 50 employees are employed by the employer within 75 miles.

Serious Heath Condition means an Illness, Injury, impairment, or physical or mental condition that involves:

- Any period of incapacity or treatment connected with inpatient care (e.g., an overnight stay) in a Hospital, Hospice, or residential Medical Care facility;
- Any period of incapacity requiring absence of more than three calendar days from work, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a health care provider; or
- Continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than 3 calendar days, and for prenatal care.

"Health Care Provider" means:

- Doctors of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices; or
- Podiatrist, dentists, clinical psychologists, optometrists and chiropractors authorized to practice, and performing within the scope of their practice, as defined under state law.

LEAVE ENTITLEMENT

A Covered Employer must grant an Eligible Employee up to a total of 12 workweeks of unpaid leave (also known as "FMLA leave") during any 12-month period for one or more of the following reasons:

1. The birth or placement of a Child for adoption or foster care;
2. To care for an immediate Family Member (Spouse, Child, or parent) with a serious health condition; or
3. To take medical leave when an Eligible Employee is unable to work because of a serious health condition.

Spouses employed by the same Employer are jointly entitled to a combined total of 12 workweeks of Family leave for the birth or placement of a Child for adoption or foster care, and to care for a Child or parent (but not a parent-in-law) who has a serious health condition.

Leave for birth or adoption (including foster care placement) must conclude within 12 months of the birth or placement. Under the following circumstances, an Eligible Employee may take FMLA leave intermittently:

1. The birth or placement of a Child for adoption or foster care, subject to the Employer's approval; or
2. Whenever it is Medically Necessary to care for a Family Member's serious health condition or because the Eligible Employee has a serious health condition and is unable to work.

NOTICE AND CERTIFICATION

A Covered Employer may require an Eligible Employee to provide:

1. 30 days' advance notice of the need for FMLA leave when the need is foreseeable;
2. Medical certificates supporting the need for leave due to a serious health condition affecting the Eligible Employee or his immediate Family Member; and/or
3. Second or third medical opinions and periodic recertification (at the Employer's expense), and periodic reports during FMLA leave regarding the Employee's status and intent to return to work.

The Eligible Employee must schedule treatment so that it will not unnecessarily disrupt the Employer's operation if possible.

MAINTENANCE OF HEALTH BENEFITS

A Covered Employer must continue to make contributions for an Eligible Employee while he is on FMLA leave. The contributions must be sent to the Benefits Office.

TERMINATION OF FMLA OBLIGATION TO MAINTAIN HEALTH CARE COVERAGE

The obligation to maintain health care coverage during a FMLA leave ends on the earliest of the:

1. Eligible Employee's return to work, or
2. End of 12 weeks of FMLA leave.

FMLA INTERACTION WITH COBRA

Leave taken under the FMLA does not constitute a "qualifying event" to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the Employee is not returning to work. If the Eligible Employee does not return to work within 12 weeks, he will have a COBRA qualifying event as outlined in Section 10.

JOB RESTORATION

Upon return to work from FMLA leave, an Eligible Employee must be restored to the Employee's original job, or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions.

SECTION 7 - THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT ("USERRA")

USERRA provides certain benefit protections to Employees on military leave in the uniformed services (including voluntary and non-voluntary service as well as active and inactive training) as follows:

1. An Employer must allow an Employee who enters military service to elect at least 24 months of continuation coverage under the Plan. The premium is similar to COBRA premium.
    a. If the military leave is less than 31 days long, health care coverage is provided as if the Employee had remained employed throughout the military leave period. The Employer can only charge the Employee the active Employee share of the premium cost, if any.
    b. If the length of the military leave is 31 or more days long, the Employer can charge 102% of the premium cost.

    These rights apply only to Employees, Spouses, and their Dependents covered under the Plan before leaving for military service.

2. Upon re-employment following an approved USERRA military leave period, exclusions and Waiting Periods may not be imposed on Employees whose Health Coverage was terminated because of service in the uniformed services unless similar exclusions and Waiting Periods are imposed on other re-employed persons. Any Deductible or Out-of-Pocket maximum satisfied prior to the leave of absence will be credited if reinstatement takes place during the same Calendar Year in which the expenses were incurred.

SECTION 8 - GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

GINA prohibits discrimination based on individuals' genetic information (such as the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history), imposes strict confidentiality requirements, restricts acquisition of genetic information, and prohibits retaliation against individuals who oppose actions made unlawful by GINA. This Plan will comply with the applicable provisions of GINA.

SECTION 9 - TERMINATION OF COVERAGE

PARTICIPANT. The coverage of any Participant covered under this Plan Document will cease on the earliest of the following dates except as provided in Section 10 - Continuation of Benefits (if applicable):

1. The date this Plan terminates;
2. The date ending the period for which any required contributions have been paid;
3. The date he is no longer Eligible for coverage under this Plan;
4. The last day of the first month that the Participant engages in Prohibited Employment (or other date specified in the section governing Prohibited Employment);
5. The date he begins active duty in the Armed Forces of any country for longer than 31 days (unless coverage is extended as permitted by law); or
6. The date of his death.

Cessation of active work will result in termination of coverage except that if the:

1. Participant is absent from work because of Illness or Injury, his coverage may be considered to continue subject to the rules governing Self-Contributions and the Self-Contribution Assistance Fund ("SCAF") provided the Participant makes any required contributions.
2. Participant is absent from work because of temporary layoff, his coverage may be considered to continue subject to the rules governing Self-Contributions and the SCAF provided the Participant makes any required contributions.
3. Participant is absent from work because of approved leave of absence, his coverage may be considered to continue subject to the rules governing Self-Contributions and the SCAF, provided the Participant makes any required contributions.
4. Participant is absent from work because of retirement, his coverage may be considered to continue, provided the Participant makes any required contributions.

If, subsequent to termination of service, a Participant is re-employed or reinstated as an Eligible Participant, he will be treated in the same manner as a new Participant at the date of such re-employment or reinstatement unless otherwise specified in another Section of this Plan.

DEPENDENT. Coverage with respect to each Dependent covered under this Plan will cease on the earliest of the following dates:

1. The end of the month in which such individual ceases to be a Dependent as defined in this Plan,
2. The date the Dependent begins active duty in the Armed Forces of any country for longer than 31 days, or
3. The end of the month a Dependent attains age 26.

Coverage with respect to all Dependents of a Participant covered under this Plan will cease on the date the Participant's benefits terminate except as provided in Section 10, Continuation of Benefits.

When coverage of a Participant and/or Dependent terminates, benefits will not be provided for any Hospital or medical services after termination even though such services are furnished as a result of an Illness or Injury occurring before such termination of coverage.

RESCISSION OF COVERAGE. The Plan may rescind your and/or your Dependents' coverage for fraud, or if you make an intentional misrepresentation of a material fact, after the Benefits Office provides you with 30 days

advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, or an intentional misrepresentation of a material fact. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you, your and/or your Dependents should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you and/or your Dependents 30 days' advance written notice:

- The Plan terminates your and/or your Dependents' coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your, and/or your Dependents' loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your and/or your Dependents' coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and/or your Dependents were covered by the Plan when you or they should not have been covered, the Plan will cancel your and/or your Dependents' coverage prospectively—for the future—once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you and/or your Dependents 30 days' advance written notice.

A rescission or prospective cancellation or discontinuation of coverage is an adverse benefit determination that may be appealed under the Plan's Claims and Appeals Procedures.

SECTION 10 - CONTINUATION OF BENEFITS

Federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, requires that a Participant and/or Dependent may elect to continue coverage up to the length of time specified below after the occurrence of any of the following events ("Qualifying Events") which would normally result in termination of coverage under the Plan provided any required contributions are paid.

Coverage may be continued for up to 18 months for a Participant and/or Dependent in the event of termination of employment (other than by reason of gross misconduct) or the reduction of Hours of a Participant (for a reason other than working in Prohibited Employment).

Continuation coverage may extend from 18 months to 29 months for a Participant and/or Dependent who is or becomes totally disabled (as determined by the Social Security Administration) within the first 60 days of COBRA continuation coverage, provided that such Participant and/or Dependent has given notice of the disability within 60 days of the Social Security determination and has requested the extended continuation period before the end of the first 18 months.

Coverage may be continued up to 36 months for a Dependent in the event of:

1. The death of the Participant;
2. The divorce or legal separation of the Participant from his Spouse;
3. The Participant's becoming entitled to Medicare and, as a result, he and his Dependents are no longer considered Eligible for coverage under the Plan; or
4. A Dependent Child's ceasing to be a Dependent under the terms of this Plan.

Coverage will be continued only for those Participants and/or Dependents who were covered under the Plan on the day immediately preceding termination. However, if a Child is born or placed for adoption with the Participant during the period of COBRA Continuation Coverage, such Child is entitled to receive COBRA Continuation Coverage with independent COBRA rights.

Coverage will not be continued beyond the earliest of the following dates:

1. The date ending the period for which any required contribution has been paid (within the grace period);
2. The date the Participant and/or Dependent first becomes entitled to Medicare or first becomes covered under another group health plan, and is not subject to that plan's pre-existing condition limitations; or
3. The date the Employer ceases to provide any group health plan.

This Section shall not apply to such Participants or Dependents for whom a greater period of continuation is provided elsewhere in this Plan Document/SPD.

CONFORMITY WITH THE LAW

If any provision of this Section is contrary to the Consolidated Omnibus Reconciliation Act of 1985 (as amended), the provision is changed to comply with the law. Anything to the contrary in this Plan Document/SPD shall be null and void.

COVERAGE FOR INTELLECTUALLY DISABLED AND/OR PHYSICALLY HANDICAPPED DEPENDENT CHILDREN

Any Dependent benefits under this Plan for an unmarried Dependent Child already covered under the Plan may be continued beyond the date the Child attains the limiting age for Dependent Children if all the following tests are met:

1. On the date the Child attains the limiting age, he is incapable of self-sustaining employment because of intellectual disability or physical handicap which is objectively verifiable by medical tests, or other appropriate evaluations;
2. The Child, on that date, is chiefly dependent on the Participant for support;
3. Proof of the intellectual disability or physical handicap is furnished to the Benefits Office not later than 31 days after the date the Child attains the limiting age; and
4. The Child is not eligible for coverage under any state or federal health plan.

However, Dependent benefits for the Child may not be continued beyond the earliest of the following:

1. Cessation of the physical handicap;
2. Failure to furnish any required proof of intellectual disability and/or physical handicap, or to submit to any required examination; or
3. Termination of Dependent Benefits for the Child for any reason other than attaining the limiting age.

The Plan will have the right to require proof of the continuation of the intellectual disability and/or physical handicap, and will have the right and opportunity to examine the Child whenever the Plan may reasonably require it during such continuation. After 2 years have elapsed from the date the Child attained the limiting age, only 1 examination will be required per year.

CONTINUATION OF COVERAGE FOR WIDOWED SPOUSES AND ELIGIBLE DEPENDENTS

Coverage under this Plan will be continued for Spouses and Eligible Dependents of deceased active Participants and Retirees under the following conditions:

1. The Spouse was married to the Participant at least 1 year prior to the Participant's death;
2. The Spouse was a Covered Person (including Eligible Dependents) at the time of the death of the Participant;
3. The Participant was covered under the Plan for at least 5 consecutive years prior to his death; and
4. The Spouse and Eligible Dependents contribute as required by the Plan on a timely basis as specified by the Trustees.

Upon the death of a Participant, the Dollar Banks may be utilized for purposes of coverage continuation for a Participant's Spouse and/or Eligible Dependents. If the Spouse remarries, coverage will be terminated as of the last day of the month in which the marriage occurs unless the Spouse demonstrates to the satisfaction of the Trustees that health care coverage is not available as the result of the marriage. If a quarterly payment has been made, a refund will be given for any remaining months in that quarter.

Spouses and Eligible Dependents may continue on the Plan under Family coverage as long as the Participant is active on the Plan. If the Participant dies, his Spouse and Eligible Dependents may continue on the Plan as long as they continue to meet Eligibility requirements and make required contributions. A Spouse cannot add Dependents following the Participant's death unless the Spouse was pregnant at the time of his death.

EMPLOYER NOTICE OF QUALIFYING EVENTS

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment (for a reason other than working in Prohibited Employment), death of the covered Participant, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

PARTICIPANT NOTICE OF QUALIFYING EVENTS

In certain circumstances, the covered Participant or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery. These circumstances are any of the following:

1. **Notice of Divorce or Separation:** Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Participant (or former Participant) from his or her Spouse.
2. **Notice of Child's Loss of Dependent Status:** Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
3. **Notice of a Second Qualifying Event:** Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4. **Notice Regarding Disability:** Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage.

5. **Notice Regarding End of Disability:** Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this Section for additional information.

Notification must be received by the COBRA Administrator, who is:

RJ Lee & Associates, a company of Accel Holdings, Inc.
1700 52nd Ave., Suite B
Moline, IL 61265
Phone: (309) 764-8080
Fax: (309) 764-3438

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

DEADLINE FOR PROVIDING THE NOTICE

For Qualifying Events described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if a Participant or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1. The date of the disability determination by the SSA.
2. The date on which a Qualifying Event occurs.
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed), or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18 month COBRA coverage period.

WHO CAN PROVIDE THE NOTICE

Any individual who is the covered Participant (or former Participant) with respect to a Qualifying Event, or any representative acting on behalf of the covered Participant (or former Participant) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

REQUIRED CONTENTS OF THE NOTICE

After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Participant or former Participant.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Covered Person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Participant or former Participant, death of the covered Participant or former Participant, disability of a Qualified Beneficiary or loss of disability status).
    a. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of Spouse and Dependent Child or Children covered under the Plan, and date of divorce or Legal Separation.
    b. In the case of a Qualifying Event that is Medicare entitlement of the covered Participant or former Participant, date of entitlement, and name(s) and address(es) of Spouse and Dependent Child or Children covered under the Plan.
    c. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).

d. In the case of a Qualifying Event that is the death of the covered Participant or former Participant, the date of death, and name(s) and address(es) of Spouse and Dependent Child or Children covered under the Plan.
e. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, and the date of the SSA's determination.
f. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.

5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Participant (or former Participant), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

CONTRIBUTION AND/OR PREMIUM REQUIREMENTS

The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the Plan Administrator must allow for a 30 day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

SECTION 11 - COORDINATION OF BENEFITS PROVISION

The provisions of this Section are for coordination of all benefits under this Plan Document with other benefits.

DEFINITIONS OF WORDS AND TERMS USED IN THIS SECTION

PLAN.

Any plan providing benefits or services for or by reason of Medical or Dental Care or treatment which benefits or services are provided by:

1. Any group, franchise, Hospital, or medical service, prepayment, or other coverage arranged through any Employer, Trustees, Union, employee benefit, or other employee association;
2. Any coverage under governmental programs, and any coverage required or provided by any statute; or
3. Any coverage sponsored by, or provided through, a school or other educational institution.

The word "**Plan"** shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not. Plan includes:

1. Group of group-type plans, including franchise or blanket benefit plans;
2. Blue Cross and Blue Shield group plans;
3. Group practice and other group prepayment plans;
4. Federal government plans or programs, including Medicare;
5. Other plans required or provided by law, excluding Medicaid or any benefit plan like it that, by its terms, does not allow coordination; and
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

THIS PLAN. Those Sections of this Plan Document/SPD which provide the benefits that are subject to these provisions.

ALLOWABLE EXPENSE. Any Medically Necessary item of expense or such other item of expense at least a portion of which is covered under at least one of the plans covering the individual for whom Claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

In the case of Health Maintenance Organization ("HMO)" or Medicare plans, this Plan will not consider any charges in excess of what an HMO or Medicare provider has agreed to accept as payment in full. When an HMO or Medicare pays its benefits first, this Plan will not consider as an Allowable Expense any charge that would have been covered by the HMO or Medicare had the Covered Person used an HMO or Medicare provider.

AUTOMOBILE LIMITATIONS. When medical payments are available under vehicle insurance, this Plan will pay excess benefits only. This Plan will always be the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

CLAIM DETERMINATION PERIOD. That portion of a Calendar Year during which he would be Eligible to receive benefits under this Plan Document/SPD in the absence of this Section.

EFFECT ON BENEFITS

These provisions shall apply in determining the benefits for an individual covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred by such individual during such period, the sum of the

1. Benefits that would be payable under this Plan in the absence of these provisions; and
2. Benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to these provisions would exceed such Allowable Expenses.

Excess Insurance. If, at the time of injury, sickness, disease, or disability, there is available, or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlement), the benefit under this Plan shall apply only as an excess over such other sources of coverage. This Plan's benefits shall be excess to any:

1. Responsible third party, its insurer, or any other source on behalf of that party;
2. First party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Policy of insurance from any insurance company or guarantor of a third party;
4. Worker's Compensation or other liability insurance company; or
5. Other source, including, but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, or school insurance coverage.

Vehicle limitation. When medical payments are available under any vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless or name, title, or classification.

For any Claims Determination Period with respect to which these provisions are applicable, the benefits that would be payable under this Plan in the absence of these provisions for the Allowable Expenses incurred for such individual during such Claims Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, except as provided in the next paragraph, shall not exceed the total of such Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had Claim been fully made therefore.

If another plan which is involved in the preceding paragraph and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined and, if the rules set forth in the next paragraph would require this Plan to determine its benefits before such other plan, then the benefits of such other plan will be ignored for the purposes of determining the benefits under this Plan.

For the purpose of these provisions, the rules establishing the order of Benefit Determination are:

1. The benefits of a plan which does not contain Coordination of Benefits provisions always shall be determined before the benefits of the plan which does contain a Coordination of Benefits provision.

2. The benefits of a plan which covers the individual on whose expense the Claim is based other than as a dependent shall be determined before the benefits of a plan which covers such individual as a dependent; however, the benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a plan which covers that person as a laid off or retired employee or as that employee's dependent; however, if the other plan is not subject to this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph shall not apply.
3. The benefits of a plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
4. When two or more plans cover the same Child as a dependent of different parents:
    a. The benefits of the plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before those of the plan of the parent whose birthday, excluding year of birth, falls later in that year; but
    b. If both parents have the same birthday, the benefits of the plan which covered the parent for a longer period of time are determined before those of the plan which covered the parent for a shorter period of time;
    c. However, if a plan subject to the rule based on the birthday of the parents as stated above coordinates with a plan which contains provisions under which the benefit of a plan which covers a person as a dependent of a male are determined before those of a plan which covers the person as a dependent of a female and if, as a result, the plans do not agree on the order of benefits, the provisions of the other plan shall determine the order of benefits;
5. If the parents are divorced or Legally Separated, it is necessary to determine if there is a court decree which establishes financial responsibility for medical, dental or other health care expenses for the Child. If there is such a decree, the benefits of the plan covering the parent who has that responsibility shall be determined before the benefits of the plan covering the other parent.
6. If there is no such decree, the benefits of the plan covering the parent who has custody of the Child shall be determined before the benefits of the plan covering the other parent.
7. If there is no such decree and the parent with custody of the Child has remarried, the order of priority is:
    a. The plan covering the parent who has custody;
    b. The plan covering the Spouse of the parent who has custody (that is, the stepparent of the Child); and
    c. The plan covering the parent without custody.
8. When rules (1) through (7) in this paragraph do not establish an order of Benefit Determination, the benefits of a plan which has covered the individual on whose expense the Claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such an individual for the shorter period of time.
9. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

When these provisions operate to reduce the total amount of benefits otherwise payable as to an individual covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of these provisions shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

When this Plan pays second after another plan, applicable Deductibles and Co-Insurance percentages contained in this Plan shall be applied to remaining Eligible Expenses.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of these provisions under this Plan or any provision of similar purpose of any other plan, the Plan Sponsor may, subject to any applicable requirements under HIPAA, release to or obtain from any insurance company or other organization or individual any information with respect to any individual which the Plan Sponsor deems to be necessary for such purposes. Subject to any applicable restrictions and/or requirements under HIPAA, as amended, any individual claiming benefits under this Plan shall furnish to the Plan Sponsor such information as may be necessary to implement these provisions.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with these provisions have been made under any other plan, the Plan Sponsor shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of these provisions and, to the extent of such payments, the Plan Sponsor shall be fully discharged from liability under this Plan.

RIGHT TO RECOVERY

Whenever payments have been made by the Plan Sponsor with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, the Plan Sponsor shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Plan Sponsor shall determine:

1. Any individual to, for, or with respect to whom such payments were made,
2. Any insurance companies, or
3. Any other organizations.

DEFINITIONS

"Medicare Benefits" means benefits for services and supplies which the Covered Person receives or is entitled to receive under Medicare Part A or B.

"ADEA Employer" means an employer which:

1. Is subject to the U.S. Age Discrimination in Employment Act ("ADEA"), and
2. Has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding Calendar Year.

COORDINATION WITH MEDICARE

Medicare is the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Individuals who have earned the required number of quarters for Social Security benefits within the specified timeframe are eligible for Medicare Part A at no cost. Ineligible individuals age 65 and over may purchase Medicare Part A by making application and paying the full cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.

Federal legislation requires that active Participants age 65 and over be given the option to elect either the Plan Sponsor's Plan or Medicare as primary coverage. If the affected Participant elects this Plan as his primary coverage, the regular benefits of this Plan will apply. If a Participant elects Medicare as his primary coverage, no benefits will be available under this Plan.

Federal legislation also requires that the Spouse who is age 65 or over of any active Participant be given the option to elect either the Plan Sponsor's Plan or Medicare as primary coverage. If the affected Spouse elects the benefits of this Plan as his primary coverage, the regular benefits of this Plan will apply. If the Spouse elects Medicare as his primary coverage, no benefits will be available under this Plan.

This Plan is the primary payer and Medicare is the secondary payer for services that would have been covered by Medicare in the case of a:

1. Participant or Dependent Spouse of a Participant covered under this Plan because of current employment who is entitled to Medicare benefits because of age; or
2. Participant or Dependent, covered under this Plan as a result of current employment, who is entitled to Medicare benefits because of Total Disability; or
3. Participant or Dependent who is entitled to Medicare benefits because of end stage renal disease until the end of the Medicare secondary coordination period.

When Medicare is the primary payer and the Participant or Dependent entitled to Medicare incurs:

1. Hospital, surgical, or other charges covered under Medicare; and
2. Charges not covered under Medicare; then this Plan's benefits will cover charges incurred to the extent that they are Eligible Expenses under this Plan and are not paid by Medicare.

The Coordination of Benefits provision (Section 11) will apply. However, if Medicare requires the use of certain medical facilities or medical providers (for example, Centers of Excellence required for certain transplant services), and those facilities are not used, no coverage will be provided for services rendered by another facility.

All of the Coordination of Benefits provisions will apply, including the provision that states a managed care participant will receive benefits under this Plan at a level that is secondary to the benefits the managed care option (for example, Medicare Plus Choice) would have provided had the Participant utilized a participating provider and/or network provider. Furthermore, this Plan shall not provide coverage for costs that may be counted towards meeting a Participant's Medicare Savings Account Policy Deductible.

1. The Plan shall have primary responsibility for expenses incurred by an Eligible active Participant or his Dependent who is:
   a. Eligible for Medicare Part A; and
   b. With respect to the Participant only, actively employed by an ADEA Employer who pays all or part of the required contributions for eligibility.
2. The Plan shall have secondary responsibility for the Eligible Participant and his Dependent if he is not actively employed by an ADEA Employer which pays all or part of the required contributions for eligibility.
3. The Plan shall have secondary responsibility for expenses incurred by a Participant who is no longer considered active (as defined under the Social Security Act and the regulations thereunder) who is eligible for Medicare benefits because he is disabled and is receiving Social Security.

Any of the above individuals must apply for Medicare at the earliest opportunity possible. Individuals not meeting the Medicare entitlement requirements must purchase Part A, paying the full cost. Additionally, all of the above Covered Persons must purchase Medicare Part B, paying the full cost. All such Covered Persons will be considered to be covered under both Medicare Parts A & B whether or not actually covered thereunder.

This Plan does not cover any services that are not covered by Medicare because the Covered Person and his health care provider have entered into a private contract (under the Balanced Budget Act of 1997 or otherwise) which exempts the services from Medicare, its regulations, and price controls.

The Plan shall have primary responsibility for the first 30 months for the Claim of a Covered Person who is Eligible for Medicare benefits solely because of end-stage renal disease where Medicare has secondary responsibility.

The 30 month period begins with the earlier of the first month in which the Covered Person:

1. Becomes entitled to Medicare Part A based on ESRD, or
2. Would have been entitled to Part A if he had filed an application for Medicare benefits.

However, the Plan may still be primary for up to a total of 33 months if dialysis begins before the individual becomes eligible for Medicare. After the period of up to 33 months expires, Medicare is the primary payer for entitled individuals with this Plan being secondary at that time.

The benefits payable to a Covered Person under this Plan shall be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the amounts paid under Medicare Part A and Part B shall not exceed the total of such Allowable Expenses.

All Eligible Expenses not paid by Medicare are subject to this Plan's Deductible and Co-Insurance provisions. An Eligible Expense under Medicare does not guarantee coverage by this Plan.

SECTION 12 – THIRD PARTY RECOVERY PROVISION

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this Section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this Section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all Claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any Claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a Claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a Claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage,

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such Claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such Claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a Claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or Claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, Injury, disease or disability.

COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

Any Covered Person who receives benefits and is therefore subject to the terms of this Section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Covered Person understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
3. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this Section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this Section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

RELEASE OF LIABILITY

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) ("Incurred") prior to the liable party being released from liability. The Covered Person's/Covered Persons'

obligation to reimburse the Plan is therefore tethered to the date upon which the Claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting Claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

EXCESS INSURANCE

If at the time of Injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits Section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; and
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor Claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said Claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

OBLIGATIONS

It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
2. To provide the Plan with pertinent information regarding the sickness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;

3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
6. To notify the Plan or its authorized representative of any incident related Claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
8. To not settle or release, without the prior consent of the Plan, any Claim to the extent that the Covered Person may have against any responsible party or Coverage;
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
10. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

DISPUTES REGARDING THIRD PARTY RECOVERY

All requests to reimburse an amount less than 100% of the amounts paid by the Fund for any reason, including any request to reduce a subrogation lien or right of reimbursement to consider attorney's fees incurred by a participant or beneficiary, are considered to be a benefit claim and are subject to the Claims Appeal Procedure set forth Section 29 of this SPD unless waived by the Plan.

Such requests must be made in writing and must include the detailed basis upon which the request is made. The Fund will issue an adverse benefit determination with respect to such request. An appeal of the adverse benefit determination may be submitted subject to the Plan's Claims Appeal Procedures.

The Claims Appeal Procedure shall be the exclusive process and means to consider such requests. Additionally, such requests are subject to the statute of limitations and forum provisions set forth in Section 29 of this SPD.

OFFSET

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount

equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

MINOR STATUS

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The Section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

SECTION 13 - HEALTH REIMBURSEMENT ACCOUNT PROGRAM ("HRA" PROGRAM)

1. The Trustees have established a HRA Program under which Participants for themselves and for their Dependents can withdraw amounts from the Participant's HRA to cover certain specified expenses which are related to, but not covered under the regular provisions of the Plan.
2. Any reference to Participant in this Article shall be deemed also to apply to a Retiree unless the context requires otherwise.
3. All reimbursements are made to Participants via ACH transfer to a designated account in a financial institution or to providers via electronic payment card (see below). No physical checks are issued.

1. HRA'sThe Plan will allocate hourly HRA Contributions paid by an Employer on behalf of a Participant into the individual HRA established by the Plan for the Participant.
2. If the Participant is working outside the jurisdiction of the Plan under a reciprocity agreement, the Plan will allocate the current contribution rate for the HRA Program from each hourly reciprocal contribution as a HRA Contribution.
3. No Contributions can be made into HRAs except those specified under the terms of the Collective Bargaining Agreement ("CBA"), and through the Retiree Supplement Program which is part of the wage/fringe agreement.

4. If the Participant dies while maintaining a balance in his HRA, the balance is available for use to pay:
   a. first, Participant expenses incurred prior to death with reimbursement to be made to estate of the Participant;
   b. then, if any balance remains after payment of Participant expenses, and the Participant has Dependents on this Plan, then the balance will be transferred to an account established by the Plan for use by such Dependents while such Dependents are Covered Persons under the Plan. The Dependent's account may be utilized in accordance with the Plan's provisions for the account established. If there is only one Eligible Dependent as beneficiary, the entire balance will be established in the name of the Dependent. If more than one Eligible Dependent is beneficiary, the balance will be split in equal amounts for each Dependent; and
   c. any remaining balance after satisfaction of (a) and (b) above shall be transferred back to the Plan.
5. If the Plan issues a reimbursement to a Participant for a qualified medical expense and/or self-contribution reimbursement, the Participant's individual HRA will be reduced by the amount of such reimbursement.
6. HRA balances can be carried forward from year to year.
7. The balance remaining in a Participant's HRA will be transferred back to the Plan, and such HRA balance will be reduced to zero if there is no account activity (i.e., no contributions to or benefit paid from the HRA) for 5 consecutive calendar years.
8. No interest will be paid on HRAs.
9. HRAs are not savings accounts from which the Participant can withdraw at will. Participants and their Dependents are not vested in their HRA balances.
10. Participants have an annual opportunity to permanently cease participation in the HRA program. Any monies that otherwise would be contributed to his HRA would then revert to the Plan. If an individual ceases to be a Participant in the Plan and subsequently becomes re-eligible, he becomes re-eligible for this benefit.
11. If an individual ceases to be a Participant in the Plan, has an HRA balance, and subsequently seeks health care coverage through a federal or state exchange, he forfeits any remaining HRA balance. The balance in the HRA will revert to the Plan.

HRA COVERED EXPENSES

A Participant may only receive reimbursement from his HRA for expenses which are:

1. Incurred on or after the date on which the Participant has an established individual HRA;
2. Expenses a Participant is required to pay;
3. Are not payable under the regular medical, dental, or vision benefits provided by this Plan or any other source;
4. For which the Participant has not previously taken a tax deduction; and
5. Expenses deductible under Internal Revenue Code Section 213(d) in excess of the benefits provided under the Major Medical Expense Benefit.

ELECTRONIC PAYMENT CARDS.

The electronic payment card allows you to pay for eligible health care expenses at the time that you incur the expense. Here is how the electronic payment card works:

1. **Electronic Payment Card Issuance.** All individuals with an HRA will receive two electronic payment

cards immediately following their effective date within the HRA. In order to be eligible for the electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program as set forth herein and in the electronic payment cardholder agreement (the "Cardholder Agreement"), including agreeing to any fees applicable to participate in the program, limitations as to electronic payment card usage, the Plan's right to withhold and offset ineligible claims, etc. A Cardholder Agreement will be provided to you. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

2. **Maximum dollar amount available**. The balance of the electronic payment card is limited to the balance of your HRA Account.
3. **Electronic Payment Card only for healthcare expenses.** You must certify proper use of the electronic payment card. As specified in the Cardholder Agreement, you certify during the applicable Plan Year that the amounts in your HRA Account will only be used for eligible health care expenses (i.e. medical care expenses incurred by you, your Spouse, and your tax Dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of electronic payment card use privileges.
4. **Only Available for use with certain service providers.** Reimbursement under the electronic payment card is limited to health care providers (including pharmacies) and places where you can purchase health care related items. The electronic payment card may be used only at merchants: (i) who have health care related merchant category codes other than the drug store or pharmacies merchant category code; (ii) who have the drug store or pharmacies merchant category code and with respect to whom 90% of the store's gross receipts during the prior taxable year consisted of items that qualify as expenses for medical care under Section 213(d) of the Code (a "90% pharmacy"); or (iii) who participate in an inventory information approval system developed by the electronic payment card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.
5. **Electronic Payment Card use.** When you incur an eligible health care expense at a pharmacy, such as a prescription drug expense, you use the electronic payment card at the pharmacy's office much like you would a typical credit or debit card. When you incur an expense through a provider, the claim should be fully processed, then HRA funds can be used to pay the expense. The provider is paid for the expense up to the maximum reimbursement amount available under the HRA Account (or as otherwise limited by the program) at the time you use the electronic payment card. Every time you use the electronic payment card, you certify to the Plan that the expense for which payment is being made is an eligible health care expense and that you have not been reimbursed by any other source nor will you seek reimbursement from another source.
6. **Substantiation.** You must obtain and retain a receipt/third party statement each time you use the electronic payment card. You must obtain a third party statement from the health care provider (e.g. receipt, invoice, etc.) each time you use the electronic payment card that includes the following information:
   a. The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug;
   b. The date the expense was incurred; and
   c. The amount of the expense; and
   d. Who incurred the expense.

Although it is not required to be submitted for all purchases, you must retain this receipt for 2 years following the close of the Plan year in which the expense was incurred. Even though payment may be made under the card arrangement, a written third party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the Claims Administrator if a third party statement is needed. If requested, you must provide the third party statement to the Claims Administrator within 30 days (or

such longer period provided in the letter from the Claims Administrator) of the request. Should the documentation not be provided or the documentation shows the expense to be ineligible, then the electronic payment card will be shut off.

There may be situations in which you will not be required to provide the written statement to the Claims Administrator, including:

a. Co-Pay Match: No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-provides that have health care related merchant category codes such as Physicians, pharmacies, dentists, vision care offices, and Hospitals) and the payment matches a specific co-payment you have under the Employer's group medical plan for the particular service that was provided or a multiple of that co-payment of not more than 5 times the dollar amount of the co-payment. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, $20, $30, $40, or $50, you will not be required to provide the third party statement to the Claims Administrator.
b. Previously Approved Claim Match: No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service providers that have health care related merchant category codes such as Physicians, pharmacies, dentists, vision care offices, and Hospitals) and the expense is in the same amount, for the same duration, and at the same provider as a previously approved expense (e.g. the Claims Administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy; each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount).
c. Carrier Match Program: No third party statement is required to be submitted to the Claims Administrator if the electronic claim file is received from your health plan carriers and the card transaction is able to identically match the claim information from the carrier file. (e.g. your prescription benefits manager, medical, dental or vision carriers).
d. Inventory Information Approval System: No third party statement is required to be submitted to the Claims Administrator if the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider. Such system verifies, at the time of purchase, that the goods being purchased constitute medical care.

> ***Note**: You should still obtain the third party receipt when you incur the expense and use the electronic payment card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it.*

7. **Correction Methods.** If such purchase is later determined by the Administrator not to be a qualified Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the electronic payment card do not occur, up to and including card suspension.
   a. Repayment of the improper amount by the Participant; and
   b. Claims substantiation or offset of future claims until the amount is repaid.
8. **Electronic Payment Card Suspension.** Failure to submit the requested documentation and submission of document showing the services to be ineligible, will result in the electronic payment card being temporarily suspended. The suspension of the card will be lifted once the appropriate documentation for the card transaction has been submitted or the account has been reimbursed for the ineligible services.

Participants should contact the Benefits Office for more detailed information concerning expenses that are and are not eligible for reimbursement

Responsibility for requesting reimbursement only for eligible expenses remains solely with the Participant.

SECTION 14 - MAJOR MEDICAL BENEFITS

BENEFITS PAYABLE

Unless otherwise stated in the Schedule of Benefits, if a Covered Person undergoes any Medically Necessary treatment or receives any Medically Necessary service specified in this Section because of Injury or Illness, the Plan, subject to all the provisions of this Plan Document, will pay for such treatment or service received based on the percentages listed in the Schedule of Benefits for Plan A and Plan B.

Out-of-Pocket means the sum of any Covered Expenses applied toward the Calendar Year Deductible plus that portion of such excess Covered Expenses not payable for such year because of the application of the Co-Payment limits as specified in the Schedule of Benefits for Plan A and Plan B, Prescription Drug Co-Pays or expenses not payable for reason of non-compliance with cost containment programs.

Amounts applied to the Out-of-Pocket limit for Network providers also shall be applied to the Out-of-Pocket limit for all other providers, and vice versa.

MAXIMUM BENEFIT

Reimbursement will continue for each Covered Person for successive Illnesses or Injuries up to the Maximum Benefit in the Schedule of Benefits.

MAJOR MEDICAL DEDUCTIBLES

The amount to be paid by the Covered Person for each Calendar Year with respect to each Covered Person is the Deductible amount shown in the Schedule of Benefits.

If, in any Calendar Year, 3 or more members of a Family Unit shall each have cumulatively incurred sufficient Covered Expenses to satisfy the Deductible specified, the Deductible shall be deemed to be satisfied for all covered Family Members for the remainder of that Calendar Year.

SECTION 15 – COVERED MEDICAL EXPENSES

Covered percentages are based on whether services are provided in-network or out-of-network. In-network Eligible Expenses are based on the PPO fee schedule. Covered Persons who obtain services from a PPO provider are not responsible for payment of any Eligible Expenses other than required Deductibles and Co-Payments (i.e., they may not be balance billed). Maximum Eligible Expenses by non-PPO providers are capped at the PPO fee schedule currently in effect. Any charges above the Allowable Expenses through the PPO are considered above the Maximum Allowable Charge, and Covered Persons may be balance billed for that amount.

The Plan will consider Medically Necessary expenses ordered by a Physician incurred for the services and supplies listed below subject to Deductible and Co-Insurance provisions and other Plan limitations.

ABORTION. Induced termination of a pregnancy by an acceptable means only if medically indicated by a diagnosis affecting the mental or physical health of the mother.

ALOPECIA AREATA. Coverage for diagnosis and treatment. Wigs, hair plugs, and hair growth stimulants are excluded from coverage.

ALLERGY. Allergy testing, serum, and injections.

AMBULANCE SERVICE. Professional ambulance service to and from the Hospital. In the event that an Illness or Injury requires specialized Emergency treatment not available at a local Hospital, transportation for such treatment is covered when ordered by a Physician. The transportation within the United States and Canada must be by regularly scheduled airlines, railroad, or air ambulance. The covered transportation is only from the city or town where the disability occurred to the nearest Hospital qualified to render special treatment. If a Covered Person is traveling outside the United States, he should investigate whether separate travel insurance would be beneficial.

AMBULATORY SURGICAL CENTER SERVICES. Payment for Covered Expenses will be made if services are given within 72 hours before or after a surgical procedure. The services rendered must be in connection with the procedure. Payment will be made on the same basis as if services were rendered in a Hospital.

ANESTHESIA. Anesthesia charges when performed in conjunction with a covered surgical procedure if the anesthetic is administered by a Physician other than the operating or assistant surgeon, or by a Certified Registered Nurse Anesthetist (C.R.N.A).

ASSISTANT SURGEON. Assistant surgeon charges are limited to 25% of the Maximum Allowable Charge allowance for the surgical procedure(s) for non-PPO providers which is based on the PPO Allowable Amount, or to 25% of the PPO Allowable Amount for the surgical procedure(s) for PPO plans.

AUTISM. Diagnosis and treatment of autism spectrum disorders for individuals under 21 years of age. Treatment is defined as pharmacy care, psychiatric care, psychological care, rehabilitative care, and therapeutic care (physical, occupational, and speech therapy) prescribed by the individual's treating Physician pursuant to a defined treatment plan. Applied behavior analysis (ABA) therapy for autism spectrum disorder is also covered when Medically Necessary. Except as specified in the Plan, other services related to education and/or treatment of developmental delay are not covered.

BIRTHING CENTER BENEFITS. Birthing Centers provide care for pregnant women through the services of a Nurse-Midwife. A Nurse-Midwife provides obstetric services with an obstetrician on 24-hour medical backup in case of complications. The mother and baby are usually discharged from the center within 10-12 hours after birth with home follow-up visits provided. Services may vary from center to center.

BLOOD. Blood transfusions, including the cost of whole blood and blood plasma if the blood was not donated or replaced in the operation of a blood bank.

BLOOD STORAGE. Expenses associated with donation of blood by the Covered Person prior to scheduled surgery or handling expenses associated with replacement by himself or a Family Member of blood used by the Covered Person.

BRACES. Braces (appliances used to support weakened or deformed body parts or to restrict movement), but not including elastic bandages, garter belts, or other similar items. This includes casts, splints, trusses, crutches, and elastic stockings when ordered by a Physician.

CARDIAC REHABILITATION. Cardiac rehabilitation, provided services are rendered:

1. For Phase 1 and Phase 2, and performed under the supervision of a Physician;
2. In connection with a myocardial infarction, coronary occlusion, or coronary bypass surgery;
3. If initiated within 12 weeks after other treatment for the medical condition ends; and
4. In a Hospital as defined by this Plan.

CARE MANAGEMENT. Care management services, administrative services, and fees, including Medical Care that may exceed Plan limitations, but will reduce the Covered Person's long-term Medical Care needs.

CATARACT SURGERY. Surgery, standard lenses, follow-up exam and the initial pair of contacts or eyeglasses following cataract surgery.

CHEMICAL DEPENDENCY RELATED SERVICES. Chemical dependency-related services as specified in the Schedule of Benefits.

CHEMOTHERAPY/RADIATION THERAPY.

COLONOSCOPY EXAMINATION.

All benefits are based on the recommended age set by the United States Preventative Task Force (USPTF) and when medically necessary:

1. One stool test for blood every year beginning at recommended age;
2. One flexible sigmoidoscopy every five years beginning recommended age;
3. Colonoscopy every 10 years beginning at recommended age;
4. Double contrast barium enema every 5 years beginning at recommended age;
5. Each test more frequently if prescribed by a Physician based upon Family history; and
6. A FDA approved at-home test (i.e., Cologuard) if prescribed and ordered by a Physician.

COMPRESSION STOCKINGS. Prescription is required, and stocking(s) must be purchased through a medical supply company. The Plan covers 1 stocking per leg every 6 months.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES. Barrier contraceptives, including diaphragms, female condoms, spermicides, cervical caps, sponges; Contraceptive devices, including intrauterine devices ("IUDs") and initial self-injectable administration. Subject to Deductible and Co-Insurance. See Sections 18, 19, and 20 for additional coverage information.

COSMETIC OR RECONSTRUCTIVE SURGERY. Cosmetic and/or Reconstructive Surgery when the surgery is necessary for:

1. Repair or alleviation of damage resulting from an Accident;
2. Because of an infection or Illness; or
3. Because of congenital disease, developmental condition, or anomaly of a covered Dependent Child that has resulted in a functional defect.

As required by the Women's Health and Cancer Rights Act of 1998, coverage shall be provided for the following:

1. Reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prosthesis and physical complications from all stages of the mastectomy, including lymphedema; and
4. Physical complications of mastectomy, including lymphedemas.

Such coverage will still be subject to the annual Deductible and Co-Insurance provisions as are otherwise applicable to any other similar procedure.

A treatment will be considered cosmetic for either of the following reasons:

1. Its primary purpose is to beautify; or
2. There is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Illness, Injury, or congenital abnormality.

The term "cosmetic services" includes those services, which are described in IRS Code Section 213(d).

CONTINUOUS POSITIVE AIRWAY PRESSURE ("CPAP") MACHINES AND SUPPLIES FOR TREATMENT OF SLEEP APNEA (Please refer to DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES BENEFIT). The Plan will cover initial purchase of a CPAP machine and supplies upon evidence of Medical Necessity, and evaluation of the cost of purchase versus rental. The Plan will pay for machines and supplies consistent with the purchase and replacement provisions of Medicare.

Item	Time Period for Replacement of Supplies and Machine
Machine Purchase	5 Years
Heated Humidifier	5 Years
Repair	Determined necessary due to normal wear and tear
Humidifier Chamber	6 Months
Mask	3 Months
Headgear	6 Months
Nondisposable Filter	6 Months

Disposable Filter - 2	1 Month
Tubing	3 Months
Full Face Cushions - 2	1 Month
Nasal Pillows - 2	1 Month
Chin Straps	6 Months
Oral Interface	3 Months

CPAP supplies are covered in accordance with the schedule approved by the Centers for Medicare and Medicaid Services ("CMS") guidelines.

DENTAL TREATMENT/SERVICES AND ORAL SURGERIES CONSIDERED UNDER THE MEDICAL PLAN. Benefits are limited to treatment within 90 days of an Accidental Injury. Injury resulting from chewing or biting will not be considered an Accidental Injury.

The following oral surgeries will also be considered payable benefits:

1. The correction of congenital abnormalities of the jaw;
2. Treatment of fractures of facial bones;
3. Excisions of mandible joints;
4. Excision of impacted teeth;
5. Excision of lesions;
6. Incision of accessory sinus, mouth, salivary glands, or ducts;
7. Excision of tumors or cysts from the mouth;
8. Cutting procedures on the gums and mouth tissue for treatment of disease with the exception of periodontal disease which is covered under the Dental Benefit;
9. Excision of exostroses of the jaws and hard palate provided that this procedure is not performed in preparation for dentures;
10. External incision and drainage of cellulitis;
11. Plastic reconstruction or repair of the mouth or lips to correct Accidental Injury;
12. Dental general anesthesia and Hospital or Ambulatory Surgical Center charges provided to any of the following:
    a. A Child under 5 years of age upon a determination by a licensed dentist and the Child's treating Physician that such Child requires necessary dental treatment in a Hospital or Ambulatory Surgical Center due to a dental condition or a developmental disability for which patient management in a dental office has proved to be ineffective; or
    b. Any Covered Person upon a determination by a licensed dentist and the individual's treating Physician that such Covered Person has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

DIABETES SERVICES. Services such as insulin, syringes, lancets, and test strips for home use are available through the Prescription Drug portion of the Plan. Services such as, but not limited to, nutritional counseling, diabetes education, alcohol swabs, and glucose monitors will be considered under the medical portion of the Plan.

DIAGNOSTIC SERVICES. Services performed for the express purpose of determining the cause of definite symptoms experienced by the patient, not in connection with routine physical examinations except as specified in this Plan Document. Covered Expenses include:

1. Pathology;
2. Radiology; and
3. Physician's interpretation.

DOMESTIC VIOLENCE/DOCUMENTED MEDICAL CONDITION. With respect to any Injury which is otherwise covered by the Plan, the Plan will provide benefits otherwise provided for the treatment of an Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition.

DRUGS AND MEDICATIONS. Drugs and medications (including insulin) prescribed by a Physician and dispensed by a licensed pharmacist, which are necessary for the treatment of an Injury or Illness. Please refer to the **PRESCRIPTION DRUG PLAN BENEFITS** under Section 19.

DURABLE MEDICAL EQUIPMENT ("DME") AND PROSTHETIC DEVICES BENEFIT. Coverage for DME and Prosthetic Devices must be ordered or provided by or under the direction of a Physician for use outside a Hospital, Skilled Nursing Facility, or Inpatient rehabilitation facility. Pre-notification of the utilization review/case management organization is required for any item for which the cost to rent or purchase is $1,000 or more. For more information, please refer to the Schedule of Benefits.

Coverage is provided for Prosthetics and Durable Medical Equipment listed below that meet the minimum specifications that are Medically Necessary. No coverage is provided for repair, replacement, or duplicates, nor is coverage provided for health services related to the repair or replacement, except when necessitated due to a physiological change or to improve physical function.

1. Purchase of artificial limbs, artificial eyes, and other Medically Necessary Prosthetic Devices made necessary because of an Illness or Injury, limited to a single purchase of each type of Prosthetic. A Prosthetic Device replaces a limb or body part.
2. Rental or purchase, at the discretion of the Plan Administrator, of Durable Medical Equipment, including, but not limited to, the following:
   a. Braces, including necessary adjustments to shoes to accommodate braces;
   b. Oxygen and rental of equipment for the administration of oxygen, including tubing, connectors, and mask;
   c. Standard wheelchairs;
   d. Standard Hospital-type beds;
   e. Delivery pumps for tube feedings, including tubing and connectors; and
   f. Match Medicare guidelines for CPAP machines and supplies for treatment.

ELECTIVE STERILIZATION. Tubal ligations and vasectomies, but not reversals of the procedures.

EXTENDED (SKILLED) CARE FACILITY SERVICES. Room and board up to the lesser of the facility's regular daily semiprivate rate or 50% of the most common daily semiprivate rate of the Hospital in which most recently confined, and other services and supplies for a maximum of 120 days per Calendar Year.

Confinement must begin within 14 days of discharge from a Hospital Confinement for the same or related conditions provided a duly qualified Physician is supervising such care and certifies in writing that the patient continues to need skilled nursing care or supportive therapeutic services as part of a regimen of Medical Care.

GASTRIC BYPASS/BARIATRIC SURGERY. This includes related procedures for treatment of obesity such as, but not limited to, lap band surgery.

GENETIC TESTING.

1. Prenatal Genetic Screening. Effective January 1, 2021, the following prenatal genetic testing is a covered medical expense
provided that the tests are within the following Level A recommendations established by the American College of Obstetrics and Gynecology (ACOG):

a. First or second trimester screening tests for fetal aneuploidy disorders (e.g., Down Syndrome), or specific inherited disorders such as cystic fibrosis and sickle cell disease; and

b. Follow-up diagnostic tests for the same conditions if an initial screening indicates a likelihood of a genetic defect. Pre-certification by the Plan's utilization review organization for prenatal genetic testing is recommended.

2. Other Genetic Testing. Effective January 1, 2021, genetic testing is covered if performed (1) in connection with the identification an actual treatment plan for a diagnosed illness, (2) is Medically Necessary, and (3) is considered to be the standard of care for the diagnosis. Pre-certification by the Plan's utilization review organization for genetic testing is required.

The Plan excludes screening and testing: (a) of family members, (b) by multiple methods for the same disorder(s), (c) multigene panels for diseases such as cancer, (d) tests to determine the child's gender or hereditary predispositions (predictive tests), and (e) home testing kits.

HEARING AIDS/EXAMINATIONS. Paid at the benefit level described in the Schedule of Benefits and in Section 24.

HEMODIALYSIS SERVICES.

HOME HEALTH CARE. This is care furnished in the patient's home by a Home Health Care Agency for the following Medically Necessary services and supplies for up to 100 visits per calendar year not to exceed 4 hours per visit if not already covered elsewhere under Major Medical Benefits:

1. Part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.);
2. Part-time or intermittent home health aide services consisting primarily of caring for the patient;
3. Physical therapy, occupational therapy, and speech therapy;
4. Social services counseling;
5. Drugs, medicine, dressing, laboratory tests ordered by a Physician;
6. Dietary guidance by qualified nutritionists; and
7. Home infusions.

Home Health Care requires precertification of coverage.

HOSPICE CARE BENEFITS. This Plan will pay for the services charged by a licensed Hospice Care Program, at the benefit level and up to the maximum limits as shown in the Schedule of Benefits. Eligible Expenses will include the following charges:

1. Nursing care by a Registered Graduate Nurse (R.N.), or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse (R.N.);
2. Physical therapy, occupational therapy, and speech therapy when rendered by a licensed therapist;
3. Medical supplies, including drugs and biologicals, and the use of medical appliances;
4. Physician services;
5. Psychological and dietary counseling;
6. Services, supplies, and treatment deemed Medically Necessary and ordered by a licensed Physician; and
7. Bereavement counseling which are services for the Family Unit ordered and received under a Hospice Care Program, consisting of supportive services rendered after the death of the Terminally Ill Covered Person by members of the Hospice Team. Benefits for Bereavement Counseling Services are payable only if the following conditions are met:
   a. On the day immediately prior to death the Terminally Ill Covered Person was in a Hospice Care Program and a member of the Family Unit;
   b. The charges are incurred within 6 months following the date of the Terminally Ill Covered Person's death; and
   c. Benefits are limited to a total of 15 Visits per Family Unit.

Items that are not covered under Hospice Care are:

1. Funeral arrangements;
2. Financial or legal counseling which includes estate planning or the drafting of a will;
3. Homemaker or caretaker services which are not solely related to care of the Covered Person, including sitter or companion services for either the Covered Person who is ill or other members of the Family Unit;
4. Transportation; or
5. Housecleaning and maintenance of the house.

Services are limited to Terminally Ill patients with fewer than 6 months to live.

HOSPITAL CONFINEMENT BENEFITS. This includes bed and board, general nursing care, meals and dietary services provided by the Hospital. All semi-private room or ward accommodations are covered subject to mandatory precertification of coverage.

1. Room and Board. Semi-private room accommodations and general nursing services. Room charges made by a Hospital having only private rooms will be paid as if the room were a semi-private room. Expenses for special care units, including general nursing services. Special care units include intensive care units, cardiac care units, respiratory care units, step down units, Emergency care facilities, and other units considered by the Plan to be special care units. If a private room is Medically Necessary for isolation purposes, the private room charge will be considered as semi-private.
2. Hospital Services and Supplies. Benefits for Medically Necessary services and supplies furnished during a covered Hospital Confinement.

HOSPITAL OUTPATIENT TREATMENT. Benefits will be payable for Medically Necessary services and supplies furnished by the Outpatient department of a Hospital.

HOSPITAL PRE-ADMISSION TESTING. To avoid unnecessary time confined in the Hospital, it is recommended that Covered Persons have diagnostic pre-work completed on an Outpatient basis before Hospital admission. This applies to tests performed within seven (7) days prior to admission and be ordered by a Physician.

IMMUNOSUPPRESSANTS.

INFERTILITY TESTING. Charges incurred for infertility testing programs and related services and supplies for active and Retired Participants and their Dependent Spouses.

INPATIENT PHYSICIAN BENEFITS. In-Hospital Visits by a Physician for treatment of an Injury or Illness are covered benefits of this Plan. This benefit includes consultations by other Physicians if Medically Necessary and recommended by the attending Physician. The consulting Physician must be conferring in a medical area different from that of the attending Physician or any other consulting Physician. Charges for covered services will be paid up to the Maximum Allowable Charge for each service for non-PPO providers or Indemnity plans which is based on the PPO Allowable Amount, or to the PPO Allowable Amount for each PPO provider service.

MAMMOGRAMS. Charges for routine mammograms (including 3D mammograms), and mammograms (including 3D mammograms) required because of an Illness or Family history. Frequency based upon current recommendations of the American Cancer Society. Payment as specified in the Schedule of Benefits.

MANIPULATIVE THERAPY. Subject to Medical Necessity provision. Maintenance care is not covered. The following services are Eligible for coverage:

1. Ultrasound	If provided in the chiropractor's office
2. Electrical stimulation (TENS)	If provided in the chiropractor's office
3. Hot and cold packs	If used for therapy in the chiropractor's office; purchase for use at home is not covered
4. Diathermy	If provided in the chiropractor's office
5. Manipulation	If provided in the chiropractor's office
6. Office calls	
7. Traction	If provided in the chiropractor's office
8. X-ray and laboratory services	
9. Active Release Technique	CPT codes 97110, 97112 & 97140 only

Services excluded from coverage:

1. Acupuncture	13. Massage therapy
2. Whirlpool treatments	14. Chelation therapy
3. Colonic therapy/irrigations	15. Computerized axial tomography
4. Magnetic resonance imaging	16. Graphic x-ray analysis
5. Hair analysis, toxic metal analysis heavy metal screening, mineral cellular analysis	17. Hand-held dopler
6. Inertial extensilizer	18. Iris analysis, iridology
7. Kinesiology	19. Living cell analysis

8. Moire contoura graphic analysis
9. Nutritional counseling
10. Oxygen therapy
11. Ream's lab or Ream's test
12. Thermographic procedures
20. Biosterometric studies
21. Over-the-counter drugs/preparations
22. Rolfing
23. Sublingual or oral therapy
24. Other services not listed as Covered

MATERNITY EXPENSE BENEFITS. This Plan complies with all provisions of the Newborns' and Mothers' Health Protection Act of 1996.

Eligible maternity expenses due to pregnancy of a Participant, Covered Spouse, or Covered Dependent will be considered on the same basis as any other Illness. Benefits will be paid according to the Plan provision for the type of expense incurred; i.e., Hospital expenses under the Hospital expense benefit, obstetrical delivery as a surgical expense, etc. Eligible maternity expenses include the services of a licensed and/or certified Nurse-Midwife. No benefits are payable for:

1. The Covered Dependent's Child once he is born.
2. Surrogacy whether for a Participant or Covered Spouse.
3. At-home births.

MEDICAL SUPPLIES. Supplies that are Medically Necessary and prescribed by a Physician:

1. Surgical supplies, casts, splints, trusses, and crutches.
2. Oxygen and rental of equipment for its administration.
3. Rental up to the purchase price or, at the Plan Administrator's option, the purchase of Hospital-type equipment, including wheelchair or Hospital-type bed, iron lung or other respiratory paralysis equipment, or kidney dialysis equipment.
4. Artificial limb(s) or eye(s) and Prosthetic Appliances required because of Injury or Illness.
5. Blood, if not replaced, and blood derivatives.
6. Leg, back, arm, and neck braces required because of Injury or Illness.
7. Wigs limited to a $300 Lifetime Maximum for wigs needed for hair loss following chemotherapy.
8. Initial lenses or glasses immediately following cataract surgery or cataract lenses (replacement of cataract lenses only when prescription changes).
9. Injectible medications not covered under the Prescription Drug Plan unless approved by the Benefits Administrator.
10. Insulin, needles, and syringes unless covered under the separate Prescription Drug benefit.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS. Benefits are available for Inpatient or Outpatient care for mental health and Substance Abuse conditions, including individual and group psychotherapy, Medically Necessary nutritional counseling, psychiatric tests, and expenses related to the diagnosis when rendered by a covered provider. Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

MENTAL AND NERVOUS RELATED SERVICES. Mental and Nervous related services as specified in the Schedule of Benefits. This benefit also includes: Medically necessary Nutritional counseling, Psychiatric Medical Institution for Children ("PMIC"). Inpatient residential care for Children diagnosed with Biologically

Based Mental Illness. Individual must be under 19 years of age, have a chronic, persistent condition, and have failed intensive outpatient therapy. Benefit is subject to review for Medical Necessity. Precertification of Inpatient Stay, and continued Case Management/Utilization review for the duration of the treatment. See Definitions of Biologically Based Mental Illness and Psychiatric Medical Institution for Children for additional information.

MORBID OBESITY. Medically Necessary charges for Morbid Obesity, including, but not limited, to Physician office Visit charges, behavior modification, and required x-ray and laboratory examinations. A person is considered morbidly obese if the patient's weight is more than 100 pounds over the ideal weight of a medium-frame person based on standard charts used by the life insurance industry. See Gastric Bypass/Bariatric Surgery in the Schedule of Benefits for additional information and limitations.

MOTHER AND NEWBORN HOSPITAL CONFINEMENT. Coverage for a Hospital stay following a normal vaginal delivery will be not less than 48 hours for both the mother, if a Covered Person, and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a caesarian section will be not less than 96 hours for both the mother, if a Covered Person, and the newborn Child unless a shorter stay is agreed to by both the mother and her attending Physician.

NEWBORN SERVICES. Payment for Covered Charges incurred by a well newborn Child for Hospital and Physician services during Hospital Confinement immediately following birth will be made on the same basis as for any Illness. Benefits will be payable if the Participant has properly enrolled his Dependent for Dependent Benefits and the Dependent Benefits are effective. When a newborn incurs charges as a result of Illness, Injury, or congenital abnormality, payment for Covered Expenses incurred for Hospital and Physician services during Hospital Confinement immediately following birth will be made on the same basis as for any Illness provided the Participant properly has enrolled his Dependent for Dependent Benefits and the Dependent Benefits are effective. Circumcision of a male infant is covered. No benefit is payable for the child of a Covered daughter.

NURSING CARE. Care provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.).

OCCUPATIONAL THERAPY Occupational therapy provided by a licensed occupational therapist. Occupational therapy must be ordered by a Physician, result from an Illness or Injury, and improve a body function. Occupational therapy must be in accordance with the Physician's exact orders as to type, frequency and duration. Occupational Therapy in conjunction with applied behavior analysis (ABA) therapy for autism spectrum disorder is also covered when Medically Necessary.

ORGAN TRANSPLANT BENEFITS. In addition to the standard transplant benefits stated in this Plan, additional benefits may be available when a Covered Person participates in the Centers of Excellence Transplant Program offered through the utilization review/case management organization. This Transplant Program may provide additions to the standard transplant benefit. Participation in the program is voluntary. **Benefits paid will not exceed the rate that would have been charged had the procedure been performed at a Center of Excellence Facility nearest to the facility in which the transplant takes place if it is not performed at a Centers of Excellence Facility**. Contact the utilization review/case management organization to receive information concerning the benefits of participating in the Centers of Excellence Program. Travel, lodging, and related expenses for an accompanying family member/support person are reimbursable up to a $5,000 Lifetime Maximum in cases in which travel outside the Covered Person's area of residence is required to obtain treatment at a Centers of Excellence Facility. Such expenses must be allowable under IRS Code Section 213(d), and not

exceed the dollar amounts allowed under IRS Code Section 213(d). Expenses must be itemized, accompanied by receipts, and approved by the Benefits Administrator.

Benefits are payable for organ and tissue transplant services. These services must be incurred during a transplant benefit period that begins while a recipient is covered for these benefits.

A transplant benefit period is the time beginning 5 days before the date of the organ or tissue transplant. It ends 18 months after the organ or tissue transplant was completed.

Benefits are payable if the recipient receives an opinion on the Medical Necessity for transplant surgery from the utilization review/case management vendor. The opinion must be given:

1. By a board-certified specialist in the involved field of surgery; and
2. In writing, and the specialist must certify alternative procedures, services, or courses of treatment would not be effective in the treatment of the patient's condition.

The following conditions must be met:

1. The condition is life-threatening; and
2. Such transplant for that condition is not the subject of an ongoing phase III clinical trial; and
3. Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency, or other such organization recognized by medical specialists who have appropriate expertise; and
4. The patient is a suitable candidate for the transplant approved by the Plan.

Organ or Tissue Transplant Services include the following:

1. Organ and tissue procurement, consisting of removing, preserving, and transporting the donated organ (subject to coordination with any other medical benefits covering a living donor);
2. Hospital room and board, and medical supplies;
3. Diagnosis, treatment, and surgery by a Physician;
4. Private nursing care by a Registered Nurse (R.N.) and/or a Licensed Practical Nurse (L.P.N.);
5. The rental of wheelchairs, Hospital-type beds, and mechanical equipment required to treat respiratory impairment;
6. Local ambulance service, medication, other diagnostic services, laboratory tests, and oxygen;
7. Rehabilitative therapy consisting of speech therapy (not for voice training or a lisp), audio therapy, visual therapy, occupational therapy, and fist-therapy; and
8. Surgical dressing and supplies.

Covered organ or tissue transplants include the following procedures: bone marrow, heart, heart/lung, liver, lung, pancreas, kidney, and cornea.

Charges for organ or tissue transplant services incurred during a transplant benefit period will be paid as follows:

1. Charges for organ and tissue procurement,
2. Charges for private nursing care, and
3. Charges for all covered services. The Plan pays the percentages outlined in the Schedule of Benefits for all covered services.

If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for charges incurred for 1 and 2 above.

Two or more transplant benefit periods are treated as follows:

1. If they are due to unrelated causes, they are treated as separate periods.
2. If they are due to related causes, they are treated as separate periods if:
   a. In the case of a Participant, they are separated by a return to Active Work;
   b. In the case of Covered Dependents, they are separated by at least 3 consecutive months.
3. If they are due to related causes, they are treated as one period when not separated as shown in 2 above.

Services that are not covered under the organ transplant benefit are:

1. Services and/or supplies for an organ transplant other than bone marrow, cornea, heart, heart/lung, lung, kidney, liver, and pancreas, unless other organ transplants are approved;
2. Services or supplies related to any transplant involving mechanical organs; or
3. Expenses associated with the purchase of any organ.

OVER-THE-COUNTER COVID TESTS. As required by applicable law, the Plan covers the costs of over-the-counter (OTC) COVID-19 tests without an order or clinical assessment by a Physician as long as a Public Health Emergency exists as determined by applicable federal authorities.

ORTHOTICS. Orthotics are covered if Medically Necessary and prescribed by a Physician to maintain the health of an individual who has a specific medical condition that requires the orthotic device. The device must be necessary to enable the Covered Person to carry out normal activities of daily living. Custom-made orthotics require documentation of a significant medical condition/disease. Orthotics are considered Durable Medical Equipment. Predetermination of benefits is required.

OXYGEN. Oxygen and the equipment for its use and administration.

PHYSICAL THERAPY. Physical therapy provided by a registered physical therapist. Physical therapy must be ordered by a Physician, result from an Illness or Injury, and improve a body function. Physical therapy must be in accordance with the Physician's exact orders as to type, frequency, and duration.

PHYSICIAN'S OR SURGEON'S SERVICES. Services for Medical Care and treatment. Surgeon's services may be subject to the Pre-Surgical Benefit Review provision which includes Inpatient admissions and certain Outpatient procedures.

PRE-ADMISSION TESTING. Charges incurred on an Outpatient basis for X-rays, laboratory examinations and other tests ordered by a Physician prior to a scheduled Hospital admission for covered services.

PREGNANCY OF DEPENDENT DAUGHTER. Charges for the pregnancy of an Eligible Dependent daughter are covered as any other Illness, but charges for the baby are not covered.

PREVENTIVE HEALTH/ROUTINE PHYSICALS/WELL BABY/WELL CHILD. Routine physical examinations and diagnostic tests performed as part of the examination including but not limited to

gynecological examinations, pap tests, prostate screenings, school/sport physicals, and immunizations. Benefits are payable as described in the Medical Benefits.

PRIVATE-DUTY NURSING. Private-Duty Nursing charges of a Registered Graduate Nurse (R.N.) in or out of a Hospital, or a Licensed Practical Nurse (L.P.N.) in a Hospital. Private-Duty Nursing services are covered only to the extent they are Medically Necessary and prescribed by a Physician.

SECOND OPINIONS. The Plan will accept a second and, if necessary, a third opinion with payment according to plan benefits. Precertification of an admission or outpatient surgery requiring benefit review is still necessary for consideration of maximum Plan benefits.

SEX ASSIGNMENT/REASSIGNMENT. Subject to Medical Necessity, the Plan covers the following sex assignment/reassignment services when ordered by a provider or Physician.

1. Psychotherapy;
2. Pre- and post-surgical hormone therapy; and
3. Sex reassignment surgery/ies. Surgery must be performed by a qualified provider. The service requires Precertification.

SLEEP DISORDERS. Care and treatment for sleep disorders if deemed Medically Necessary.

SMOKING CESSATION. Nicotine transdermal systems and prescription medications to promote smoking cessation unless otherwise covered by the Prescription Drug Plan.

SPEECH THERAPY. Services provided by a certified speech therapist to:

1. Restore speech loss; or
2. Correct an impairment due to a congenital defect for which corrective surgery has been performed; or
3. Correct an impairment caused by an Injury or Illness not caused by a mental, psychoneurotic, or personality disorder.

SURGICAL BENEFITS. This Plan complies with all provisions of the Women's Health and Cancer Rights Act of 1998.

Surgical benefits include professional fees for performing any Medically Necessary surgical procedure in or out of the Hospital to treat an Illness or Injury. Surgical benefits include manual and operative procedures including, but not limited to, the repair of injuries, correction of deformities and defects, diagnosis and cure of certain diseases, and those procedures normally considered as surgical. Surgical consideration is limited to the Maximum Allowable Charge for each procedure for non-PPO providers which is based on the PPO Allowable Amount, or to the PPO Allowable Amount for each procedure for PPO plans.

Multiple surgical procedures performed during the same operative session will be payable according to the following allowances after applying the appropriate Deductible amount and Co-Insurance rate:

1. 100% of the Maximum Allowable Charge for the first or greater procedure for non-PPO providers which is based on the PPO Allowable Amount, or to 100% of the PPO Allowable Amount for the first or greater procedure for PPO plans;

2. 50% of the Maximum Allowable Charge for the second procedure for non-PPO providers which is based on the PPO Allowable Amount, or to 50% of the PPO Allowable Amount for the second procedure for PPO plans; and
3. 50% of the Maximum Allowable Charge for each non-incidental procedure for non-PPO providers which is based on the PPO Allowable Amount, or to 50% of the PPO Allowable Amount for each non-incidental procedure for PPO plans.

TELEHEALTH. Prior to March 1, 2020, the Plan provided full coverage for telephone consults or e-mail consults provided by a Physician for non-emergent care, including mental health care/behavioral medicine, through the Plan's vendor. Common examples of which to use telehealth for non-emergent medical care, include but are not limited to the following:

1. Care after provider office hours;
2. Care while out of town or on vacation;
3. Care when unable to be seen by your primary care provider(s);
4. Second opinions; and
5. Research and advice on a particular health condition.

During the interim period of March 1, 2020 to December 31, 2020, or the end of the COVID-19 public health emergency declared by the U.S. Secretary of Health and Human Services, whichever is later, in order to provide vital health care services to individuals seeking such services, but who are ordered, discouraged or are otherwise precluded from seeking those services at a healthcare facility or "brick and mortar" location due to COVID 19, this provision will allow benefits toward telehealth services if the reason for the Telehealth Service, defined as the use of digital information and virtual technologies, i.e. computer, tablet, mobile device, or remote management of an individual's health, is not otherwise excluded.

This provision will allow payment for the allowable Telehealth service without requiring the eligible individual to seek Telehealth services from MD Live providers. Telehealth services will be payable at the current benefit level as provided in the Schedule of Benefits for PPO and Non-PPO allowable charges and benefit levels.

This provision will remain in effect through December 31, 2020, or the end of the COVID-19 public health emergency declared by the U.S. Secretary of Health and Human Services, whichever is later, unless otherwise terminated or amended by the Board of Trustees.

The Plan Administrator or its designee shall have the discretion and authority to determine if an expense, service, supply or device, as it relates to this provision, meets the above criteria necessary for benefit application.

TEMPOROMANDIBULAR DISORDERS (TMD). Treatment of Temporomandibular Disorders (TMD).

WIG. Charges associated with the initial purchase of a wig after chemotherapy, subject to $300 Lifetime Maximum.

X-RAY AND LABORATORY EXAMINATIONS. Examinations made for diagnostic or treatment purposes.

SECTION 16 - NO SURPRISES ACT SERVICES AND PROTECTIONS

The No Surprises Act, signed into law in December 2020, protects Participants and Dependents who receive Emergency Services at a Health Care Facility (or at an independent freestanding emergency department). The law also protects Participants and Dependents who receive services from out of network Air Ambulance services. In addition, the law protects Participants and Dependents who receive non-Emergency Services from an out-of-network provider at an in network or PPO Health Care Facility. Effective October 1, 2022, Participants and Dependents receiving these services will only be responsible for paying their network cost sharing and cannot be balance billed by the provider or facility.

For purposes of this No Surprise Act claims, an "out-of-network" provider or "Non-PPO" provider refers to a provider that is not in the Plan's "Preferred Provider Organization" ("PPO") network, and an "in network" provider or "PPO" provider refers to a provider that is in the Plan's PPO network.

The requirements of the No Surprises Act shall supersede and apply in the event that there is a conflict between the coverage provisions and terms of this Plan Document/SPD and the federal No Surprises Act.

Air Ambulance Services

Air ambulance services are medical transport for patients by a rotary wing air ambulance or fixed wing air ambulance. The No Surprises Act requires Air Ambulance Services, to the extent covered by the Plan, to be covered as follows:

- Air ambulance services from an out-of-network provider are covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider;
- The cost-sharing amount will be calculated as if the total amount that would have been charged for the services by an in-network provider of air ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services;
- Any cost-sharing payments the participant or dependent makes with respect to covered air ambulance services will count toward your in-network deductible and in-network out-of-pocket maximum in the same manner as those received from an in-network provider; and
- In general, a participant or dependent cannot be balance billed for these air ambulance services.

Continuing Care Patients

If a participant or dependent is a Continuing Care Patient and the Plan terminates its contract with an in-network provider or an in-network facility or Hospital, or benefits are terminated because of a change in terms of providers' and/or facilities' participation in the Plan, the Plan will do the following:

- Provide notice of the Plan's termination of its contracts with the in-network provider or facility and inform the patient or their representative of the patient's right to elect continued transitional care from the provider or facility; and
- Allow the patient (90) days of continued coverage at the in-network cost sharing to allow for a transition of care to an in-network provider or facility.

For purposes of this coverage, termination does not include a termination of a contract for failure to meet applicable quality standards or for fraud.

A Continuing Care Patient is an individual who is: (a) receiving a course of treatment for a Serious and Complex Condition, (b) scheduled to undergo non-elective surgery (including any post-operative care); (c) pregnant and undergoing a course of treatment for the pregnancy; (d) determined to be terminally ill and receiving treatment for the illness; or (e) is undergoing a course of institutional or inpatient care from the provider or facility.

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

Emergency Services

The No Surprises Act requires Emergency Services to be covered as follows:

- Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;
- Without regard to whether the health care provider furnishing the Emergency Services is an in-network provider or an in-network facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on non-in-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from in-network providers and in-network facilities;
- Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by an in-network provider or an in-network facility;
- By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services;
- By counting cost-sharing payments you make with respect to non-in-network Emergency Services toward your in-network provider deductible and in-network provider out-of-pocket maximum in the same manner as those received from an in-network provider; and
- In general, participants and beneficiaries cannot be balance billed for these Emergency Services.

Non-Emergency Services

The No Surprises Act requires non-Emergency Services performed by an out-of-network provider at an in-network Health Care Facility to be covered as follows:

- 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;

- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such in-network provider were equal to the Recognized Amount for the items and services; and
- By counting any cost-sharing payments made toward any in-network provider deductible and in-network provider out-of-pocket maximums applied under the Plan (and the in-network provider deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an in-network provider.
- In general, participant and beneficiaries cannot be balance billed for these items or services.

Notice and Consent Exception

Non-emergency items or services provided or performed by an out-of-network provider at an in-network Health Care Facility will be covered based on the Plan's out-of-network provider benefits and will not be subject to the financial protections of the No Surprises Act if:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the patient (or their representative) is provided with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on treatment, the names of any in-network providers at the facility who are able to provide treatment, and that the patient may elect to be referred to one of the in-network providers listed; and
- The patient gives written informed consent to continued treatment by the out-of-network provider acknowledging that the patient understands that continued treatment by the out-of-network provider result in greater expenses.
- The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the out-of-network provider satisfied the notice and consent criteria and, therefore, these services will be covered as follows:
    - 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;
    - With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services; and
    - By counting any in-network provider deductible and in-network provider out-of-pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by an in-network provider.
    - In general, participants and beneficiaries cannot be balance billed for these items or services.

Choice of Health Care Professional

The Plan does not require the selection or designation of a primary care provider (PCP) or pediatrician. You have the ability to visit any network or out-of-network health care provider; however, payment by the Plan may be less for the use of an out-of-network provider.

Access to Obstetrical and Gynecological Care

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

External Review Process

The External Review Procedures set forth herein shall apply to No Surprise Act service claims.

Incorrect Provider Directory

The provider directory will be updated at least every ninety (90) days. If a participant or dependent is informed by the Plan through a telephone, electronic, or internet-based inquiry, or receives information from a print or electronic Provider directory that a provider is an in-network provider, but, in fact, the provider is an out-of-network provider and services are furnished by the out-of-network provider, the Plan will:

- Apply a cost-sharing amount that is no greater than the cost-sharing amount that would have been assessed if the provider was an in-network provider; and
- Apply the out-of-pocket limit, if any, as if the services were provided by an in-network provider.

SECTION 17 - COST MANAGEMENT PROGRAMS

MANDATORY PRE-ADMISSION REVIEW

If a Covered Person requires Hospital Confinement, including Partial Hospital Confinement, for an Injury or Illness or requires certain Outpatient procedures, authorization must be obtained from the utilization review/case management vendor at least 7 days prior to a non-Emergency admission or procedure if reasonably possible. In the event of an Emergency admission or procedure, authorization must be obtained within 48 hours after the admission.

Full benefits for Hospital charges and certain Outpatient procedures will be paid only for approved admissions and confinement days, and approved procedures.

If admission and length of stay approval, as well as approval for certain Outpatient procedures, is not obtained as specified above, a $100.00 per occurrence penalty reduction will be applied to unauthorized Hospital Confinements.

If confinement extends beyond the approved length of stay, additional days must be authorized by the utilization review/case management vendor. The same requirements and reduction penalties will apply to the additional days.

Charges for any part of a Hospital Confinement not deemed to be Medically Necessary by the utilization review vendor will be excluded.

PRECERTIFICATION REQUIRED FOR CERTAIN PROCEDURES WHETHER INPATIENT OR OUTPATIENT

When surgery is recommended for a Covered Person or certain other procedures are recommended, a Pre-Surgical or Pre-Procedural Benefit Review by the utilization review/case management vendor is required. This applies to all Inpatient Surgeries and selected Outpatient procedures as identified below:

Abdominoplasty
AICD and Biventricular device insertions
AV Fistula or graft access for dialysis
Back or neck procedures: IDET (intradiscal Electrothermal Annuloplasty), Percutaneous Radiofrequency Neurotomy, Artificial Intervertebral Disk Implantation, Automated Percutaneous Lumbar Diskectomy (APLD)
Bariatric (weight loss) Surgery
Bioengineered skin and soft tissue replacement
Biopsies as primary procedures, outside of physician office
Blepharoplasty

Breast Reduction
Capsule Camera Endoscopy
Chemical Dependency / Behavior Health - Partial Hospitalization or Intensive Outpatient Therapy Program
Chemotherapy
CT Angiogram
CT Calcium screening
Dialysis
Durable Medical Equipment in excess of $1,000 to purchase or if total rental costs exceed $1,000
Excess skin removal arms and chests and legs
Genetic Testing (except for Prenatal Genetic Screening which is recommended)
Home Care
Hospice services
Hyperbaric Oxygen
Hysterectomies
Specialty Drug Infusions and Injectables of specialty drugs outside of pharmacy benefit plan
Maxillo-facial surgery - *unless orthognathic surgery is excluded by Plan language
MRI of the heart
Nasal Surgeries
Oncology related PET, CT, or MRI
Oncology related surgeries
Osteochondral Autografts
Panniculectomy
Partial or Full Joint Replacements
Port insertions
Prosthetic and Orthotic in excess of $1,000 to purchase or if total rental costs exceed $1,000
Radiation oncology
Rehab program (such as Pulmonary, Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Therapy) beyond 12 visits per injury or illness

Sclerotherapy
Sex Reassignment Surgery/ies
Shock wave lithotripsy plantar fasciitis
Spinal surgeries - Including spinal injections for pain management
Tonsillectomies/Adenoidectomies over age 18
Transplant Candidacy Evaluation
UP3/UPPP – uvulopalatopharyngoplasty
Varicose vein surgery
Ventral hernia repair
Virtual Colonoscopy

These procedures can be precertified by calling the "800" number found on the Participant's insurance identification card. If review does not support the need for surgery or the procedure as outlined above, the patient/Covered Person may appeal the decision according to the appeal provisions contained in this Plan.

MEDICAL CARE MANAGEMENT

Medical care management is a care management program to identify Covered Persons with catastrophic or chronic conditions while covered under this Plan. This program assists Covered Persons with the following:

1. Improved understanding of his medical condition with an emphasis on health improvement and education;
2. Care planning and coordination with his physicians and other medical services; and
3. On-going monitoring and follow-up.

The following are examples of diagnoses which might constitute a catastrophic Illness or Injury:

- Neonatal high risk infant
- Cerebral vascular accident (CVA)
- Multiple sclerosis
- Amyotrophic Lateral Sclerosis (ALS)
- Leukemia
- Major head trauma and brain injury secondary to illness
- Any Claim expected to exceed $25,000
- Spinal cord injuries
- Amputations
- Multiple fractures
- Severe burns
- AIDS
- Transplants

In addition to catastrophic Illnesses, the care managers may contact Covered Persons with chronic conditions or conditions requiring a large volume or high dollar medical services in the plan year.

When a care manager is notified of a Covered Person who might be appropriate for this program, the Covered Person is notified and his attending physician(s) is called for medical information to assist with the coordination of his care and treatment plan.

All services and supplies authorized by the treatment plan will be considered Covered Expenses whether or not they are otherwise covered under the Plan. The benefit level for alternative treatment settings may be the same as the Hospital benefit level in the absence of the medical Care Management program. For all other services and supplies, the benefit level will be the same as the benefit for Outpatient medical treatment in the absence of the program.

Care management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SECTION 18 – LIMITATIONS APPLICABLE TO MAJOR MEDICAL BENEFITS

Benefits shall not be payable for:

ABORTION. Elective abortions.

ADOPTION EXPENSES. Services, supplies, or other fees incurred in the process of adopting a child. The child will become a covered Dependent on the effective date of the legal placement for adoption. There are no benefits for surrogate parenting.

ALCOHOL. Care, supplies, treatment, and/or services to a Covered Person arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply: (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) if the Injury resulted from a medical condition (including both physical and mental health conditions).

ALTERNATIVE THERAPY. Acupuncture, acupressure therapy, massage therapy, hypnotism, aquatic therapy, craniosacral/cranial therapy, myofunctional therapy, applied, kinesiology, prolotherapy, rolfing, biofeedback, dance therapy/movement therapy, and similar therapies.

AMBULANCE SERVICE. Except as specifically provided by the Plan.

AUTOMOBILE INSURANCE. Any expense incurred as a result of a motor vehicle accident if that expense was covered or was required to be covered by the laws of any state by automobile insurance. This exclusion is intended to provide that the insurance benefits covering motor vehicle accidents are primary.

BEHAVIOR MODIFICATION. Services provided for changing or modifying behavior such as anger management.

BLOOD. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery. Blood administration for the purpose of general improvement of physical condition.

CHILD OF DEPENDENT. Charges for the child of a Dependent daughter following birth.

COLLEGE SPORTS. Any expenses incurred as the result of an Injury which occurs while the Covered Person is competing in college varsity or junior varsity organized competitive sports when a separate policy is in force.

CONTRACEPTIVES. Hormonal Contraceptives such as oral drugs, patches, rings, self-injectables with the exception of the initial administration; emergency Contraceptives such as "morning after" pill. See Sections 15, 19, and 20 for additional information.

COSMETIC. Cosmetic or Reconstructive Surgery unless the surgery is necessary:

1. For repair or alleviation of damage resulting from an Accident;
2. Because of infection or Illness;

3. Because of congenital disease, developmental condition, anomaly of a covered Dependent Child which has resulted in a functional defect; or
4. When surgery is required for the reconstruction of either a breast on which a mastectomy has been performed, or on the other breast in order to produce symmetry of appearance.

COSMETICS. Cosmetics, dietary supplements, and health and beauty aids.

COUNSELING. Non-medical counseling or ancillary services, including but not limited to custodial services, education, training, occupational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back-to-school or return-to-work services, work hardening programs, driving safety and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism, or mental disability.

CUSTODIAL CARE. Domiciliary care, rest cures, services that are primarily educational in nature, or any maintenance-type care which is not reasonably expected to improve the patient's condition (except Hospice Care as specified). Occupational therapy unless it is being performed to restore a physical function. Assistance in the activities of daily living, including but not limited to, eating, bathing, dressing, or other custodial services, self-care services, or homemaker services.

DATE OF COVERAGE. Charges incurred prior to the Effective Date of coverage, or charges incurred after the termination date of coverage.

DEDUCTIBLE. Charges arising from care, supplies, treatment, and/or services that are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Covered Person's responsibility in accordance with the terms of the Plan.

DENTAL. Any expense or charge in connection with dental work or oral surgery (unless otherwise provided by the Plan), except expenses for such services required for correction of damage caused by an Accidental Injury sustained by a Covered Person or for tumors or cysts of a Covered Person and except as provided in Section 21.

DEVELOPMENTAL DELAY. Charges made for functional therapy for learning or vocational disabilities, or for speech, hearing, and/or occupational therapy if such therapy is being provided due to developmental delay.

EDUCATIONAL. Charges for educational or vocational services, including but not limited to, schooling, books, and supplies. Charges for testing and/or treatment of learning disabilities including, but not limited to, dyslexia.

EMPLOYER MEDICAL DEPARTMENT. Services or supplies received from a dental or medical department maintained by or on behalf of an Employer, a mutual benefit association, Labor Union, Trustees, or similar persons or groups.

EMPLOYMENT RELATED. Charges arising out of or in the course of any employment or occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, or any such similar law. This applies whether or not Workers' Compensation or any similar law actually covers the charges incurred, or whether such employment is with the Employer, another employer, or self-employment.

ERROR. Care, supplies, treatment, and/or services that are required to treat injuries that are sustained, or an Illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a provider wherein such Illness, Injury, infection, or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

EYE CARE. Glasses, contact lenses, or eye examinations, and/or treatment (surgical or non-surgical treatment of refractive error for the correction of vision, or fitting of glasses except as specified). Any expense for surgical correction of myopia and/or other refractive errors, including, but not limited, to Radial Keratotomy ("RK"), Anterior Lens Keratotomy ("ALK"), and laser in situ keratomileusis ("LASIK"), orthoptics, or visual training.

EXERCISE. Exercise or wellness programs except for Physician supervised cardiac rehabilitation, occupational therapy, or physical therapy.

EXPERIMENTAL/INVESTIGATIONAL/INVESTIGATIVE. Drugs, medical supplies, medical devices, medical equipment, medical or surgical procedures, treatments, or services which are Experimental and/or Investigational, or do not meet accepted standards of medical practice. For details, refer to Section 1. The fact that a Physician has prescribed, ordered, recommended, or approved the treatment, services, or supply, or the fact that the requested treatment, services, or supply is the only available treatment for particular condition, does not itself make it Eligible for payment. The Trustees retain the right and discretion to determine whether a treatment, service, or supply is Experimental/Investigational/Investigative. Likewise, the Trustees have the authority and discretion to approve coverage under the Plan, notwithstanding the fact that a treatment, service, or supply would ordinarily be excluded from coverage as being Experimental/Investigational/Investigative if: (1) it is being requested for a life-threatening Illness or Injury; and (2) the requested procedure or treatment is promising, but unproven, and; (3) the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health (NIH).

EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY ("ESWL"). ESWL for musculoskeletal and orthopedic conditions.

FAMILY MEMBER. Any treatment or service rendered by a member of the immediate family (Participant, Spouse, Child, brother, sister, or parent of the Covered Person or his Spouse whether the relationship exists by blood or in-law). Services performed by a person who resides with the patient.

FETAL REDUCTION. Except when Medically Necessary due to a life threatening condition affecting the mother.

FOOT CARE. Routine foot care, diagnosis and treatment of weak, strained, unstable, or flat foot conditions, and the prescription of supportive devices for such conditions, treatment of metatarsalgia, bunions, non-prescription arch supports, braces, trusses, and supports for sports activities, except as otherwise specified. Also excluded is the treatment of toenails or superficial lesions of the feet such as corns, calluses and hyperkeratosis. This exclusion does not include operations that involve the exposure of bones, tendons or ligaments, or the treatment of toenails because of a metabolic or peripheral-vascular disease.

FROZEN EMBRYO STORAGE.

GENETIC TESTING/COUNSELING/SCREENING. Except as specified under Section 15 of this Plan, the following services are not covered: Genetic testing and/or counseling. Genetic screening or pre-implantation genetic screening. See Section 15 of the Plan for additional information.
General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant proven risk factors for genetically linked inheritable disease.
GOVERNMENT HEALTH PLAN. Charges for services and supplies which are provided by any government health plan except for state-sponsored medical assistance programs. In the case of a state-sponsored plan, benefits payable under the Plan will be reduced or denied, and will be paid to the state. Any amount paid will be considered benefits paid under the Plan, and will constitute a full discharge of liability to the extent of payment.

HAIR LOSS. Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician, except for an initial wig after chemotherapy. See ALOPECIA AREATA for coverage information.

HAZARDOUS PURSUIT, HOBBY, OR ACTIVITY. Charges for services, supplies, care and/or treatment due to an Illness or Injury caused directly or indirectly from engaging in unreasonably dangerous or extreme activities or hobbies, including but not limited to, bungee jumping, skydiving, traveling to countries with advisory warnings, and vehicular racing of any kind (including automobile racing, motorcycle racing, and all-terrain vehicle racing). An activity or hobby is unreasonably dangerous or extreme if it is characterized by a constant or imminent threat of danger or risk of bodily harm or death. This exclusion does not apply if the Illness or Injury resulted from being the victim of an act of domestic violence or underlying medical condition and is not the result of participation in any of the activities described above.

HEARING AIDS. This includes, but is not limited to, semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids ("BAHA"). A hearing aid is any device that amplifies sound. These items may be covered under the separate Hearing Aid Benefit. It also includes aids or devices that assist with non-verbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, personal digital assistants ("PDA"), Braille typewriters, visual alert systems for the deaf, and memory books.

HOME CONSTRUCTION.

HOME HEALTH CARE AGENCY. Services as follows:

1. Food, food supplements, home delivered meals;
2. Transportation;
3. Nursing care services except as otherwise specified; and
4. Housekeeping services.

HOSPITAL ADMISSIONS. Admission to the Hospital on a weekend or holiday. Hospital benefits will not be payable under this Plan for Friday, Saturday, Sunday, or holiday admissions unless the confinement is:

1. Medically Necessary as determined by the Plan;
2. For a medical Emergency;
3. For maternity; or
4. For a next-day surgical procedure.

HOSPITAL CONFINEMENT. Principally confined for observation, diagnostic evaluations, physical therapy, x-rays, or laboratory tests when such services or procedures can be safely performed on an Outpatient basis.

HOSPITAL EMPLOYEES. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility, and paid by the Hospital or facility for the service.

ILLEGAL ACT. Charges resulting from or occurring during the commission of a crime, illegal act, felonious act, or while engaging in an illegal occupation or act, or aggravated assault by the Covered Person, except claims which result from domestic abuse/violence.

IMPULSE CONTROL DISORDER. Diagnosis and/or treatment of impulse control disorders such as pathological gambling.

INCURRED BY OTHER PERSONS. Charges arising from care, supplies, treatment, and/or services that are expenses actually Incurred by other persons.

INFERTILITY TREATMENT. Charges for any treatment or procedure for which the purpose is to enhance the possibility of reproduction, including but not limited to in-vitro fertilization, artificial insemination, gamete intra-fallopian transfer, zygote intra-fallopian transfer, induced ovarian hyperstimulation, and tubal embryo transfer procedures, fertility drugs, or the reversal of sterilization.

MARRIAGE OR FAMILY COUNSELING. Note: This may be available through the Employee Assistance Program ("EAP").

MEDICAL SUPPLIES. Medical supplies such as, but not limited to bandages, trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

MEDICALLY NECESSARY. Charges for services that are not Medically Necessary.

MENTAL/NERVOUS DISORDER. Any expense incurred for the care of treatment of a mental or nervous disorder except as specified by the Plan.

MILITARY SERVICE. Any loss, expense or charge incurred while a Covered Person is on active duty or in training in the armed forces, national guard, or reserves of any state or country, except as required under USERRA or any other applicable law.

MISCELLANEOUS CHARGES. Any expense or charge for failure to appear for an appointment as scheduled, for completion of Claim forms, attorney's reports, or late stay charges. PPO discount amounts, cash discounts, over-the-counter ("OTC") items, shipping costs, interest, telephone consultations (except as provided by Telehealth provider), for medical information, and/or sales tax.

NEGLIGENCE. Care, supplies, treatment, and/or services for Injuries resulting from negligence, misfeasance, nonfeasance, or malpractice on the part of any licensed Physician.

NO CHARGE. Services for which there is no charge.

NO LEGAL OBLIGATION TO PAY. Care, supplies, treatment, and/or services that are provided to a Covered Person for which the provider of a service customarily makes no direct charge, or for which the

Covered Person is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the Covered Person or this Plan may be liable for necessitating the fees, care, supplies, or services.

NON-COVERED PROCEDURE. Services related to complications of a non-covered procedure.

NOT ACCEPTABLE. Charges arising from care, supplies, treatment, and/or services that are not accepted as standard practice by the American Medical Association ("AMA"), American Dental Association ("ADA"), or the Food and Drug Administration ("FDA").

NOT RECOMMENDED. Charges for care, treatment, services, and supplies not recommended and approved by a Physician.

NOT RESPONSIBLE. Charges for which the Covered Person would not be responsible in the absence of this Plan.

NOT SPECIFIED. Charges for services, treatment, or supplies that are not specified as covered under this Plan.

NUTRITIONAL SUPPLEMENTS. All nutritional supplements and formulae are excluded except for infant formula needed for the treatment of inborn errors of metabolism.

OBESITY. Diagnosis and/or treatment relating to weight loss or dietary control, including the diagnosis and/or treatment of obesity whether or not it is, in any case, a part of the treatment plan for another Illness. Medically Necessary charges for Morbid Obesity will be covered. Coverage for gastric by-pass/bariatric surgery determined to be Medically Necessary, and any complications thereof will be limited to a $40,000 Lifetime Maximum.

OTHER THAN ATTENDING PHYSICIAN. Charges arising from care, supplies, treatment, and/or services that are other than those certified by a Physician who is attending the Covered Person as being required for the treatment of Injury or Illness, and performed by an appropriate provider.

OUTSIDE HMO NETWORK. Any expense incurred by an employed Spouse who has coverage provided through his employer under a Health Maintenance Organization ("HMO") when such Spouse utilizes providers outside of the HMO network.

OUTSIDE THE UNITED STATES. Charges incurred outside the United States if the travel to such a location is for the primary purpose of obtaining medical services, drugs or supplies. Charges incurred outside the United States unless they are the result of a medical emergency. Air ambulance charges except as specified within the United States and Canada. Charges incurred outside the United States must be paid by the Participant and will be reimbursed to the Participant by the Plan after review to determine whether they are eligible charges. Participants and Covered Dependents traveling outside the United States are encouraged to investigate other insurance such as travel insurance, depending upon duration of travel.

PERSONAL CONVENIENCE. Personal convenience or comfort items such as CPAP cleaners, air conditioners, air purifiers, water purifiers, dehumidifiers, orthopedic mattresses, hypoallergenic pillows, blood pressure devices, scales, exercise cycles, elastic bandages, non-Prescription Drugs and medicines, first-aid bandages, waterbeds, and non-Hospital adjustable beds.

PHYSICAL EXAMINATIONS. Reports, evaluations, or hospitalizations not required for health reasons, including but not limited to: pre-marital, pre-employment, insurance, government licenses, forensic, or custodial evaluations.

PRIVATE DUTY NURSING. Private Duty Nursing care during a period in which the Covered Person is receiving Home Health Care Agency services.

PRIOR TO EFFECTIVE DATE. Charges incurred by a Covered Person prior to the effective date of his coverage under this Plan.

PROTON BEAM RADIATION THERAPY. For treatment of prostate cancer, and for any other Illness unless recognized as standard of care for that Illness.

PROVIDER ERROR. Care, supplies, treatment, and/or services required as a result of unreasonable provider error.

RECOVERIES OBTAINED. Any expense incurred for an Illness or Injury incurred as a result of the action, conduct, or liability of person, party, firm, corporation, insurance carrier, or governmental agency for which any recovery has been obtained either before or after attaining Eligibility for benefits hereunder, whether by suit, judgment, settlement, compromise, or otherwise.

REPLACEMENT BRACES. Braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional, or the age of the brace makes it no longer functional.

SEXUAL DYSFUNCTION. Charges related to the diagnosis and/or treatment of sexual dysfunction, including surgery or impotency (unless resulting from a physical Illness or Injury).

SLEEP DISORDERS. Care and treatment for sleep disorders unless deemed Medically Necessary.

SPEECH THERAPY. Speech therapy for remedial purposes, educational purposes, or for initial development of natural speech. This would apply to Children who have not established a natural speech pattern for reasons that do not relate to a congenital defect. In these cases, speech therapy would be considered educational in nature and not eligible for coverage. Speech therapy would not meet coverage criteria for the following conditions: chronic voice strain, congenital deafness, delayed speech, developmental or learning disorders, environmental or cultural speech habits, hoarseness, infantile articulation, lisping, mental disability, resonance, stuttering, and voice defects of pitch, loudness, and quality.

Speech Therapy in conjunction with applied behavior analysis (ABA) therapy for autism spectrum disorder is also covered when Medically Necessary.

STERILIZATION. Sterilization reversal procedures, male or female.

SURROGACY. A method of reproduction whereby a woman agrees to become pregnant and deliver a child for a contracted person, regardless of whether the woman is doing this on behalf of a Covered Person.

TELEPHONE. Telephone, email or internet consultations other than telehealth benefits under this Plan.

THERAPY. Therapy or treatment intended primarily to improve or maintain general physical condition, or for the purpose of enhancing job, school, athletic, or recreational performance, including but not limited to, routine, long-term, or maintenance care which is provided after the resolution of the acute medical problem, and when significant therapeutic improvement is not expected.

TRAVEL/TRANSPORTATION. Cost of travel or lodging related to receiving medical treatment except as specified under ORGAN TRANSPLANTS.

UNREASONABLE. Charges arising from care, supplies, treatment, and/or services that are not reasonable in nature or in charge (see definition of Maximum Allowable Charge), or are required to treat Illness or Injuries arising from and due to a provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating provider whose error caused the loss(es).

VETERANS ADMINISTRATION HOSPITAL. Any expense for charges made by a Veterans Administration Hospital or by a Physician employed by such Hospital if the disability is service-related. Any expenses which the Covered Person is not legally required to pay or which are for Medical Care furnished without charge, paid for or reimbursable by or through the government or a nation, state, province, county, municipality, or political subdivision, or any instrumentality or agency of such government, except where specifically prohibited by applicable statute.

VITAMINS/SUPPLEMENTS. Charges for vitamins (not including vitamins that require a prescription such as pre-natal vitamins), herbal medicines, appetite suppressants and nutritional supplements.

WAR. Charges resulting from or occurring (1) as a result of war or any act of war, whether declared or undeclared, civil war, hostilities, or invasions; (2) during service in the armed forces of any country; (3) during resistance to armed aggression; or (4) during participation in a riot or civil insurrection.

WITH RESPECT TO ANY INJURY WHICH IS OTHERWISE COVERED BY THE PLAN, THE PLAN WILL NOT DENY BENEFITS OTHERWISE PROVIDED FOR TREATMENT OF THE INJURY IF THE INJURY RESULTS FROM BEING THE VICTIM OF AN ACT OF DOMESTIC VIOLENCE OR A DOCUMENTED MEDICAL CONDITION. TO THE EXTENT CONSISTENT WITH APPLICABLE LAW, THIS EXCEPTION WILL NOT REQUIRE THIS PLAN TO PROVIDE PARTICULAR BENEFITS OTHER THAN THOSE PROVIDED UNDER THE TERMS OF THE PLAN.

SECTION 19 - PRESCRIPTION DRUG PROGRAM

Note: The fact that a Physician writes a prescription does not guarantee it is covered under this Plan.

PRESCRIPTION DRUGS - RETAIL

The Plan has selected a Pharmacy Benefit Manager to provide benefits for retail Prescription Drugs. The Prescription benefits are provided outside the medical/surgical benefits of the Plan and, therefore, are not subject to the Plan maximums.

If a Covered Person incurs expenses for Covered Prescription Drugs, the Prescription Drug Plan will pay 100% of the cost of the Prescription minus the per Prescription Co-Payment shown in the Prescription Drug Benefit Summary of Benefits.

A Covered Person may select either a Brand Name Drug or Generic Drug, and pay the applicable Co-Payment. If a Generic Drug equivalent is available, but the Covered Person elects to use the Brand Name Drug, the Covered Person will be responsible for the Brand Name Drug Co-Payment plus the cost difference between the Brand Name Drug and Generic Drug.

If the Physician both supplies and injects the medication, the medication is covered under the major medical benefit rather than the Prescription Drug Benefit. The Plan Administrator reserves the right to determine the relative cost of Physician-supplied medication compared to the same medication obtained through the Prescription Drug benefit, and to limit payment to the lower of the two costs.

Reimbursement:

1. Participating Pharmacies. If a Prescription is filled at a participating pharmacy, the Covered Person will pay the Co-Pay amount per Prescription.
2. Non-Participating Pharmacies. If a Prescription is filled at a non-participating pharmacy, the Covered Person must pay the entire cost of the Prescription. For reimbursement, a Prescription Drug Claim form must be completed and sent by the Covered Person along with the original pharmacy receipt to the Pharmacy Benefit Manager for processing. Reimbursement for up to the Maximum Allowable Charge for the Prescription minus the Prescription Co-Payment will be made to the Covered Person. Claims should be submitted within 3 months after dispensing. In no event will Claims received more than 12 months after dispensing be considered.

Legend Drugs that are Medically Necessary are covered. Medically Necessary means that the Prescription Drug provided by a Physician or pharmacy is required to diagnose or treat an Illness or Injury.

Maximum dosage of a prescription medication that may be supplied through a retail (local) pharmacy is 30 day supply unless purchased through the 90 Day at Retail Program.

PRESCRIPTION DRUGS – MAIL ORDER

The Pharmacy Benefit Manager will provide benefits for mail order Prescription Drugs. The Prescription benefits are provided outside the medical/surgical benefits of the Plan and, therefore, are not subject to the Plan maximums.

The Plan will provide benefits for Prescription Drugs through the Mail Order Drug Service as described in the Prescription Drug Benefits Summary.

The mail order program is particularly beneficial for those Covered Persons who take regular medication over an extended period of time (maintenance medication). Maintenance medication is usually associated with the treatment of such Illnesses as anemia, arthritis, diabetes, emotional distress, epilepsy, heart disorders, high blood pressure, thyroid or adrenal conditions, and ulcers.

If a Covered Person while covered under the Mail Order Drug Service incurs expenses for Prescription Drugs, the Plan will pay 100% of the cost of the prescription minus any per-prescription Co-Pay shown in the Prescription Drug Benefits Summary.

Legend drugs are drugs prohibited from being dispensed without a prescription, meaning a Prescription Drug prescribed by a licensed prescriber practicing within their scope of expertise and within applicable state and federal regulation to diagnose or treat an Illness or Injury.
The mail order drug service may dispense a minimum 30 day to a maximum 90 day supply of medication for each covered Prescription or refill.

The Plan requires the payment of the 30 day co-pay per fill for mail order medications that can only be mailed 30 days at a time.

A Covered Person may select either a Brand Name Drug or Generic Drug, and pay the applicable Co-Payment. If a Generic Drug equivalent is available, but the Covered Person elects to use the Brand Name Drug, the Covered Person will be responsible for the Brand Name Drug Co-Payment plus the cost difference between the Brand Name Drug and Generic Drug.

90 DAY AT RETAIL PROGRAM

The Pharmacy Benefit Manager will provide benefits for 90 Day at Retail for maintenance drugs. The Prescription benefits are provided outside the medical/surgical benefits of the Plan and, therefore, are not subject to the Plan maximums.

The Plan will provide benefits for Prescription Drugs through the 90 Day at Retail as described in the Prescription Drug Benefits Summary.

The 90 Day at Retail program is particularly beneficial for those Covered Persons who take regular medication over an extended period of time (maintenance medication) and do not want to use the Mail Order program. Maintenance medication is usually associated with the treatment of such Illnesses as anemia, arthritis, diabetes, emotional distress, epilepsy, heart disorders, high blood pressure, thyroid or adrenal conditions, and ulcers.

If a Covered Person, while covered under the 90 Day at Retail program, incurs expenses for Prescription Drugs, the Plan will pay 100% of the cost of the prescription minus any per-prescription Co-Pay shown in the Prescription Drug Benefits Summary.

Legend drugs are drugs prohibited from being dispensed without a prescription, meaning a Prescription Drug prescribed by a licensed prescriber practicing within their scope of expertise and within applicable state and federal regulation to diagnose or treat an Illness or Injury. The 90 Day at Retail program may dispense a maximum 90 day supply of medication for each covered Prescription or refill.

A Covered Person may select either a Brand Name Drug or Generic Drug, and pay the applicable Co-Payment. If a Generic Drug equivalent is available, but the Covered Person elects to use the Brand Name Drug, the Covered Person will be responsible for the Brand Name Drug Co-Payment plus the cost difference between the Brand Name Drug and Generic Drug.

STEP THERAPY PROGRAM

Covered Persons being prescribed a prescription for the first time for a drug that is included in the Step Therapy program will automatically be included in that program, and will be required to follow its guidelines.

COVERED ITEMS

Covered Persons may select either a Brand Name Drug or a Generic Drug, and pay the applicable Co-Payment. However, if a generic equivalent medication is available, but the Covered Person voluntarily selects a Brand Name Drug, he is responsible for the Brand Name Drug Co-Payment plus the difference in cost between the Generic Drug and Brand Name Drug.

The fact that a prescriber has prescribed, ordered, recommended, or approved a Prescription Drug, medication, test, device, or supply does not in itself make it eligible for payment.

BEE STING KITS. Epi-pen and Anakit.

COMPOUNDED DRUGS. Drugs that have a minimum of one eligible legend drug.

CONTRACEPTIVES. Hormonal Contraceptives, including oral drugs, patches, rings, self-injectables; and emergency Contraceptives, including the "morning after" pill. See Sections 15, 18, and 20 for additional coverage information.

DIABETIC TESTING PRODUCTS. Includes such products as tabs, tapes, and strips.

INSULIN. Insulin with a prescription.

INJECTIBLES and Intravenous medications other than insulin or medications contained in bee sting kits as noted above. The Pharmacy Benefit Manager will complete review processing for Medical Necessity before filling prescription.

HUMAN GROWTH HORMONES. Pre-authorization by the pharmacy benefit manager is required.

LEGEND DRUGS. Legend drugs are drugs prohibited from being dispensed without a prescription, meaning a Prescription Drug prescribed by a licensed prescriber practicing within their scope of expertise and within

applicable state and federal regulation to diagnose or treat an Illness or Injury.. According to generally accepted medical practice, the Prescription Drug must be:

1. Consistent with and appropriate for the treatment or diagnosis of the symptoms, Illness, or Injury;
2. Of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures;
3. The most appropriate and cost-effective Prescription Drug which can safely be provided to the patient; and
4. Not chiefly for the convenience of the patient, patient's family, Physician, or other provider.

OVER-THE-COUNTER MEDICATIONS. As specified in the Schedule of Benefits. Physician's prescription is required for coverage.

PRENATAL VITAMINS. Following Diagnosis Of Pregnancy.

SEXUAL DYSFUNCTION. Pre-authorization from the pharmacy benefit manager is required.

SYRINGES AND NEEDLES. When necessary for the administration of covered items.

PREVENTIVE MEDICATION LIST

Your pharmacy benefit plan includes coverage for certain generic preventive medications. You may not have a copayment for these medications. These drugs help protect against or manage a medical condition. Preventive drugs are intended to maintain your quality of life and keep you from developing other health conditions.

A listing of the most commonly prescribed preventive drugs are available from the pharmacy benefit manager. Refer to your prescription ID card for contact information.

Medicare Primary Covered Persons are covered under a NECA – Local No. 145 IBEW sponsored Medicare Prescription Drug Plan. For benefits and coverage, reference your Evidence of Coverage book that has been provided to you by the insurance company. If you have questions, please contact the Benefits Office at (309) 764-8080.

SECTION 20 - LIMITATIONS APPLICABLE TO PRESCRIPTION DRUG PROGRAM BENEFITS

Benefits shall not be payable for:

ALLERGENS OR ANTIGENS.

APPETITE SUPPRESSANTS and weight loss agents.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES. Barrier and Emergency Contraceptives, including diaphragms, female condoms, spermicides, cervical caps, and sponges; and

Contraceptive devices, including IUDs and initial self-injectable administration. See Sections 15, 18, and 19 for additional coverage information.

COSMETIC. Prescription drugs for cosmetic purposes.

EXCESS NUMBER DISPENSED. Refill in excess of number specified by Physician.

EXPERIMENTAL/INVESTIGATIONAL MEDICATIONS. Plan limits authorization to FDA approved indications. If requesting medication coverage for an off-label indication, the prescriber must include clinical evidence in the form of peer reviewed, published, randomized controlled trial(s) as part of the coverage request. Use for the defined indication is outside of the plan's coverage allowance. Treatments without adequate peer-reviewed clinical evidence in the form of randomized controlled trials are considered Experimental / Investigational.

EXPIRED PRESCRIPTIONS. Any refill dispensed after 1 year from the Physician's original order.

FERTILITY DRUGS.

HAIR GROWTH. Minoxidil, Rogaine and other hair growth agents.

INPATIENT MEDICATION. Medication which is to be taken by or administered to a Covered Person, in whole or in part, while he is a patient in a Hospital, rest home, sanitarium, Skilled Nursing Facility/Extended Care Facility, convalescent Hospital, nursing home, or similar institution, or is receiving Home Health Care.

LEGEND DRUGS. Legend drugs used for non-FDA approved indications.

OVER-THE-COUNTER MEDICATIONS. Only as specified in the Schedule of Benefits and when prescribed by a licensed prescriber..

PHARMACY ITEMS. Items that may or may not be covered under the medical plan (such as braces, bandages, medical supplies, diagnostic machines, etc.) and ostomy supplies.

SMOKING DETERRENTS. Nicorette gum and other smoking deterrents except as otherwise provided under this Plan.

SYRINGES. Hypodermic needles and Syringes for use other than with insulin or medications to counteract the effects of allergic reactions to bee stings.

VITAMINS. Wellness and dental vitamins, rinses and fluoride agents, except prenatal vitamins. Prescription strength Vitamins D and K require pre-authorization.

WORKERS' COMPENSATION BENEFITS. Prescriptions for which a Covered Person is entitled to receive any Workers' Compensation benefits.

SECTION 21 - COVERED DENTAL BENEFITS

DENTAL NETWORK. For more information regarding the Plan's Dental Network, please review the Schedule of Benefits.

BENEFITS PAYABLE. If a Covered Person receives any necessary Dental Services or treatment specified in this Section, the Plan, subject to all the provisions of this Plan Document, will be:

1. 80% of the Maximum Allowable Charge for covered preventive, basic, and major services; and
2. 50% of the Maximum Allowable Charge for covered Orthodontia services.

MAXIMUM BENEFIT. For each Covered Person, the maximum amount payable is the Maximum Benefit stated in the Dental Benefit Summary.

ALTERNATE PROCEDURES. If 2 or more alternate procedures, services, or courses of treatment may satisfactorily correct a dental condition, the least expensive procedure will be considered for payment. Such determination will be made by the Claims Administrator based upon professionally endorsed standards of dental care.

PRE-DETERMINATION OF DENTAL CARE COSTS. If the estimated expenses for the performance of a Dental Service or series of Dental Services can reasonably be expected to meet or exceed $300, the Claims Administrator shall review estimated expenses prior to the performance of the service or services. If the Claims Administrator does not agree through Pre-treatment Review, or if a description of the procedures to be performed and an estimate of the Dentist's charges are not submitted in advance, the amount of expenses included as Covered Dental Expenses will be determined by the Claim Administrator, taking into account alternate procedures, services, or courses of treatment based upon professionally endorsed standards of dental care.

The Covered Person is responsible for the total dentist's bill irrespective of the amount payable by the Plan.

COVERED DENTAL EXPENSES

Covered Dental Expenses include Reasonable and Customary necessary expenses incurred for the services and supplies listed below.

COVERED PREVENTIVE SERVICES

1. Full mouth oral exams once every 5 consecutive years
2. Periodic oral examinations, but not more than once every 6 months
3. Prophylaxis, including cleaning, routine scaling and polishing, but not more than once every 6 months
4. Topical fluoride application for Dependents under age 19 not more than once per Calendar Year
5. Space maintainers for Dependents under age 19
6. Sealants for Dependents under age 19
7. Dental x-rays as follow:
   a. full mouth/panoramic x-rays as part of a routine exam once every 5 Calendar Years
   b. bitewing x-rays as part of a routine exam, but not more than once every 6 months.
   c. other dental x-rays and lab tests as deemed necessary
8. Preparation of a complete treatment plan.

COVERED BASIC SERVICES

1. Palliative Emergency treatment and Emergency oral examinations
2. Fillings (amalgam, composite, plastic and acrylic)
3. Extractions
4. Endodontics (root canal therapy)
5. Repair of removable dentures, broken crowns, inlays, and bridgework
6. Re-cementing of crowns, inlays, and/or bridges
7. Biopsies of oral tissue
8. Pulp vitality tests, but not more than once during any Calendar Year
9. Home visits by a Physician when Medically Necessary in order to render a covered Dental Service
10. Oral surgery
11. Apicoectomy
12. Hemisection
13. Denture adjustments and relining and/or rebasing
14. Addition and/or replacement of teeth to fixed bridgework or dentures (full or partial) due to the extraction of natural teeth which occurred while covered under this Plan
15. General anesthesia administered in connection with a covered Dental Service only if administered by an individual licensed to administer general anesthesia
16. Injection of antibiotic drugs
17. Periodontics:
    a. Occlusal equilibration when no restoration is involved
    b. Gingivectomy and gingivoplasty
    c. Gingival curettage
    d. Scaling and root planing
    e. Osseous surgery (osteoplasty and ostectomy), including flap entry and closure
    f. Surgical periodontic examination
    g. Mucogingivoplastic surgery
    h. Management of acute periodontal infection and oral lesions

COVERED MAJOR SERVICES

1. Inlays (not part of a bridge)
2. Onlays (not part of a bridge)
3. Crowns (not part of a bridge)
4. Inlays, onlays, gold fillings, crowns (including precision attachments for dentures)
5. Fixed bridge repairs
6. Dentures, full and partial, and bridges, fixed and removable as follows:
    a. Dentures to replace one or more natural teeth
    b. Bridgework to replace one or more natural teeth (including inlays and crowns to form abutments)
7. Replacement of or addition of teeth to an existing removable denture (full or partial), or fixed bridgework as follows:
    a. Replacement is necessary to correct temporomandibular joint disturbances caused by the existing denture or bridgework when the prosthesis cannot be modified economically to correct the condition; or
    b. Replacement is necessary when an immediate temporary denture was inserted shortly following extraction of teeth and cannot be modified economically to the final shape required; or
    c. The existing denture or bridgework was installed at least 5 years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.
8. Dental Implants.

COVERED ORTHODONTIA SERVICES

1. Installation of Orthodontic appliances and all Orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth.
2. Diagnostic services, including examination, study models, radiographs and all other diagnostic aids used to determine Orthodontic needs only once in any 5 year period, commencing with the date of the initial Visit.
3. Active Orthodontic treatment for 36 consecutive months or less; retention treatment for 18 consecutive months or less.

SECTION 22 - LIMITATIONS APPLICABLE TO DENTAL BENEFITS

Benefits shall not be payable for:

APPLIANCES.

1. Replacement performed fewer than 5 years after a placement or replacement except as specified (the Covered Person is responsible for providing the date of placement or replacement if it did not occur while covered under this Plan).
2. Appliances or restorations necessary to increase vertical dimensions and/or restore the occlusion.
3. Splinting for periodontal purposes and/or other appliances or restorations whose primary purpose is to stabilize periodontally involved teeth.
4. Replacement and/or repair of any appliance used during the course of Orthodontia treatment.

COSMETIC. Dental care which is provided solely for the purpose of improving appearance when form and function of the teeth are satisfactory, and no pathological condition exists.

CROWNS.

1. Replacement of a defective or lost crown inserted until 5 years have passed since the date of insertion (the Covered Person is responsible for providing the date of insertion if it did not occur while covered under this Plan).
2. Temporary crowns or gold foil restorations.

DENTURES & BRIDGES.

1. Replacement at any time of dentures or bridges which can be made serviceable.
2. Adjustments during the first 6 months following denture placement performed by the same or associated Physician who provided or repaired the appliance.
3. Charges for replacement of bridges or dentures lost, stolen, or misplaced.

EFFECTIVE DATE. Charges incurred for dental services which were ordered or started before coverage began including, but not limited to, the installation, manufacture, or fitting of dental restorations (filings, inlays, crowns, bridgework, and dentures).

EXPERIMENTAL. Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.

HOME USE. Expenses related to services or supplies of the type normally intended for sport or home use.

MEDICAL BENEFITS. Services, supplies, or treatment covered under the medical benefits provisions of the Plan except when necessary due to an Accidental Injury.

MEDICALLY NECESSARY. Charges for services or supplies which are not Medically Necessary, according to accepted standards of dental practice.

MYOFUNCTIONAL THERAPY. Charges for myofunctional therapy, or correction of harmful habits.

NO CHARGE. Charges for services or supplies for which no charge is made that the Covered Person is legally obligated to pay or for which no charge would be made in the absence of Dental Expense Benefits.

NON-LICENSED DENTIST OR PHYSICIAN. Charges for 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.

ORAL CANCER SCREENING. Oral cancer screenings performed in a Dentist's office are not covered.

ORAL HYGIENE. Charges for oral hygiene and dietary instruction.

ORTHODONTIA. Treatment rendered within 5 years after the completion of a course of orthodontia treatment.

PERIODONTAL SPLINTING.

PERSONALIZED DENTAL SERVICE. Added restorations to artificial teeth, use of magnets, or similar procedures.

PLAQUE CONTROL. Charges for a plaque control program.

SECTION 23 - COVERED VISION BENEFITS

Benefits are payable as shown in the Schedule of Benefits.

If a Covered Person incurs charges for necessary visual services or supplies on the recommendation of an optometrist or ophthalmologist, the Plan, subject to all provisions of this Plan Document, will pay up to $200.00 every 2 Calendar Years if provided by an out-of-network provider.

If an active Participant incurs charges for safety glasses with corrective lenses, the Plan will pay for lenses every Calendar Year and for frames every Calendar Year. If provided by an out-of-network provider, check with the vision plan for current pricing schedule.

Charges payable under this benefit are not subject to the Deductible and Co-Insurance, and shall include eye examinations and eye wear (including contact lenses) not otherwise covered under the Plan.

SECTION 24 - HEARING AID BENEFIT

GENERAL

If a Covered Person incurs expenses for a hearing aid, benefits will be payable up to the maximum set forth, and subject to the provisions of this Subsection. Hearing examinations are covered under the Major Medical benefits if performed by a certified/licensed audiologist.

BENEFITS PAYABLE

Benefits are payable for Covered Expenses incurred in connection with a hearing aid, including repair, if:

1. An examination (payable under Major Medical) indicates a need for it; and
2. The examination is conducted by an audiologist who is certified by:
   a. The American Speech and Hearing Association, or
   b. The applicable State Department of Public Health; and
3. Service/repair of hearing aid.

The audiologist may not necessarily provide the hearing aid as long as the hearing aid is one that is prescribed by him. When the Covered Person submits a Claim for reimbursement, the person must submit evidence of the audiologist's credentials.

COVERED EXPENSES

Covered Hearing Aid charges consist of the following:

1. The hearing aid (monaural or binaural) prescribed as a result of an examination, including ear mold(s), the hearing aid instrument, cords, and other necessary ancillary equipment; and
2. The cost of necessary repair and/or service.

HEARING AID BENEFIT EXCLUSIONS

No benefits are payable under this Section for:

1. The cost of hearing aid batteries;
2. Charges for rental or purchase of amplifiers;
3. Any expense that is not for a hearing examination or for a hearing aid;
4. Any service or materials provided as a result of Workers' Compensation or occupational disease law, or for which no charge is made, or provided by or payable under the Plan or law of any government, Federal or state, or any political subdivision;
5. Hearing examinations required by an employer as a condition of employment, or which the employer is required to provide because of a labor agreement; and
6. Charges incurred in excess of the benefit maximum stated in Schedule of Benefits.

SECTION 25 - WEEKLY INCOME/LOSS OF TIME BENEFIT

(Active Participants, Including Those Covered by Participation Agreements)

If an active Participant, while covered under this Section of the Plan, becomes Totally Disabled because of non-occupational Injury or Illness, this Benefit will be payable during the continuance of such disability, commencing with the day benefits begin. Weekly Income shall not be payable for more than the maximum benefit period for one period of disability.

Two or more periods of disability due to the same or a related Injury or Illness shall be considered one period of disability unless separated by the Participant's return to full-time duties of his regular occupation for a continuous period of at least 2 weeks.

Two or more periods of disability due to an unrelated Injury or Illness are considered one period of disability unless separated by the Participant's return to full-time work for more than 2 continuous weeks.

For purposes of this Section, it is understood that, in most cases, return to work with restrictions for light duty is not an option given the nature of the electrical industry. An individual who is allowed to return to work with restrictions concerning light duty and for whom no such opportunities are available will continue to be considered Totally Disabled and Eligible for benefits under the other provisions of this Section.

For purposes of this Section, in the event no work is available to an Employee after being released to work, the term "return to full-time duties" or "return to full-time work" shall be satisfied if the Employee has signed the Union "Out of Work List Book" and has no rejections or refusals of any work. The Employee must have signed the book within 5 business days of being released to work and been on the "Out of Work List Book" for a continuous period of at least 2 weeks to be eligible for a new period of disability. Verification will be required by the Employee.

An active Participant will not be eligible to collect this benefit if collecting another form of compensation with the exception of workers' compensation.

The day benefits begin, the Weekly Income benefit amount and the maximum benefit period shall be determined for a Participant as shown in the Weekly Income Benefits Summary.

Benefits shall not be payable for:

1. Any Injury or Illness resulting from war or any act of war, whether declared or undeclared, or from participation in a riot, or from commission of a felony or assault; or
2. Any period of disability during which the Participant is not under the regular care and attendance of a Physician; or
3. Any disability caused by intentionally self-inflicted Injuries or attempted suicide.

Benefits shall be based on a 7 day week.

It is important for the active Participant to notify the Benefits Office when he has been released to go back to work. A copy of the release from the physician is required by the Benefits Office.

If an active Participant is collecting a benefit under this Section of the Plan, and has been released to go back to work and failed to notify the Benefits Office, he will be required to repay the Plan for the overpayment. The Benefits Office will calculate the amount to be repaid and will notify the Employee.

When the active Participant is notified of the overpayment of disability benefit and does not repay the overpayment, the Benefits Office will notify the Claims Administrator to have all medical, dental, prescription, drug and vision claims denied until the entire overpayment has been reimbursed to the Plan. Once the overpayment is paid in full, the Benefits Office will notify the Claims Administrator to reprocess any denied claims.

SECTION 26 - GENERAL PROVISIONS

ADMINISTRATION

Unless otherwise specified in Section 1, the Board of Trustees shall be the Plan Administrator/Sponsor of this Plan. The Plan Administrator shall be in charge of and responsible for the operation and administration of the Plan. The Plan Administrator shall have sole, full, and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies, or omissions in the Plan and related documents; to make determinations with regard to issues relating to eligibility for benefits, to decide disputes that may arise relative to a Covered Person's rights, and to determine all questions of fact and law arising under the Plan.

The Plan Administrator is hereby designated the Named Fiduciary with respect to the administration of the Plan for the purposes of the Employee Retirement Income Security Act of 1974 as amended ("ERISA"). The Trustees are designated the Named Fiduciary with respect to the investment and management of the assets of the Plan. The Plan Administrator shall have the right from time to time to delegate to such persons or entities such Plan administration duties and responsibilities as the Plan Administrator deems appropriate. The Plan Administrator shall maintain such records as shall be necessary for the administration of the Plan. The Plan Administrator shall file all reports and documents that are required by law to be filed by the Plan Administrator. The Plan Administrator shall adopt and implement such procedures including, but not limited to, utilization review and case management procedures as are deemed necessary in the sole discretion of the Plan Administrator to administer the Plan.

The Plan Administrator may appoint a Claims Administrator to receive and initially review and process Claims for Plan benefits. Any appeals of denied Claims for Plan benefits shall be directed to the Plan Administrator for determination. The Plan Administrator shall have the full and final authority and discretion to determine Eligibility for Plan benefits and to construe the terms of the Plan, including the making of factual determinations.

The Plan Administrator shall be responsible for forwarding Covered Persons' eligibility information to appropriate Claims Administrators. The Plan Administrator also shall be responsible for notifying the Claims Administrator in writing of any changes with respect to any Covered Persons entitled to coverage or any other facts necessary for determining Plan coverage and for processing Claims for Plan benefits. The Claims Administrator is not a fiduciary.

This Plan is funded by contributions from participating Contractors pursuant to a Collective Bargaining Agreement(s) and any required contributions from Members.

ASSIGNMENT OF BENEFITS

The benefits in this Plan Document/SPD, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. A Covered Person shall not sell, assign, pledge, transfer or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against the Plan and imposes no duty or obligation on the Plan. The Plan will not honor any such purported sale, assignment, pledge, transfer or grant.

However, subject to written direction of the Covered Person, all or a portion of the benefits, if any, provided for by this Plan for Hospital, nursing, medical or surgical services may be paid directly to the provider of such service, but it is not required that the service be rendered by a particular provider.

PROOF OF CLAIMS

The payment of any benefit set forth in this Plan Document/SPD is subject to the provision that the Covered Person furnish such proof and releases as the Plan Administrator may reasonably require before approving the payment of any such benefit.

Proof of Claim must be given to the Claims Administrator within 12 months after the Covered Expense is incurred by the Covered Person. This is discussed under Section 27 **– HOW TO FILE A CLAIM and ADDITIONAL INFORMATION REQUIRED TO PROCESS CLAIMS.** Failure to provide proof of Claim within the time specified will not invalidate or reduce any Claim if it was not reasonably possible to furnish such proof within the time specified. However, when a Covered Person's coverage terminates for any reason, written proof must be given to the Claims Administrator within 90 days of the date of termination of coverage.

PHYSICAL/DENTAL EXAMS AND AUTOPSY

The Board of Trustees or its Designee shall have the right and opportunity to designate a Physician or dentist to examine the Covered Person whose Injury or Illness is the basis of Claim when and so often as it may reasonably require during the pendency of Claim hereunder. The Trustees have the right to require an autopsy in case of death unless it is forbidden by law.

FACILITY OF PAYMENT

If any Covered Person is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt for any payment due him and no guardian has been appointed, the Plan Administrator may, at its option, make such payment to the individual or individuals as have, in the Plan Administrator's opinion, assumed the care and principal support of such Covered Person. If the Covered Person should die before all amounts due and payable to him have been paid, the Plan Administrator may, at its option, make such payment to the executor or administrator of his estate or to his surviving wife, husband, mother, father, child, or children, or to any other individual or individuals who are equitably entitled thereto.

Any payment made by the Plan Administrator in accordance with these provisions shall fully discharge the Plan to the extent of such payment.

CHANGE OR DISCONTINUANCE OF BENEFITS

The Board of Trustees may at any time change or discontinue the benefits provided in this Plan Document/SPD, but no change or discontinuance may affect in any way the amount or terms of any benefits payable under this Plan Document/SPD prior to the date of such change or discontinuance. Any change or discontinuance of the benefits provided in this Plan Document/SPD shall be evidenced by a written instrument signed by the Board of Trustees, but no such notification is required prior to the effective date of the change or discontinuance in benefits provided.

NONDISCRIMINATION

In the administration of this Plan, the Plan Administrator will act so as not to discriminate unfairly between individuals in similar situations at the time of the action. The Claims Administrator will be entitled to rely on any such action without being obliged to inquire into the circumstances.

STATEMENTS

No person has the authority to make any verbal statements of any kind at any time which are legally binding upon the Board of Trustees or Plan Administrator, or which alter this Plan Document/SPD. No written statement made by a Covered Person shall be used by the Claims Administrator in a contest unless a copy of the instrument containing the statement is or has been furnished to the Covered Person or the person making the Claim.

No statement made by the Board of Trustees, Plan Administrator, Benefit Administrator, or Covered Person shall void any coverage or reduce any benefits or be used in defense of a Claim unless it is in writing.

EFFECT OF PRIOR COVERAGE

Coverage for any Covered Person under this Plan Document/SPD replaces any prior coverage in effect for that Covered Person provided under any immediately Prior Plan Document/SPD or policy.

OUT-OF-POCKET MAXIMUM

If any part of the Out-of-Pocket maximum has been paid under the Prior Plan, the Out-of-Pocket maximum will be reduced by that amount.

DEDUCTIBLE REQUIREMENT

If the Prior Plan coverage Deductible requirement had been fully satisfied during the Calendar Year in which this Plan took effect, this Plan's Deductible requirement will be considered satisfied for the balance of that year. Charges which were incurred under the Prior Plan coverage, and which did not qualify for benefits under the Prior Plan coverage solely because of its Deductible requirements, will count toward satisfying this Plan's Deductible requirement if they meet the following conditions:

1. The charge would qualify as Covered Medical Expenses under this Plan, and
2. This Plan's Deductible requirement is satisfied within the prescribed period.

CLERICAL ERROR

Any clerical error (by the Board of Trustees, Plan Administrator, or Claims Administrator) in keeping pertinent records, or a delay in making an entry, will not invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

MISSTATEMENTS

If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan, and its amount.

MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated on an enrollment form, the misstated age will be immediately changed to the correct age. If the age is a determining factor in the Eligibility of a Covered Person, the availability of a benefit or the amount of a benefit, any benefit affected by the misstatement will be adjusted immediately, and any overpayment of benefits will be requested back from the provider(s) of service and/or the Covered Person.

MISSTATEMENT OF RELATIONSHIP

If the relationship of the Participant to a covered Dependent has been misstated on an enrollment form, and the correct relationship results in an ineligible person being covered on the Plan, the ineligible person will be terminated as of the original Effective Date, and any benefits paid will be requested back from the provider(s) of service and/or the Covered Person. The ineligible person will not be eligible for any extended benefits under the Plan.

MISUSE OF IDENTIFICATION CARD

If the Covered Person allows a non-Covered Person to use any NECA – Local No. 145 IBEW Welfare Plan, or affiliate-issued identification card for any reason, any benefit issued will be requested back from the provider(s) of service and/or the Covered Person.

CONFORMITY WITH THE LAW

If any provision of the Plan Document/SPD is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

APPLICABLE LAW

The Plan shall be construed and administered in accordance with ERISA.

SEVERABILITY

In the event that any provision of the Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

LIABILITY AND INDEMNIFICATION OF PLAN FIDUCIARIES, OFFICERS, AND EMPLOYEES

To the extent permitted by law, no Trustee, officer, or employee of the Plan shall incur any personal liability of any nature for any act done or omitted to be done in good faith in connection with his duties relative to the Plan except in cases of dishonesty, gross negligence, or willful misconduct. Such Trustees, officers, and employees shall be indemnified and held harmless by the Board of Trustees from and against any liability, including reasonable attorneys' fees, to which any of them may be subjected by reason of any such good faith act or conduct in their Trustee, officer, or employee capacity. Any indemnification payments made by reason of this provision shall not be made from the assets of the Plan nor any Trust established in conjunction with the Plan.

A Plan Fiduciary shall be personally liable to make good to the Plan losses to the Plan resulting from each breach by him of the responsibilities, obligations, or duties imposed upon Fiduciaries by ERISA and to restore to the Plan any profits made by such Fiduciary through such Fiduciary's use of Plan assets. A Plan Fiduciary may purchase Fiduciary liability insurance to cover such liability.

The Board of Trustees shall fully protect and indemnify each Trustee, officer, and employee of the Plan serving as a Plan fiduciary at the request of the Board of Trustees for any liability, service as a fiduciary of the Plan (if the fiduciary did not act dishonestly, or in willful or grossly negligent violation of the law or regulation under which such liability, loss, cost, damage, or expense arose), or expense incurred (including reasonable legal fees and expenses) by being a part plaintiff or defendant to any suit in law or in equity brought by or against such fiduciary for any cause other than his own dishonest, willful, or grossly negligent acts. The Claims Administrator is not a fiduciary.

PROTECTION AGAINST CREDITORS

To the extent permitted by law and except as otherwise provided in this Section, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same shall be void.

NO EMPLOYMENT CONTRACT

Nothing in the Plan shall confer any rights of continued employment to any Employee of the Employer or in any way alter an Employee's status as a terminable at will Employee of the Employer. Furthermore, the Plan does not constitute a contract of employment.

NO VESTING

The benefits provided under this Plan to Covered Persons are neither guaranteed nor vested benefits.

RECOVERY OF BENEFIT OVERPAYMENT

If any Plan benefit paid to or on behalf of a Covered Person should not have been paid or should have been paid in a lesser amount, and the Covered Person (or legal representative of a minor or incompetent) failed to repay the amount promptly, the overpayment may be recovered by the Plan Administrator from any monies then payable or which may become payable in the form of benefits payable under this Plan. The Board of Trustees also reserves the right to recover any such overpayments by appropriate legal action. If legal action results in legal and/or court fees for the Plan, the Board of Trustees reserves the right to recover such fees from the Covered Person in addition to any overpayments.

HEADINGS

The headings of the Plan are for reference only and shall not determine the interpretation or construction of this Plan.

MULTIPLE COUNTERPARTS

This Plan Document/SPD may be executed in multiple counterparts, each of the same force and effect.

CONVERSION PRIVILEGES

There are no conversion privileges under this Plan.

CUSTODIAL/PRIMARY CARE PARENT

The Plan Administrator shall furnish to the custodial-primary care parent of a Dependent who is covered by this Plan and who is under the age of 18 such information as is allowed to be shared with a parent/custodian under state law and the HIPAA Protected Health Information Regulations. This information shall include providing an explanation of benefits paid by the Plan with respect to the Dependent upon request by the custodial-primary care parent. The Plan Administrator shall develop rules with respect to what information is to be provided to the Benefits Administrator by the custodial-primary care parent which shows that the claimed custodial-primary care parent is actually the custodial-primary care parent under the terms of a decree of dissolution of marriage, modification of a decree of dissolution of marriage or custody decree.

MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

SECTION 27 - HOW TO FILE A CLAIM AND ADDITIONAL INFORMATION REQUIRED TO PROCESS CLAIMS

HOW TO FILE A CLAIM

Submission of a "Clean Claim" assists in the prompt processing of payment. A Clean Claim is one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a Claim from a provider who is under investigation for fraud or abuse, or a Claim under review for Medical Necessity.

All enrollment forms required to obtain benefits may be secured from the Benefits Office. Instructions on the enrollment form should be followed carefully. This will expedite processing your Claims. Be sure all questions are answered fully, including the completion or attachment of any required medical statements and information concerning any other insurance coverage in effect for your covered Dependents or you. When the form has been received and processed, the Participant will be notified of the benefits paid. If any benefits have been denied, the Participant will receive a written explanation.

ADDITIONAL INFORMATION THAT MAY BE REQUIRED TO PROCESS CLAIMS

In order to process Claims correctly, the Plan and its Administrator will sometimes require more information than is provided with the Claim. Failure to receive this additional information may result in a delay in a processing or the denial of the Claim. Some of the information such as other insurance coverage can be handled prior to receiving Claims by filling out the appropriate forms in advance. These forms are available through the Benefits Office.

If a Covered Person receives a letter from the Plan or its Administrator requesting additional information, he should fill out the request in full, sign and date the letter, and return to the address listed as soon as possible.

Examples of some (but not all) of the additional information that may be required are listed below.

1. **Other Insurance Coverage.** The Plan requires notification if a Covered Person has other coverage that could affect payment of claims under this Plan. Notification should occur within 30 days of acquiring other insurance coverage.

2. **Accident Information.** If a Covered Person is involved in any type of Accident, the Plan will require the Accident information to process a Claim. Because plans do not cover work related injuries and because plans have a provision concerning third-party liability, the Accident information is required to determine if the Plan is liable for the Accident related charges, or if a third party (or parties) is liable. If a Covered Person is involved in a motor vehicle Accident, the Plan will require the Accident report and the name, address, and telephone number of the auto insurance carrier(s) involved.

3. **Divorce Decree.** This Plan requires proof of divorce date. If there are Dependents covered under the Plan, the Plan requires a **certified** copy of the divorce decree.

PHYSICIANS AND/OR HOSPITALS MUST SUBMIT CLAIMS TO THE ADDRESS SHOWN ON THE MEDICAL ID CARD.

SECTION 28 – NO SUPRISES ACT SERVICES CLAIMS

The Plan will make an initial payment or notice of denial of payment for Emergency Services, non-emergency services at network facilities by Non-PPO providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the out-of-network provider. A "clean claim" is a claim that is accompanied by all information needed to decide, adjudicate or process the claim. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services. If a claim relates to Emergency Services, Non-emergency services from an out-of-network provider at a network facility and Air Ambulance services from out-of-network provider, you cannot be required to pay more than the network Cost-Sharing Amount under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required Cost-Sharing Amount.

The Plan will pay a total plan payment directly to the Non-PPO provider that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount. The out-of-network rate means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system.

SECTION 29 - CLAIM REGULATIONS

Claims will be categorized as "Pre-Service Claims", which includes Urgent Care Claims and pre-authorization of benefits, and "Post-Service Claims", which are defined as all Claims that are not "Pre-Service" Claims. A Claim is defined as "any request for a Plan benefit or benefits made by a claimant or by a representative of a claimant that complies with a Plan's reasonable procedure for making benefit Claims".

PRE-AUTHORIZATION OF BENEFITS

Should the medical provider of service request or require a pre-approval of benefits for a particular service, the request should be made by the provider of service, in writing, to the Utilization Review/Case Management vendor listed on the medical identification card. The request should include:

1. Name of the Participant;
2. Social Security number of the Participant;
3. Group name and/or group number;
4. Name and birth date of the patient;
5. Name or description of the service, including a procedure code(s), if applicable;
6. Complete diagnosis, including ICD code(s);
7. Any applicable patient history, including Prescription Drugs;
8. Letter of Medical Necessity; and
9. Any other support documentation the provider wishes to submit.

Failure to provide any of the above information may delay the request.

URGENT CARE CLAIMS

A request for an Urgent Care Claim Benefit Determination may be made by telephone, but the Claims Administrator reserves the right to require additional information in writing. Please refer to **URGENT CARE CLAIM** in the **"DEFINITIONS"** Section for a description of what constitutes an Urgent Care Claim.

The utilization review/case management vendor will determine within 24 hours of receipt of the pre-approval request if the information received is incomplete and more information is required to make a decision. Once the necessary information is received, a response will be made to the provider of service within 72 hours. All decisions made will be based on the Schedule of Benefits in effect at the time the services would be rendered and the continued Eligibility of the patient. If the determination is negative or if you or the provider request an additional review, a response will be made to the provider within 72 hours of the receipt of the request. A determination of Urgent Care Claims may be made by the Claims Administrator.

PRE-SERVICE CLAIMS*

The utilization review/case management vendor will determine, within 5 days of receipt of the pre-approval request, whether the information received is incomplete, and whether more information is necessary to make a decision. Once the necessary information is received, a response will be made to the provider of service within 15 days. All decisions made will be based on the plan of benefits in effect at the time the services would be rendered and the continued Eligibility of the patient. If the Claim Benefit Determination is negative, or if you or the provider request an additional review, a response will be made to the provider within 30 days of the receipt of the request.

POST-SERVICE CLAIMS

The Claims Administrator will make a Claim Benefit Determination within 30 days of receipt of Post-Service Claims. All decisions made will be based on the plan of benefits in effect at the time the services are rendered and the Eligibility of the patient.

*The Plan may utilize any claims processing and appeal response deadline and/or time extension permitted by ERISA Claims Regulations.

RESOLUTION OF DISPUTE

If the Claim Benefit Determination is adverse, then the Covered Person has the time specified below to submit an appeal or request for review.
Any request for review should be done in writing, and include the information listed above in the Pre-Authorization of Benefits Section. The request for review should be mailed or faxed (309-764-3438) to:

NECA – Local No. 145 IBEW Benefits Office
1700 52nd Avenue
Suite B
Moline, Illinois 61265

CLAIMS PROCESSING

Ordinarily, a decision on a Claim will be made by the Utilization Review/Case Management vendor within the prescribed time frames discussed above. In processing claims, no bonus or incentive shall be paid to a claims reviewer based on the number of denials.

1. If the Claim is denied in whole or in part, the Participant will receive a notice that includes the following:

- The identity of the claim involved;
- The specific reason or reasons for the claim denial or other adverse benefit determination, including any standards used in denying the claim;
- Specific reference to the pertinent Plan provisions upon which the decision is based;
- A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
- A copy of the Plan's internal appeal procedures and external review processes, time periods to appeal your claim, and information regarding how to initiate an appeal;
- A statement that you have the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- A statement that you may bring a lawsuit under ERISA Section 502(a) after the appeal of your claim is completed;
- If the denial was based on an internal rule, guideline, protocol, or similar exclusion or limit, a statement that a copy of such internal rule, guideline, protocol, or similar criteria that was relied on will be provided free of charge to you, upon request;
- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of such scientific or clinical judgment for the denial will be provided free of charge to you upon request; and

- A description of the expedited review process applicable to urgent care claims if the notice is a denial of an urgent care claim.

2. If the Claim is a disability claim, the Participant will receive the following information set forth in the claims procedures applicable to Weekly Income/Loss of Time Benefits set forth below.

CLAIMS APPEAL PROCEDURE

To the maximum extent allowed by law, the Plan Administrator shall have sole, full, and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies, or omissions in the Plan and related documents; to make determinations with regard to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participant's rights; and to determine all questions of fact and law arising under the Plan.

If an applicant's initial Claim for Plan benefits is denied in whole or in part, such applicant shall be entitled to a full and fair review of his Claim under the following appeal procedures.

Upon denial of an individual's application for benefits, he shall be furnished a written statement of the specific reason for denial, including reference to the specific Plan provisions on which the denial is based, a description of any additional material or information necessary for the individual to establish his right to benefits and an explanation of why such material or information is necessary. This written notice shall also contain an explanation of the appeal procedure which the individual can follow to have his Claim for benefits reviewed.

An individual who has been denied benefits, or his duly authorized representative, shall have the following rights in appealing the initial decision:

1. The right to submit additional proof of entitlement to benefits;
2. The right to access their entire claim file and examine any document in possession of the Plan related to the application; and
3. The right within 180 days of receipt of the notice of the denial of benefits to appeal the decision to the Plan Administrator by submitting a written statement setting forth which of the reasons for denial of the application he disagrees with, including any supporting documents of additional comments related to the appeal provided, however, that appeals of denial of Urgent Health Care Claims may be made orally or in writing, and the claimant may submit supporting information by telephone, fax, or other expeditious means.

This information should be supplied to the Plan Administrator at the following address:

NECA – Local No. 145 IBEW Benefits Office
1700 52nd Avenue
Suite B
Moline, Illinois 61265

In the normal case, the Plan Administrator shall make the determination on the basis of the supporting file documents and person's written statement as submitted; provided, a claimant shall be permitted to present evidence and testimony during the review process, to appear before the Board of Trustees for oral hearing, or both. Claimants will be notified of and will have an opportunity to respond to any new evidence in advance of an appeal decision. In the event the person is required or permitted to appear before the Board of Trustees, the hearing shall be held at the next regular meeting of the Board of Trustees, or at such other time as may be

determined by the Board of Trustees with reasonable notice of the date, time, and place of the hearing given to the individual.

The Board of Trustees shall make a full and fair review of each appeal and issue its decision in writing within the following time limits:

Urgent Health Care	72 hours
Pre-Service Claims	30 days
Post-Service and all other Claims	Generally, the next quarterly Board of Trustees meeting.

For Post-Service claims, decisions on appeals involving will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the date of the meeting at which the decision was reached.

The review will ordinarily be made by the Board of Trustees and, in any event, cannot be made by the same person(s) who made the initial denial (or be a subordinate of such person). The review will be de novo; that is, no deference will be given to the initial denial, and the review will consist of a "fresh" consideration of the circumstances.

The review will take into account everything submitted by the claimant in the review process, regardless of whether it was submitted previously or relied upon in the initial denial. Any review of a determination based upon "medical judgment" shall require consultation by the Plan with a health care professional independent of any involved in the initial denial. The independent health care professional must have appropriate training and experience in the field of medicine involved in the medical judgment.

The decision of the Board of Trustees on the appeal shall be written in a clear and understandable manner and shall include the specific reasons for the decision, a copy thereof to be furnished to the appellant. Specifically, the decision shall include the following:

- The identity of the claim involved;
- The specific reason(s) for the determination, as well as any Plan standards used in denying the claim, and a statement that you have the right to request, free of charge, the denial code and its corresponding meaning;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge; and
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline, or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on Medical Necessity,

or because the treatment was Experimental or Investigative, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the Plan's terms to your claim, or a statement that it is available upon request at no charge.

Other Participant Rights

1. The Participant may designate a representative to act for a Covered Person in the review procedure. The designation of a representative must be in writing because it is necessary to protect against disclosure of information about a Covered Person to an unauthorized representative.
2. After a written request for review has been received by the Claims Administrator, the Covered Person or his authorized representative may, by appointment, ask to see pertinent documents and may submit written issues, comments, and additional medical information within 30 days after the Claims Administrator receives the written request for review. The Claims Administrator reserves the right to consult independent outside specialists to assist in the review process, particularly with regard to medical necessity.
3. If the Claim appeal is denied in whole or in part and the Covered Person has additional information that he believes should be considered, a written request for re-consideration by the Board of Trustees may be submitted to:

   NECA – Local No. 145 IBEW Benefits Office
   1700 52nd Avenue
   Suite B
   Moline, Illinois 61265

This request must be submitted within 30 days of the final denial by the Claims Administrator, and must include specific reasons for the request for consideration. The Board of Trustees will respond in writing within 120 days of the request.

If a Participant has any questions about the Claims procedures or the review procedure, he/she should contact the Benefits Office.

WEEKLY INCOME/LOSS OF TIME BENEFIT CLAIMS AND APPEALS PROCEDURES

Claims Procedures for Weekly Income/Loss of Time Benefit Claims

A claimant must file a claim for Weekly Income/Loss of Time Benefits with the Benefits Office. For Weekly Income/Loss of Time Benefits, the Plan reserves the right to have a physician examine a claimant (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

If a claim for Weekly Income/Loss of Time Benefits is denied in whole or in part, the claimant will be informed of the denial within 45 days of the date the initial claim was received, regardless of whether all necessary information was included with the claim, unless one of the extensions as described herein below applies:

1. Extension

Special circumstances may require more time to review a claim. If so, written notice will be provided within the 45-day period explaining the reason for the delay and setting a date upon which the notice will be issued no

later than 30 days after the end of the initial 45-day benefit determination period. If special circumstances again require more time to review a claim, a second 30-day extension may be taken subject to written notice within the initial 30-day extension, subject to the same rules.

2. Additional Information

If, during the review, additional information is required from the claimant, the claimant will be so notified within the required time periods for notice of a decision or extension as detailed above. The claimant will have at least 45 days to provide such information. A written notice of any denial will be issued within 30 days following the date the claimant provides the information or the expiration of the time period for providing such information, unless special circumstances require a second 30-day extension, subject to the same rules.

In the event that a claim for Weekly Income/Loss of Time Benefits is denied in whole or part, the Plan will provide the claimant with notice of an initial Adverse Benefit Determination. The notice will state:

- The specific reason or reasons for the Adverse Benefit Determination, including any Plan standards used in denying the claim;
- Reference to the specific Plan provision on which the determination was based;
- A description of any additional material or information necessary to process the claim and an explanation of why such material or information is needed;
- A copy of the Plan's review procedures, the time period to appeal the Adverse Benefit Determination, and information regarding how to initiate an appeal;
- A statement that the claimant may bring a lawsuit under ERISA Section 502(a) after the appeal of the claim is completed;
- A discussion of the Adverse Benefit Determination, including an explanation of the basis for disagreeing with or not following:
    - i. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - ii. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - iii. A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
- In the event that the denial is based on a medical necessity exclusion, an experimental treatment exclusion, or a similar exclusion/limit, the notice will include either an explanation of the scientific or clinical judgment for the denial, which applies the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan, if any, relied upon in making the denial or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

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

- Finally, all notices under this section shall be provided in a culturally and linguistically appropriate manner as required by U.S. Department of Labor regulations.

The Weekly Income/Loss of Time Benefit claims procedures apply to Weekly Income/Loss of Time Benefit claims filed on and after April 1, 2018 Weekly Income/Loss of Time Benefit claims filed before April 1, 2018, shall be subject to the claims procedures in effect when the Weekly Income/Loss of Time Benefit claim was filed.

Appeal and Review of Weekly Income/Loss of Time Benefit Claims

The claimant, or his/her duly Authorized Representative, may file a written appeal of a denied Weekly Income/Loss of Time Benefit claim by sending the written appeal to the Plan Administrator within one-hundred eighty (180) days after receiving written notification of the denial (in whole or in part) of a claimant's Weekly Income/Loss of Time Benefit claim .

The claimant, or his/her duly Authorized Representative will be provided, upon request and free of charge, copies of all documents, records and other information relevant to the claim for Weekly Income/Loss of Time Benefits. A document, record or other information is relevant if it was relied upon, submitted, considered or generated in the review or demonstrating compliance with the claims processing requirements. The claimant, or his/her duly Authorized Representative, may also submit written comments, documents, records, and other information relating to the Weekly Income/Loss of Time Benefits claim to the Plan Administrator and to the Board of Trustees

The Board of Trustees or its authorized Committee will review the denied claim according to the terms and conditions of the Plan. The review will consider all comments, documents, records and other information submitted by the claimant, regardless of whether the information was submitted or considered in the initial determination. The review will not defer to the decision on the initial claim, and the review will not be conducted by the same individuals who made the initial Adverse Benefit Determination. If the initial denial was based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Further, the health care professional so consulted will not be the same health care professional or a subordinate of the same health care professional who was consulted, if at all, in connection with the initial denial.

If any new or additional evidence is considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim for Weekly Income/Loss of Time Benefits, or if any new or additional rationale is reached regarding the claim, the Plan Administrator shall provide the claimant with such evidence and/or rationale as soon as possible and sufficiently in advance of the deadline for a determination by the Board of Trustees. The Plan Administrator shall also provide the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan.

The Trustees or its authorized Committee will meet quarterly to render a determination on appeals of Weekly Income/Loss of Time Benefits received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting will be decided at the next following quarterly meeting. If special circumstances require a delay in the decision, the decision will be rendered no later than the third quarterly meeting following receipt of the appeal, and the claimant will be notified of the reasons for the delay prior to any extension. The claimant will be notified of the decision within five days of the date the decision is made.

The decision on any review of Weekly Income/Loss of Time Benefits claim will be given to the claimant in writing. The notice of a denial of a claim on review will state:

- The specific reason or reasons for the Adverse Benefit Determination, including any Plan standards used in denying the claim;
- Reference to the specific Plan provision on which the determination was based;
- A statement that the claimant are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to the claim for Weekly Income/Loss of Time Disability Benefits;
- A discussion of the Adverse Benefit Determination, including an explanation of the basis for disagreeing with or not following:

    j. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

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

    iii. A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

- In the event that the denial is based on a medical necessity exclusion, an experimental treatment exclusion, or a similar exclusion/limit, the notice will include either an explanation of the scientific or clinical judgment for the denial, which applies the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan, if any, relied upon in making the denial or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
- A statement of the right to bring an action under Section 502(a) of ERISA, which statement shall also describe any applicable contractual limitations period that applies to the right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; and
- Finally, all notices under this section shall be provided in a culturally and linguistically appropriate manner as required by U.S. Department of Labor regulations.

The Weekly Income/Loss of Time Benefit claims procedures apply to Weekly Income/Loss of Time Benefit claims filed on and after April 1, 2018, Weekly Income/Loss of Time Benefit claims filed before April 1, 2018, shall be subject to the claims procedures in effect when the Weekly Income/Loss of Time Benefit claim was filed.

EXTERNAL REVIEW PROCEDURES - NO SURPRISES ACT

I. External Review of Standard Claims

This External Review procedure is applicable claims eligible for External Review as required by the No Surprises Act. Generally, this will pertain to denials related Emergency Service, applicable Non-Emergency Service and/or Air Ambulance Service claims as defined in the section of this Plan addressing the No Surprises Act. All other claims (*i.e., claims that are not covered by External Review requirements of the No Surprises Act*) are subject to the claims and appeal procedures set forth in Section 29 of the Plan Document/SPD.

Your request for external review of claims subject to the No Surprises Act, must be made, in writing, within four (4) months of the date that you receive notice of an initial adverse benefit determination or adverse Appeal Claim benefit determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them differently.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Appeal Claim Benefit Determinations.

You do not need to exhaust the internal review and appeals process if the Plan fails to follow all the requirements for internal review. However, this does not apply to the Plan's minor violations of regulatory procedures or actions that are not prejudicial, are attributable to good cause, or are beyond the control of the Plan and made in the context of a good-faith exchange of information or are not reflective of a pattern or practice of non-compliance.

A. ***Preliminary Review***

1. Within five business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:

   a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   b. The Adverse Determination concerns a claim involving a claim eligible for External Review as required by the No Surprises Act.
   c. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;
   d. You have exhausted the Plan's internal claims and appeals process (except in limited, exceptional circumstances); and
   e. You have provided all the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:

a. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
b. If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. ***Review by Independent Review Organization (IRO)***

If the request is complete and eligible, the Plan will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The IRO must be accredited by URAC or similar nationally-recognized accrediting organization. The Plan will rotate assignment among at least three (3) IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim. Such additional information must be submitted within 10 business days. Information submitted after 10 business days may not be considered by the IRO.

2. Within five business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.

3. If you submit additional information related to your claim, the assigned IRO must, within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if, upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

4. The IRO will review all the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it were new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer(s).

5. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

6. The assigned IRO's decision notice will contain:

    a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount [if applicable]), and the reason for the previous denial);
    b. The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
    c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    d. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    e. A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;
    f. A statement of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
    g. A statement that judicial review may be available to you; and
    h. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

II. Expedited External Review of Claims

You may request an expedited external review if:

1. You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

A. *Preliminary Review*

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in section I.A.1, are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in section I.A.2.

B. *Review By Independent Review Organization*

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, at the above section I.B. In reaching a decision, the assigned IRO must review the claim *de novo* (as if it were new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above in section I.B.6, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

III. After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

IV. Payment of Claims

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or federal law. In addition, such otherwise binding decisions do not preclude the Plan from making payments on the claim or providing benefits to the claimant at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

V. Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, or termination) or retention will not be made on the basis of whether that person is likely to support a denial of benefits.

EXCLUSIVE FORUM FOR RESOLUTION OF DISPUTES

Plan Participants and their covered Dependents consent to the jurisdiction and venue of any court (state or federal) of general jurisdiction over Rock Island County, Illinois, specifically, but not limited to, the United States District Court of the Central District of Illinois and the Rock Island Circuit Court, for the purpose of any action or proceeding brought to secure payment of benefit under this Plan or to secure or enforce the performance of any of the terms and conditions of the Plan. Plan Participants further agree to bring any legal proceedings arising out of this Plan or the relationship between the Plan and the Participant or his/her Dependents only in the courts mentioned above.

STATUTE OF LIMITATIONS

A Participant or Beneficiary may not bring any action in court regarding a benefits denial:

- Before all remedies under the Plan's claim and appeals procedures have been exhausted; and
- After three years from the expiration of the time allowance within which the Participant or Beneficiary was required to file a claim with the Plan.

Notwithstanding the foregoing, any legal action must be initiated within 12 months of the date the Plan issues an adverse benefit determination on an appeal.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person on whose behalf such payment was made.

A Covered Person, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of

1.5% per month. If the Plan must bring an action against a Participant, provider or other person or entity to enforce the provisions of this Section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Participants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery Provision; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This subparagraph (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

SECTION 30 - STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

1. Receive information about your Plan and benefits.
2. Examine without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
3. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. A reasonable charge may be made for these documents.
4. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
5. Continue group health plan coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
6. Obtain copies of all Plan documents and other Plan information upon written Request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Failure to provide such information within 30 days of the date of written request may result in penalties being charged to the Plan Administrator of up to $110 per day.
7. Obtain a complete list of the employers and employee organizations sponsoring the Plan upon written request to the Plan Administrator. This information is available for examination by Covered Persons in the Benefits Office at 1700 52nd Avenue, Suite B, Moline, Illinois 61265.
8. Obtain from the Plan Administrator, upon written request, information concerning whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently, and in the interest of a Covered Person and other Plan participants and beneficiaries. No one, including the Employer, or any other person, may fire a participant or otherwise discriminate against a participant in any way to prevent a participant from obtaining a welfare benefit or exercising his rights under ERISA. If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a participant can take to enforce the above rights. For instance, if you request materials from the Plan and you do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

If the participant has any questions about the Plan, you should contact the Plan Administrator. If the participant has any questions about this statement or your rights under ERISA, or if you require assistance in obtaining documents from the Plan Administrator, you should contact either the nearest area office of the U.S. Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. A participant also may obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration at 1-866-444-3272 or on the internet at http:/www.dol.gov/ebsa/publications/main.html.

SECTION 31 - PRIVACY POLICY

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice describes how your Protected Health Information ("PHI") may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. HIPAA requires us to provide this Notice of Privacy Practices to you.

The HIPAA Privacy Rule protects certain medical information known as PHI. Generally, PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

1. Your past, present, or future physical or mental health or condition;
2. Providing health care to you; or
3. Making past, present, or future payments for providing health care to you.

OUR RESPONSIBILITIES

We are required by law to:

1. Maintain the privacy of your PHI,
2. Notify you of any breach of unsecured PHI,
3. Provide you with certain rights with respect to your PHI,
4. Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI, and
5. Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use or disclose your PHI in certain situations without your permission. The main reasons for which we may use and may disclose your PHI are to evaluate and process any requests for coverage and claims for benefits. Your PHI may be used:

FOR TREATMENT. We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

FOR PAYMENT. We may use or disclose your PHI to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may share your PHI with health

care provider in connection with the payment of health claims or to another health plan to coordinate benefit payments.

FOR HEALTH CARE OPERATIONS. We may use and disclose your PHI for plan operations. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. If medical information is used for underwriting, genetic information may not and will not be used or disclosed for this purpose.

TO BUSINESS ASSOCIATES. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree in writing with us to follow appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

TO THE CLINIC. The Plan has contracted with Everside Health, LLC, a business associate, to manage a health clinic and provide services related to the Plan's health care operations. As a part of the Plan's health care operations, the Plan is sharing both historic and current medical and prescription drug claims data with Activate Healthcare as an ongoing population-based activity to improve the overall health of the Fund's participants, reduce health care costs, and engage in disease management and care coordination.

AS REQUIRED BY LAW. We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

TO PLAN SPONSORS. We may disclose PHI to certain employees of the Employer so that they can administer the plan. Those employees will only use or disclose PHI as needed to perform plan administration functions or as otherwise required by HIPAA, unless you have specifically authorized other disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS. It is also possible that we may use and disclose your PHI in these situations:

ORGAN AND TISSUE DONATION. If you are an organ donor, we may release your PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

MILITARY AND VETERANS. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

WORKERS' COMPENSATION. We may release your PHI for Workers' Compensation or similar programs.
PUBLIC HEALTH RISKS. We may disclose your PHI for public health actions. These actions generally would be to:

1. Prevent or control disease, Injury, or disability;
2. Report births and deaths;
3. Report child abuse or neglect;
4. Report reactions to medications or problems with products;
5. Notify people of recalls of products they may be using;
6. Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
7. Notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

HEALTH OVERSIGHT ACTIVITIES. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

LAWSUITS AND DISPUTES. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

LAW ENFORCEMENT. We may disclose your PHI if asked to do so by a law enforcement official:

1. In response to a court order, subpoena, warrant, summons, or similar process;
2. To identify or locate a suspect, fugitive, material witness, or missing person;
3. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
4. About a death that we believe may be the result of criminal conduct; and
5. About criminal conduct.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

RESEARCH. We may disclose your PHI to researchers when:

1. The individual identifiers have been removed; or
2. When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

We are required to make disclosures of your PHI in these situations:

GOVERNMENT AUDITS. We must disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

DISCLOSURES TO YOU. If you request, we must disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. If you request, we also must provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed due to your specific authorization.

OTHER DISCLOSURES

PERSONAL REPRESENTATIVES. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., if you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. You have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
2. Treating such person as your personal representative could endanger you; and
3. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

AUTHORIZATIONS. Other uses or disclosures of your PHI including, but not limited to, psychotherapy notes, most marketing purposes and any disclosures that constitute a sale of PHI, will only be made with your written authorization. You may revoke written authorization at any time, but the revocation must be in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed based on the written authorization you provided before we received the revocation.

YOUR RIGHTS

You have the following rights with respect to your PHI:

RIGHT TO INSPECT AND COPY. You have the right to inspect and copy certain PHI that may be used to make decisions about your health care benefits. To inspect and copy your PHI, you must submit your request in writing to Benefits Office, 1700 52nd Avenue Suite B Moline, Illinois 61265. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Benefits Office, 1700 52nd Avenue Suite B Moline, Illinois 61265.

RIGHT TO AMEND. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to Benefits Office,

1700 52nd Avenue Suite B Moline, Illinois 61265. You must provide a reason why and in what respect you believe your record is incorrect.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Is not part of the medical information kept by or for the Plan;
2. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
3. Is not part of the information that you would be permitted to inspect and copy; or
4. Is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to request an accounting of certain disclosures of your PHI. The accounting will not include disclosures:

1. For purposes of treatment, payment, or health care operations;
2. Made to you;
3. Made pursuant to your authorization;
4. Made to friends or family in your presence or because of an emergency;
5. For national security purposes; and
6. Incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Benefits Office, 1700 52nd Avenue Suite B Moline, Illinois 61265. Your request must state a time period of no more than 6 years.

Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on your PHI that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.
We will always comply with a restriction request if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full and the use or disclosure is for payment or health care operations.

To request restrictions, you must make your request in writing to Benefits Office, 1700 52nd Avenue Suite B Moline, Illinois 61265. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your Spouse.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Benefits Office, 1700 52nd Avenue Suite B Moline, Illinois 61265. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

RIGHT TO BE NOTIFIED OF A BREACH. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Benefits Office, 1700 52nd Avenue Suite B Moline, Illinois 61265.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Plan Administrator 309-764-8080. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

We may change the terms of this Notice and make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any significant change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mailing a copy of the revised notice within 60 days after the change.

SECTION 32 - SECURITY POLICY

The Health Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information (ePHI) that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI:

1. It receives pursuant to an appropriate authorization (as described in 45 CFR Section 164.504(f)(1)(ii)); or
2. That qualifies as Summary Health Information and that it receives for the purpose of either:
   a. Obtaining premium bids for providing health insurance coverage under the Plan, or
   b. Modifying, amending or terminating the Plan (as authorized under 45 CFR Section 164.508).

If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

The Plan Sponsor shall, in accordance with the Security Regulations:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities, and not for employment-related actions, or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures of this Plan provision shall be subject to the Plan's sanctions.
3. Ensure than any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.
4. Report to the Plan any Security Incident of which it becomes aware.

DISCLOSURE OF PHI TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524).

8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

PLAN SPONSOR OBLIGATIONS

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Benefits Office.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

SCHEDULE OF BENEFITS

NECA – LOCAL NO. 145 IBEW WELFARE PLAN

SCHEDULE OF BENEFITS (OCTOBER 1, 2022)

MEDICAL BENEFITS – TERMS APPLICABLE TO BOTH PLAN A AND B

All benefits shown in this Schedule of Benefits above are subject to Individual and Family Deductible amounts, co-insurance rates, and out-of-pocket maximums as shown. In addition, the Plan reserves the right to audit claims, including reviewing bills and identifying charges that are not Medically Necessary and/or within the definition of Maximum and Allowable Charge.

For additional information regarding **Major Medical Benefits**, refer to Section 14 of the SPD.

For additional information regarding **Covered Medical Expenses**, refer to Section 15 of the SPD.

For additional information regarding **Limitations Applicable to Major Medical Benefits**, refer to Section 18 of the SPD.

PLAN A

Deductible

	PPO	NON-PPO
Per Individual Per Calendar Year	$600.00	$700.00
2-Person Family Per Calendar Year	$1,200.00	$1,400.00
Family Per Calendar Year	$1,500.00	$2,100.00

Deductible - Terms and Conditions

- Deductible to be applied before benefits are paid.
- Deductible applies unless noted.
- Deductible is waived for benefits listed as payable at 100%.
- 4th quarter carryover Deductible does not apply.

Out-of-Pocket Maximum

	PPO	NON-PPO
Per Individual Per Calendar Year	$1,600.00	$1,850.00
2-Person Family Per Calendar Year	$3,200.00	$3,700.00
Family Per Calendar Year	$4,300.00	$5,800.00

Out-of-Pocket Maximum – Terms and Conditions

- **Included:** Calendar Year Deductible and Co-Insurance.
- **Not Included:** Prescription Drug Co-Pays, failure to Pre-Cert penalty.

Medical Plan Lifetime Maximum

Unlimited

Non-PPO Place of Service Limitations

Expenses that are incurred due to a Medical Emergency will have eligible charges considered at the PPO level of benefits unless otherwise required by the No Surprises Act.

Individuals who are referred outside the PPO Network by a PPO Physician will have Eligible Expenses considered at the non-PPO level of benefits unless otherwise required by the No Surprises Act.

If a PPO Physician or PPO facility refers x-ray and/or laboratory services to a non-PPO provider, those services will have Eligible Expenses considered at the PPO level of benefits as required by the No Surprises Act.

Professional services, which are provided by a non-PPO provider but rendered at a PPO facility, will have Eligible Expenses considered at the non-PPO level of benefits except as required by the No Surprises Act.

Maximum Allowable Charge limitations may result in an individual being responsible for Out-of-Pocket costs above the Out-of-Pocket maximums listed above for non-PPO providers. Maximum Allowable Charge limitations are based on PPO fee schedule.

Payment is made for Eligible Expenses only.

Medical Benefits	PPO	Non-PPO	General Plan Limits & Coverage Terms and Limitations
Ambulance	85%	80%	
Ambulatory Surgery Center	90%	80%	
Anesthesia – Inpatient/Outpatient	90%	80%	
Birthing Centers	90%	80%	
Chemical Dependency & Related Services - **Inpatient and Partial**	90%	80%	Pre-Certification/Non-Compliance Penalty (Inpatient and Partial) - $100 Co-Pay for Non-Compliance Limited to semi-private room
Chemical Dependency & Related Services - **Room & Board**	90%	80%	
Chemical Dependency & Related Services - **Inpatient Misc.**	90%	80%	
Chemical Dependency & Related Services - **Inpatient Physician Visits**	90%	80%	
Chemical Dependency & Related Services - **Outpatient**	85%	80%	
Chemical Dependency & Related Services - **Group Therapy**	85%	80%	
Chemotherapy	85%	80%	
Colonoscopy	100%	80%	**All Benefits are based on the recommended age set by the United States Preventative Task Force (USPTF)** 1 stool test for blood every year. One flexible sigmoidoscopy every 5 years; Colonoscopy every 10 years. Double contrast barium enema every 5 years; and Each test more frequently if medically necessary. A FDA approved at-home test (i.e., Cologuard) if prescribed and ordered by a Physician Subject to Co-Insurance and Deductible if out-of-network.
Durable Medical Equipment/Prosthetics	85%	80%	The utilization review/case management organization must be pre-notified of any item which costs $1,000 or more to rent or purchase. Orthotics are limited to $200 per foot every two years.
Gastric Bypass/Bariatric Surgery	85%	80%	Lifetime Maximum for surgery and related services and including complications - $40,000, subject to medical necessity
Hearing Aid Exam	80%	80%	See, Section 24 of SPD
Hearing Aid Benefit	80%	80%	Limited to $2,400 every 3 Calendar Years. See, Section 24 of SPD.
Home Health Care	85%	80%	100 Visits per Calendar Year. 4 hour maximum per day Pre-Certification/Non-Compliance Penalty - $100 Co-Pay for Non-Compliance.

Hospice/Respite Care - **Inpatient Room & Per Facility Board**	85%	80%	Limit of 120 days at $155 per day
Hospice/Respite Care - **Bereavement Counseling**	85%	50%	15 Visits per Family; Co-Insurance does not apply to Out-of-Pocket Maximum.
Hospital Benefits - **Inpatient Room and Board**	90%	80%	Pre-Certification/Non-Compliance Penalty (Inpatient) - $100 Co-Pay for Non-Compliance Limited to Semi-private room.
Hospital Benefits - **Inpatient Misc**.	90%	80%	
Hospital Benefits - **Inpatient Physician Visits**	90%	80%	
Hospital Benefits - **Hospital Pre-Admission Testing**	90%	80%	
Hospital Benefits - **Outpatient Services**	90%	80%	
Hospital Benefits - **Emergency Room Services**	90%	80%	Subject to additional $50.00 Deductible; waived if admitted from the Emergency Room.
Hospital Benefits - **Emergency Room Physician Care**	90%	80%	
Independent X-Ray and Lab Facility	85%	80%	
Mammograms (including 3D Mammograms)	100%	80%	Frequency based upon current recommendations of the American Cancer Society. Subject to Deductible and Co-Insurance if Out-of-network.
Manipulative Therapy	85%	80%	Annual maximum of $1,200. Maintenance care excluded, subject to medical necessity.
Medical Supplies	85%	80%	
Mental and Nervous Related Services - **Inpatient Acute Hospital**	90%	80%	Pre-Certification/Non-Compliance Penalty (Inpatient & Partial) - $100 Co-Pay for Non-Compliance. Semi-private room.
Mental and Nervous Related Services - **Inpatient Room & Board**	90%	80%	
Mental and Nervous Related Services - **Inpatient Residential Psychiatric Care for Children in a Psychiatric Medical Institution for Children (PMIC)**	90%	80%	Limited to Children through Age 18. See, benefit description and PMIC definition.
Mental and Nervous Related Services - **Inpatient Misc.**	90%	80%	
Mental and Nervous Related Services - **Inpatient Physician Visits**	90%	80%	
Mental and Nervous Related Services - **Partial Hospitalizations**	90%	80%	
Mental and Nervous Related Services - **Group Therapy Outpatient**	85%	80%	
Mental and Nervous Related Services - **Group Therapy**	85%	80%	
Occupational Therapy	85%	80%	Precertification required after 12 visits
Organ Transplants	85%	80%	Contact utilization review/case management organization for Centers of Excellence Program.
Physical Therapy	85%	80%	Precertification required after 12 visits
Physician Office Services - **Office Visits**	85%	80%	
Physician Office Services - **Minor Office Surgery**	85%	80%	
Physician Office Services - **Diagnostic X-Ray and Lab**	85%	80%	
Physician Office Services - **Injections**	85%	80%	
Physician Office Services - **Allergy Services**	85%	80%	
Physician Office Services - **Allergy Injections**	85%	80%	
Physician Office Services - Chiropractic Care	85%	80%	See, Manipulative Therapy

Physician Office Services - **Outside X-Ray and Lab**	85%	80%	
Preventative Services	100%	100%	Includes well Child visits and Immunizations, Preventative Office Visit, School and Sport Physicals, Diagnostic X-Ray and Lab. Deductible and Co-Insurance waived.
Radiation Therapy	85%	80%	
Skilled Nursing/Extended Care Facility	85%	80%	Limited to 120 days per Calendar Year.
Smoking Cessation Benefit	80%	80%	Deductible waived.
Speech Therapy	85%	80%	Service for remedial, educational, or initial development of natural speech are excluded. ABA Therapy is covered as specified in the SPD. Precertification required after 12 visits.
Surgery - **Inpatient**	90%	80%	Pre-Certification/Non-Compliance Penalty (Inpatient) - $100 Co-Pay for Non-Compliance.
Surgery - **Outpatient**	90%	80%	
Temporomandibular Disorders	85%	80%	No Annual or Lifetime Limit.

PLAN B

Applicability

Plan B is only to Retirees, Employees covered by the Plan as a result of a Participation Agreement or Collective Bargaining Agreement approved by the Board of Trustees, and to COBRA beneficiaries.

Once Plan B is elected, a Retiree and/or Covered Persons may not subsequently elect to return to Plan A.

Under Plan B, Dental Coverage is optional. If Dental Coverage is waived, then it cannot subsequently be added.

Deductible

	PPO	NON-PPO
Per Individual Per Calendar Year	$1,200.00	$1,200.00
2-Person Family Per Calendar Year	$2,400.00	$2,400.00
Family Per Calendar Year	$3,600.00	$3,600.00

Deductible - Terms and Conditions

- Deductible to be applied before benefits are paid.
- Deductible applies unless noted.
- Deductible is waived for benefits listed as payable at 100%.
- 4th quarter carryover Deductible does not apply.

Out-of-Pocket Maximum

	PPO	NON-PPO
Per Individual Per Calendar Year	$2,350.00	$2,350.00
2-Person Family Per Calendar Year	$4,700.00	$4,700.00
Family Per Calendar Year	$7,300.00	$7,300.00

Out-of-Pocket Maximum – Terms and Conditions

- **Included:** Calendar Year Deductible and Co-Insurance.
- **Not Included:** Prescription Drug Co-Pays, failure to Pre-Cert penalty.

Medical Benefits – Plan B

Medical benefits provided under Plan B are the same as the medical benefits provided under Plan A, except as specified below.

Medical Benefits	PPO	Non-PPO
Co-Insurance	80%	70%

PRESCRIPTION DRUG BENEFIT SUMMARY

Benefit	Co-Payment	General Plan Limits & Coverage Terms and Limitations
Participating Retail Pharmacy - **Preventative Generic Drug**	$5.00	Co-Payment is for 30 Day Supply
Participating Retail Pharmacy - **Generic Drug**	$10.00	
Participating Retail Pharmacy - **Brand Name Drug**	$40.00	
Retail 90 Program - **Generic Drug**	$25.00	
Retail 90 Program - **Brand Name Drug**	$60.00	
Mail Order - **Generic Drug**	$25.00	Co-Payment is for 90 Day Supply
Mail Order - **Brand Name Drug**	$60.00	
Over-the-Counter Medications* - **Prilosec OTC** - **Omeprazole OTC** - **Prevacid OTC**	$5.00	42-Day Supply *Over-the-Counter medications are not covered under the Medicare Prescription Drug Plan. OTC Medications require a physician's prescription.
Over-the-Counter Antihistamines - **Claritin/Claritin D/Claritin RDT** - **Alavert/Alavert-D** - **Loratadine/Loratadine w/Pseudoephedrine** - **Zyrtec OTC**	$5.00	30-Day Supply *Over-the-Counter medications are not covered under the Medicare Prescription Drug Plan. OTC Medications require a physician's prescription.

Other Coverage Terms

Maximum dosage of a Prescription medication that may be supplied through a retail (local) pharmacy is a 30 day supply. A Covered Person may purchase up to a 90 day supply of Maintenance Drugs through the Mail Order Program, or at a participating Retail 90 participating pharmacy.

If a prescription filed through the Mail Order or Retail 90 program can only be dispensed in 30 day supplies, the Covered Person must pay the 30 day co-pay per fill.

If a Generic Drug equivalent is available, but the Covered Person elects to use a Brand Name Drug, the Covered Person will be responsible for the Brand Name Drug Co-Payment plus the cost difference between the Brand Name Drug and Generic Drug.

The following management programs are added to the plan of benefits:

- RxMaximize Copay Assistance Program
- Infusion Care Path Program

For more information about prescription drug benefits contact the Benefits Office or MedOne 1-888-655-0143.

A complete description of the Prescription Drug benefit is found in Sections 19 and 20 of this Plan.

Plan A and B

Prescription Drug Benefits specified above apply to Plan A and B.

Medicare Eligible Participants

Medicare Primary Individuals are covered under the NECA – Local No. 145 IBEW sponsored Medicare Prescription Drug Plan. For benefits and coverage, reference your Evidence of Coverage book that has been provided to you by the insurance company.

DENTAL BENEFIT SUMMARY

Dental Benefits			
Deductible to be applied before benefits are paid:	$0.00 (No Deductible)		
Dental Maximum			
Preventive, Basic and Major Dental Benefits	Age 19 and over - Limited to $2,500 per Calendar Year Under age 19 - unlimited		
Note: Pre-determination of Dental Care costs for procedures costing $300 or more is recommended.			
Please refer to **COVERED DENTAL EXPENSES** in Sections 21 and 22 in the SPD for specifics on covered and excluded services.			
Dental Benefit	**Plan Pays**	**You Pay**	**General Plan Limits**
Preventative Dental Benefits - **Routine Oral Exams**	80%	20%	Limited to 1 every 6 months
Preventative Dental Benefits - **Prophylaxis (Cleaning)**	80%	20%	Limited to 1 every 6 months
Preventative Dental Benefits - **Bitewing X-Ray**	80%	20%	Limited to 1 every 6 months as part of Routine Exam
Preventative Dental Benefits - **Full Mouth/Panoramic X-Ray**	80%	20%	Limited to 1 every 5 Calendar Years as part of Routine Exam
Preventative Dental Benefits - **Space Maintainers**	80%	20%	Dependents under age 19.
Preventative Dental Benefits - **Topical Fluoride Treatment**	80%	20%	Dependents under age 19. Limited to 1 per Calendar Year
Preventative Dental Benefits - **Sealants**	80%	20%	Dependents under age 19.
Basic Dental Benefits - **Filings**	80%	20%	
Basic Dental Benefits - **Emergency/Palliative Office Visits**	80%	20%	
Basic Dental Benefits - **Oral Surgery**	80%	20%	
Basic Dental Benefits - **Extractions**	80%	20%	The removal of impacted wisdom teeth is covered under the medical portion of the Plan.
Basic Dental Benefits - **Repair of Crowns, Bridges, Inlays and Dentures, Periodontics, Endodontics**	80%	20%	
Major Dental Benefits - **Crowns**	80%	20%	
Major Dental Benefits - **Pontics (Artificial Teeth)**	80%	20%	
Major Dental Benefits - **Bridges, partial and complete**	80%	20%	
Major Dental Benefits - **Dentures, partial and complete, including relining and addition of teeth**	80%	20%	
Orthodontia	50%	50%	$2,000 Lifetime Maximum. Orthodontia benefits are available to all Covered Persons.
Plan A and B			
Dental Benefits specified above apply to Plan A. Unless waived, Plan B participants and beneficiaries are also eligible for the Dental Benefits specified above.			

VISION BENEFIT SUMMARY

Coverage from In-Network Provider	
Vision Exam	Covered in full every 2 Calendar Years
Prescription Glasses - **Single vision, lined bifocal, lined trifocal lenses, and progressive lenses** - **Polycarbonate lenses for Dependent Children**	Covered in full every 2 Calendar Years
Frames - **Frame of your choice covered up to $175.*** **or** Contacts* - **Covered up to $175.00***	Every 2 Calendar Years *Contact your VSP Provider for information regarding additional savings. **When you choose contacts instead of glasses, your $175.00 allowance applies to the cost of your contacts. There is a copay not to exceed $60 for your contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.
Safety Glasses* Not Available for Dependents or Retirees. *The safety lenses and frames provided under this Plan must be certified as safe for work environment by meeting the necessary requirements set forth by the American National Standards Institute.	
Lenses - **Single vision, lined bifocal, lined trifocal, progressive lenses, and polycarbonate lenses.**	Covered in full Every Calendar Year
Frames - **Frame of your choice covered up to $120.***	Covered Every Calendar Year *Contact your VSP Provider for information regarding additional savings.
Vision Benefit - Extra Discounts and Savings	
Diabetic Eyecare Plus Program (related to Type 1 and Type 2 diabetes)	$20 Copay
Laser Vision Corrections Discounts	Please contact 800-877-7195 for more information regarding Laser Vision Corrections Discounts
Prescription Glasses and Sunglasses	• Average 35-40% savings on all non-covered lens options • 20% off additional glasses and sunglasses, including lens options, from the same doctor on the same day as your WellVision Exam, or receive 20% off from any doctor within 12 months of your last WellVision Exam.
Retinal Screening	• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.
Coverage from an Out-of-Network Provider	
Exam & Eyewear	$200 every 2 Calendar Years
Plan A and B	
Vision Benefits specified above apply to Plan A and B.	

WEEKLY INCOME BENEFIT SUMMARY

Weekly Income Benefit Summary	
For Active Participants Only (including Participants covered by a Participation Agreement). A complete description of the Weekly Income benefit is found in Section 25 of this Plan.	
Waiting Period	First (1st) Day of Disability due to Accident Eighth (8th) Day of Disability due to Sickness
Weekly Benefit - **Occupational Coverage**	$50.00 per week
Weekly Benefit - **Non-Occupational Coverage**	$475.00 per week
Daily Benefit	One-seventh (1/7) of the Weekly Benefit Amount
Maximum Benefit Period	Twenty-six (26) weeks per Disability

LIFE INSURANCE AND ACCIDENTAL DEATH/DISMEMBERMENT INSURANCE

Life Insurance and Accidental Death/Dismemberment Insurance	
Life Insurance and Accidental Death and Dismemberment benefits are insured. See your certificate of insurance for details regarding eligibility, conversion options, exclusions, claims procedures and other applicable terms and conditions. *Active Participants include Participants covered by a CBA or Participation Agreement. Dependents of Active Participants are not eligible for Life Insurance and Accidental Death and Dismemberment Benefits. **Retired Participants include Participants formerly covered by a CBA or Participation Agreement. Dependents of Retirees are not eligible for Life Insurance.	
Active Participants*	
Life Insurance	$20,000.00
Accidental Death and Dismemberment	$20,000.00
Retired Participants (Effective April 1, 2022)**	
Life Insurance	$10,000.00
Plan A and B	
Life Insurance and Accidental Death and Dismemberment benefits specified above apply to Plan A and B.	