I.B.E.W. LOCAL NO. 38
HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT FOR ACTIVE & RETIREE INSIDE, RESIDENTIAL AND TELEDATA ELECTRICIANS

(May 1, 2022)

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LOSS OF GRANDFATHERED STATUS

Effective January 1, 2014, this group health plan will no longer be considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the 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. Now that your plan is no longer grandfathered, your plan must include certain consumer protections of the Affordable Care Act, for example, the requirement for the provision of preventative health services without any cost sharing. The requirements for non-grandfathered plans under the Affordable Care Act have been incorporated herein, and it is the intent of the Plan to comply with all requirements for grandfathered plans under the Affordable Care Act beginning January 1, 2014.

TO ALL MEMBERS:

The benefit plan provided to you through the I.B.E.W. Local No. 38 Health and Welfare Fund ("Fund") is described in detail on the pages that follow. The benefits described in this booklet are the benefits in place as of May 1, 2022. For claims incurred prior to May 1, 2022, please refer to the previous Plan Document/Summary Plan Descriptions and their accompanying Summary Descriptions of Material Modification. The term "You" or "Your" refer to the Employee eligible for coverage under the Fund. The benefits—hospitalization, surgical, medical, weekly disability, dental, vision, prescription, death, and accidental death and dismemberment benefits—have been selected with the thought in mind of providing both you and your dependents with the broadest protection possible. The rules for establishing and maintaining eligibility have been designed to meet the special needs of persons in the construction industry. The benefits of the plan are financed primarily by contributions made into the Fund by employers, together with the income earned on the investment of the Fund's assets. In some cases, individuals are permitted to make self-payments to help maintain coverage under the Fund.

The Fund is supervised by your Board of Trustees. The Board consists of three representatives from I.B.E.W. Local No. 38 and three representatives from the Greater Cleveland Chapter of the National Electrical Contractors Association. The duties, responsibilities and authority of the Trustees are specified by law and set forth in the Trust Agreement under which the Fund was established and is maintained. Please refer to the "Additional Information" section at the end of this booklet for more detail as to the role of the Board of Trustees in administering the Fund's benefit plan; the nature, organization and method of funding benefits of the Fund; your legal rights regarding your participation in the Fund; and miscellaneous other information about the Fund that may be of interest to you. The Fund is administered through the Administrative Office established by the Trustees to serve all of its participants and their dependents and beneficiaries.

We urge you to read this booklet carefully so that you will be familiar with the benefits available to you and your family and understand your rights and obligations under the Fund's benefit plan. Additional information regarding certain plan benefits and their payment is included in the materials provided by the Fund's third-party claim administrators, such as the PPO Provider, the Prescription Benefit Manager, the Dental Provider and Vision Provider, and this information is incorporated herein by this reference.

THE BOARD OF TRUSTEES

I.B.E.W. LOCAL NO. 38
HEALTH AND WELFARE FUND
BOARD OF TRUSTEES

Union Trustees	**Employer Trustees**
Michael Muzic	Thomas Shreves
Dan Gallagher	Brian Arthur
Dan O'Connell	David Haines

FUND OFFICE

Office Address:
I.B.E.W. Local No. 38 Health and Welfare Fund
3250 Euclid Ave. Rm #270
Cleveland, OH 44115

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P.O. Box 6326
Cleveland, OH 44101-1326

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PLEASE READ THIS BOOKLET CAREFULLY.

IMPORTANT NOTICE:

It is your responsibility to keep the Fund Office notified of:

- Current information including Address, Phone and Email.
- Life changes including marriage, divorce, birth or death of Eligible Dependent.

This is your obligation, and your failure to inform the Fund Office could jeopardize the proper payment of benefits due to you, your dependents, or beneficiaries under the Fund's benefit plan.

Keeping this information current is the ONLY way the Trustees can keep in touch with you regarding plan changes and other developments affecting your interest under the Plan.

IF YOU HAVE ANY QUESTIONS ABOUT ELIGIBILITY, BENEFITS, OR OTHER MATTERS INVOLVING YOUR HEALTH AND WELFARE FUND, CONTACT THE FUND OFFICE AT 216-431-7738.

I. GENERAL INFORMATION

A. YOUR RESPONSIBILITIES AS A PARTICIPANT IN THE I.B.E.W. LOCAL NO. 38 HEALTH AND WELFARE FUND

The primary purpose of this Plan is to pay benefits to all those who are entitled to benefits. However, in order for the Trustees and the Fund Office staff to achieve this objective, we need your cooperation. There are certain responsibilities which you, as a participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable by the Fund.

1. TAKE TIME TO READ THIS BOOKLET

A list of your responsibilities under the Plan follows. As you read this list, you will notice that none of these responsibilities is too burdensome. In fact, just a little time and effort on your part will go a long way toward protecting your best interests under the Plan.

This booklet is the primary source of information about your welfare plan. It contains all the information you need to know about how to qualify for benefits, what benefits are available, and how to file a claim for benefits.

REMEMBER: It is your responsibility to read this booklet. You owe it to yourself and your family to become familiar with the details of this Plan and this booklet provides that information. Of course, if you have any questions about the benefit program that are not answered by the booklet, be sure to contact the Fund Office at 216-431-7738.

2. NAMING AND MAKING CHANGES TO YOUR BENEFICIARY

When you first gain initial eligibility per the Plan document, you will receive a yellow IBEW Local No. 38 Welfare Fund Beneficiary Designation Card from the Fund Office. Complete and return this card to the Fund Office. You must keep this information up to date. If a beneficiary card is not on file at the time of your death, the Plan will pay the benefit per Section (IV)(C).

Please note you will also receive various beneficiary forms/cards from other funds. Please complete and return all forms/cards; information is needed in case of your death. This information must be kept current at all times.

When your marital status changes or if, for some other reason, you wish to change the name of your beneficiary, don't forget to call the Fund Office at 216-431-7738 to request a new Beneficiary Card and return it to the Fund Office. Unless you do, the latest beneficiary card on file will generally determine who receives any benefit which may be payable if you die. ***Failure to change your beneficiary, even when you want to, is often just an oversight - an oversight which could be costly to your survivors***.

ANY TIME YOU NEED TO CHANGE THE INFORMATION OR CONFIRM A CARD IS ON FILE CONTACT THE FUND OFFICE AT 216-431-7738.

3. NOTIFY THE FUND OFFICE PROMPTLY REGARDING ANY CHANGE IN YOUR ADDRESS OR BENEFICIARY

When there are changes to the Plan or benefit improvements, the Fund Office will let you know by first class mail. The Fund Office must have your current address to get in touch with you.

4. YOUR RESPONSIBILITIES TO ENSURE PROMPT PAYMENT OF CLAIMS

The Fund Office's contact information is as follows:

I.B.E.W. Local No. 38 Health and Welfare Fund
Administration Office
P.O. Box 6326
Cleveland, OH 44101-1326
Phone: (216) 431-7738
Fax: (216) 431-7719

To obtain benefits, it is necessary that all claimants comply with the applicable claim rules set forth in this SPD. The Trustees shall exercise every right provided under the terms of the Health and Welfare Plan and the rules established to prevent any claimant from receiving benefits who is, in their opinion, attempting to subvert the purposes of the Fund, or who does not present a bona fide claim.

It is your responsibility to file a claim and provide the Fund Office with any documentation that is necessary. See Article IV, Sections I and P for additional information on filing a claim or appeal with the Fund. If you need any assistance, do not hesitate to call the Fund Office.

5. EMPLOYER CONTRIBUTIONS

Benefits paid by this Plan are financed primarily by employer contributions based on the number of hours worked in covered employment. Per the Collective Bargaining Agreement with IBEW Local Union 38, Section 6.04 (b), Subsection 2, the Monthly Fringe Benefit Reports and Payments are due no later than 15 calendar days following the end of each month and Weekly Fringe Benefit Reports and Payments are due no later than 3 working days following the end of each work week.

Example: You work 160 hours in the work month of April. The Contractor would report by May 15th and the Fund Office reconciles the contributions received from the reporting Contractor. The required disbursements are made prior to the end of the month and June Eligibility is updated.

If you are working out of the jurisdiction, hours are first remitted to the Local you are working in and the following month the hours are sent to your Home Local.
Example: Out of Local 38 jurisdiction, you work 160 hours in the work month of April. The Contractor would report by May 15th to the out of jurisdiction local. The local will remit through ERTS to Local 38 by June 15th. The Fund Office reconciles all the funds received and required disbursements are made prior to the end of the month and June Eligibility is updated.

6. MAKE SELF-PAYMENTS ON TIME AND IN THE CORRECT AMOUNT

This Plan also provides that if you are unemployed or have not been able to work enough hours to maintain eligibility under the Fund, you may make self-contributions for a maximum of twelve consecutive months to obtain the required number of hours to continue your eligibility.

You will be notified when self-contributions are required to maintain your eligibility for the first self-pay month only. The Self-Pay Notice indicates the **amount due** and the **due date for the first payment**. If needed, subsequent payments are due before the first (1st) day of the benefit month. For example, a self-payment for the benefit month of April is due by March 31st. It is the Member's responsibility to contact the Fund Office regarding subsequent self-payments. Failure to pay the required amount on time will lead to a loss of eligibility.

IT IS YOUR RESPONSIBILITY TO CHECK WITH YOUR EMPLOYER AND THE FUND OFFICE TO SEE THAT YOUR EMPLOYER IS MAKING PAYMENTS REQUIRED TO MAINTAIN YOUR ELIGIBILITY IN THE HEALTH AND WELFARE FUND.

B. DEFINITIONS

To help you understand how the Plan works, the following are some defined terms which are used frequently throughout this booklet.

1. **After Hours Care –** services received in a Physician's office at times other than regularly scheduled office hours, including days when the office is normally closed such as holidays or Sundays.

2. **Alcoholism –** a condition classified as a mental disorder and described in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) or the most recent version, as alcohol dependence, abuse or alcoholic psychosis.

3. **Appeal –** a request for your plan to review a decision again.

4. **Application –** all questionnaires and forms required by the Plan to determine your eligibility.

5. **Benefit Book –** this document.

6. **Benefit Period –** the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, Coinsurance Limits, and Non-PPO Network Coinsurance Limits are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the Effective Date and the day your coverage terminates.

7. **Billed Charges –** charges for all services and supplies that the Covered Person has received from the Provider, whether they are a Covered Service or not.

8. **Birth Year –** a 12 month rolling year beginning on the individual's birth date.

9. **Card Holder –** an eligible Employee or participant of the Group who has enrolled for coverage under the terms and conditions of the Plan.

10. **Charges –** the Provider's list of charges for services and supplies before any adjustments for discounts, allowances, incentives or settlements. For a Contracting Hospital, charges are the master charge list uniformly applicable to all payors before any discounts, allowances, incentives or settlements.

11. **Coinsurance –** your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the Eligible Expense for the service. The coinsurance amount is a percentage of the Lesser Amount for Contracting Institutional Providers and Physicians and Other Professional Providers or a percentage of the Non-Contracting Amount for Non-Contracting Providers for which you are responsible after you have met your Deductible or paid your Copayment.

12. **Coinsurance Limit –** a specified dollar amount of Coinsurance expense Incurred in a Benefit Period by a Covered Person for Covered Services, received from a PPO Network Provider.

13. **Condition –** an injury, ailment, disease, illness or disorder, including both physical and mental.

14. **Contraceptives –** oral, injectable, implantable or transdermal patches for birth control.

15. **Contract –** the agreement between the PPO Provider and your Group referred to as the Group Contract. The Contract includes the Group Application, Individual Applications of the Card Holders, this Benefit Book, Schedules of Benefits and any Riders or addenda. The Contract may be referred to as the "Agreement" in other sections of this Plan.

16. **Contracting –** the status of a Hospital or Other Facility Provider which has an agreement with the PPO Provider or the PPO Provider's parent company about payment for Covered Services or that is designated by the PPO Provider or its parent as Contracting**.**

17. **Convalescent Hospital –** an institution which meets **all** the following requirements:

    a. Is regularly engaged in providing Skilled Nursing Care for injured and sick persons under 24-hour-a-day supervision by a Physician or a Registered Nurse (RN);

b. Has available at all times the service of a Physician who is a staff member of a general Hospital;

c. Has on duty 24-hours-a-day a Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Skilled Practical Nurse, and has a Registered Nurse (RN) on duty at least eight (8) hours per day;

d. Maintains a daily medical record for each patient;

e. Complies with all licensing and other legal requirements;

f. Is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged or any assisted living facility, a place for drug addicts, a place for alcoholics, a hotel, or a similar institution.

18. **Copayment –** A fixed dollar amount, if specified in the Schedule of Benefits, that you may be required to pay at the time Covered Services are performed. The amount can vary by the type of covered health care.

19. **Covered Charges –** the Billed Charges for Covered Services, except that the Plan reserves the right to limit the amount of Covered Charges for Covered Services provided by a Non-Contracting Provider to the Non-Contracting Amount determined as payable by the Plan.

20. **Covered Person –** the Eligible Employee, and if family coverage is in force, the Eligible Employee's Dependent(s).

21. **Complications of Pregnancy –** Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

22. **Covered Service –** a Provider's service or supply as described in the Health Care Benefits section of the SPD for which the Plan will provide benefits, as listed in the Schedule of Benefits.

23. **Custodial Care –** care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting their activities of daily living. Custodial Care is care which can be taught to or administered by a lay person and includes but is not limited to (a) administration of medication which can be self-administered or administered by a lay person or (b) help in walking, bathing, dressing, feeding or the preparation of special diets. Custodial Care does not include care provided for its therapeutic value in the treatment of a Condition.

24. **Deductible –** The amount you owe for health care services your plan covers before your plan begins to pay.

25. **Drug Abuse –** a Condition classified as a mental disorder and described in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) or the most recent version, as drug dependence abuse or drug psychosis.

26. **Durable Medical Equipment –** Equipment and supplies ordered by a health care provider for everyday or extended use.

27. **Effective Date –** 12:01 a.m. on the date when your coverage begins.

28. **Eligible Dependent –** the Eligible Employee's Spouse and Child or Children, as defined below. However, an Eligible Employee's Child that is also eligible for coverage as an Employee shall not be considered an "Eligible Dependent" under the Plan. Conversely, an Eligible Employee's Spouse can be covered as both an "Eligible Dependent" and "Employee."

The term "Child" or "Children" shall include:

a. All Children from birth to age twenty-six (26), including legally adopted children and foster children, regardless of marital status, work status, living status, or financial dependency. Step-children are also included provided that the Employee shows proof that the step-child(ren) is financially dependent on the Employee and living with him or her. Grandchildren and Spouses of children are not considered eligible dependents.

b. Children who are incapable of self-sustaining employment by reason of mental or physical handicap, and who became so incapable prior to attainment of the termination age stated above and who are primarily financially dependent upon the Eligible Employee, provided the Eligible Employee furnishes due proof of such incapacity within thirty-one days of the date such dependent child's coverage would otherwise terminate due to attainment of the terminating age.

c. Children who are designated as an Alternate Recipient under a Qualified Medical Child Support Order (QMCSO).

29. **Eligible Expense –** maximum amount on which payment is based for covered health care services

30. **Eligible Person –** eligible Employees and their Eligible Dependents.

31. **Eligibility Rules –** the rules establishing eligibility for coverage and benefits under the Plan as established by the Trustees, see Section III, subsection A.

32. **Emergency –** an accidental traumatic bodily injury or other medical Condition (including a mental health condition or substance use disorder) that arises

suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

a. place an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;

b. result in serious impairment to the individual's bodily functions; or

c. result in serious dysfunction of a bodily organ or part of the individual.

33. Emergency Admission – an Inpatient admission to a Hospital directly from a Hospital emergency room.

34. Emergency Care – Covered Services that are furnished by a Provider within the Provider's license and as otherwise authorized by law that is needed to evaluate or Stabilize an individual in an Emergency.

35. Emergency Services – a medical screening examination as required by Federal Law that is within the capability of the emergency department of the Hospital or independent freestanding emergency department, including ancillary services routinely available to the emergency department, or independent freestanding emergency department as applicable, to evaluate an Emergency; and further medical examination and treatment that are required to Stabilize an Emergency and within the capabilities of the staff and facilities available at the Hospital or independent freestanding emergency department, including any trauma or burn center at the Hospital, as required under Section 1867 of the Social Security Act (42 U.S.C. 1395(d)) to Stabilize the patient, and, so long as all conditions in 45 CFR 149.410(b) are not met, items and services for which benefits are provided or covered under the plan that are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished.

36. Employee – members of the collective bargaining unit represented by the Union who are eligible to participate in and receive the benefits of the Trust Fund in accordance with the Trust Agreement and this Plan. In addition, the term "Employee" shall mean and include full-time, regular Employees of the Union and the Trustees, collectively, and any other entity established to administer fringe benefit, apprenticeship or related funds or other programs established through collective bargaining with the Union and the Association. The term "Employee" shall also include Non-Bargaining Employees eligible to participate through the terms of the Participation Agreement. Finally, an "Employee" shall also include persons employed full-time by an Employer who are not members of

a Union collective bargaining unit but qualify as "Alumni Employees." Alumni Employees are persons who meet all of the following conditions:

a. the person was previously an Employee in the collective bargaining unit during the current plan year or any prior plan year for all of his or her hours of service to the Employer(s).

b. the person is employed full-time by an Employer bound to a collective bargaining agreement with the Union or another agreement requiring contributions to the Fund on behalf of Employees;

c. the person is not included in another unit of employees covered by a collective bargaining unit with a labor union if health and welfare benefits were the subject of good faith bargaining between such Employer and the labor union;

d. the Employer of the person signs a participation agreement with the Plan agreeing to make contributions to the Plan on behalf of all of its Alumni Employees at the same time and in the same amount specified in the bargaining agreement;

e. no more than ten percent (10%) of the participants in the Plan are non-bargaining unit Employees.

37. **Employer –** a member or members of the Greater Cleveland Chapter of the National Electrical Contractors Association ("NECA") as well as other contributing employers who may hereafter become parties to the I.B.E.W. Local No. 38/NECA collective bargaining agreement for Inside Electricians, Residential/Teledata Electricians, or another agreement requiring contributions to the Fund on behalf of its employees.

38. **Enhanced Clinic Access** – An Agreement between the Plan and another entity for the participant and beneficiary of the Plan to receive Medical Care from a specific facility

39. **Enrollment Form –** a form you complete for yourself and your Eligible Dependents to be considered for coverage under the Plan.

40. **Essential Health Benefits –** benefits defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use 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.

41. **Excess Charges –** the amount of Billed Charges in excess of the Covered Traditional Amount or Non-Contracting Amount determined payable by the Plan for a Non-Contracting Provider, Non-Participating Physician or Other Professional Provider.

42. **Excluded Services –** health care services that your plan does not pay for or cover.

43. **Experimental or Investigational Drug, Device, Medical Treatment or Procedure** – a drug, device, medical treatment or procedure is Experimental or Investigational:

a. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

b. If reliable evidence shows that the drug, device, or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or

c. If reliable evidence shows that the consensus of 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, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure. Determination will be made by the Plan at its sole discretion and will be final and conclusive, subject to any available appeal process.

44. **Home Health Care –** health care services a person receives at home.

45. **Hospice Services –** services to provide comfort and support for persons in the last stages of a terminal illness and their families.

46. **Hospital –** an Institution that, regardless of whether the Institution operates within Ohio, would be classified as a hospital under the Ohio Revised Code in which inpatients are provided diagnostic, medical, surgical, obstetrical, psychiatric, or rehabilitation care for a continuous period longer than twenty-four hours or a hospital operated by a health maintenance organization. Hospital does not include nursing homes or residential care facilities, a health care facility operated by the

department of mental health or the department of developmental disabilities, a health maintenance organization that does not operate a hospital, the office of any private licensed health care professional, whether organized for individual or group practice, or a clinic that provides ambulatory patient services and where patients are not regularly admitted as inpatients. Hospital also does not include an institution for the sick that is operated exclusively for patients who use spiritual means for healing and for whom the acceptance of medical care is inconsistent with their religious beliefs, accredited by a national accrediting organization, exempt from federal income taxation under section 501 of the Internal Revenue Code, as amended, and providing twenty-four hour nursing care pursuant to a state statutory exemption from the licensing for nursing care as a result of providing care for the sick when done in connection with the practice of religious tenets of any church and by or for its members. Hospital also includes an institution that meets the specifications of Chapter 3727 of the Ohio Revised Code, except for the requirement that the institutions be operated within the State of Ohio.

47. **Hospitalization –** care in a Hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

48. **Immediate Family –** the Eligible Employee and the Eligible Employee's Spouse, parents, children and stepchildren by blood, marriage or adoption.

49. **Incurred –** rendered to you by a Provider. All services rendered by the Institutional Provider during an Inpatient admission prior to termination of coverage are considered to be Incurred on the date of admission.

50. **Inpatient –** a Covered Person who receives care as a registered bed patient in a Hospital or Other Facility Provider where a room and board charge is made.

51. **Institution (Institutional) –** a Hospital or Other Facility Provider.

52. **Lesser Amount –** for Contracting and Participating Providers, the Lesser Amount means the Lesser of the Negotiated Amount or the Covered Charges. For Non-Participating Physicians and Other Professional Providers, the Lesser Amount means the lesser of the Billed Charges or Traditional Amount. For the Non-Contracting Providers, the Lesser Amount means the Non-Contracting Amount.

53. **Medical Care –** professional services received from a Physician or Other Professional Provider to treat a Condition.

54. **Medically Necessary or Medical Necessity –** a service, supply and/or Prescription Drug that is required to diagnose or treat a Condition and which the Trustees or their agent determine is:

a. Appropriate with regard to the standards of good medical practice and not Experimental or Investigational Drug, Device, Medical Treatment or Procedure;

b. Not primarily for your convenience or the convenience of a Provider; and

c. The most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or Condition required that the services cannot be safely or adequately provided to you as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

55. Medicare – the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

56. Medicare Approved – the status of a Provider that is certified by the United States Department of Health and Human Services to receive payment under Medicare.

57. Mental Illness – a Condition classified as a mental disorder in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) or the most recent version, excluding Drug Abuse and Alcoholism.

58. Negotiated Amount – the amount the Provider has agreed with the Plan to accept as payment in full for Covered Services.

The Negotiated Amount for Institutional Providers does not include adjustments and/or settlement due to prompt payment discounts, guaranteed discount corridor provision, maximum charge increase limitation violations or any settlement, incentive, allowance, or adjustment that does not accrue to a specific claim.

The Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings, volume based credits or refunds or discount guarantees.

The Negotiated Amount for Contracting Institutional Providers may exceed the Covered Charges.

The Negotiated Amount for Participating Physicians and Other Professional Providers does not include any performance withhold adjustments.

In certain circumstances, the Plan may have an agreement or arrangement with a vendor who purchases the services, supplies or products from the Provider instead of the Plan contracting directly with the Provider itself. In these circumstances, the Negotiated Amount will be based upon the agreement or arrangement the Plan

has with the vendor and not upon the vendor's actual negotiated price with the Provider, subject to further conditions and limitations set forth herein.

59. **Non-Bargaining Employee** – a full-time Employee not covered by a collective bargaining agreement who is eligible to participate in the Plan. Subject to the terms of any Participation Agreement, Non-Bargaining Employees are eligible for medical, prescription drug, dental, vision and EAP benefits, and may access any of the Plan Clinics.

60. **Non-Contracting –** the status of a Hospital or Other Facility Provider that does not meet the definition of a Contracting Institutional Provider.

61. **Non-Contracting Amount –** Subject to applicable law, the maximum amount allowed by the Provider Covered Services provided to Covered Persons for a Non-Contracting Provider based on various factors, including, but not limited to, market rates for that service, Negotiated Amounts for that service, and Medicare reimbursement for that service. The Non-Contracting Amount will likely be less than the Provider's Billed Charges. If you receive services from a Non-Contracting Provider, and you are balanced billed for the difference between the Non-Contracting Amount and the Billed Charges, you may be responsible for the full amount up to the Provider's Billed Charges, even if you have met your Coinsurance Limit.

62. **Non-Covered Charges –** Billed Charges for services and supplies that are not Covered Services.

63. **Non-Participating –** the status of a Physician or Other Professional Provider that does not have an agreement with the PPO Provider about payment for Covered Services.

64. **Non-PPO Network Coinsurance –** a percentage of the Lesser Amount for Non-PPO Network Providers or the Covered Charges for Non-Contracting Providers for which you are responsible after you have met your Deductible or paid your Copayment, if applicable.

65. **Non-PPO Network Coinsurance Limit –** a specified dollar amount of Non-PPO Network Coinsurance expense for which you are responsible in each Benefit Period.

66. **Non-PPO Network Provider –** a Physician or Other Professional Provider, Contracting Hospital or Contracting Other Facility Provider, Home Health Care Agency or Hospice Provider that is not designated by the PPO Provider as a PPO Network Provider.

67. **Office Visit –** Office visits include medical visits or Outpatient consultations in a Physician's office or patient's residence. A Physician's office can be defined as a

medical/office building, outpatient department of a Hospital, freestanding clinic facility or a Hospital-based Outpatient clinic facility.

68. **Other Facility Provider –** the following Institutions which are licensed, when required, and where Covered Services are rendered which require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Other Professional Provider. The Plan will only provide benefits for services or supplies for which a charge is made. Only the following Institutions which are defined below are considered to be Other Facility Providers:

a. **Alcoholism Treatment Facility –** a facility which mainly provides detoxification and/or rehabilitation treatment for alcoholism.

b. **Ambulatory Surgical Facility –** a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.

c. **Day/Night Psychiatric Facility –** a facility which is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of mental illness. These services are provided through either a day or night treatment program.

d. **Dialysis Facility –** a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis

e. **Drug Abuse Treatment Facility –** a facility which mainly provides detoxification and/or rehabilitation treatment for Drug Abuse

f. **Home Health Care Agency –** a facility which meets the specifications of Chapter 3701.88 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and which provides nursing and other services as specified in the Home Health Care Services section of this SPD. A home health care agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

g. **Hospice Facility –** a facility which provides supportive care for terminally ill patients as specified in the Hospice Services section of this SPD.

h. **Psychiatric Facility –** a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.

i. **Psychiatric Hospital –** a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental

Illness on an Inpatient basis. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must be provided under the supervision of a registered nurse.

j. **Skilled Nursing Facility –** a facility which primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by a registered nurse, a licensed practical nurse, or a physical therapist performing under the supervision of a Physician.

69. Other Professional Provider – only the following persons or entities which are licensed as required:

a. advanced nurse practitioner (A.N.P.);
b. ambulance services;
c. anesthesiologist;
d. dentist;
e. doctor of chiropractic medicine;
f. doctor of osteopathic medicine;
g. Durable Medical Equipment or prosthetic appliance vendor;
h. laboratory;
i. licensed independent social workers (L.I.S.W.);
j. licensed practical nurse (L.P.N);
k. licensed professional clinical counselor;
l. licensed vocational nurse (L.V.N.)
m. mechanotherapist (licensed or certified prior to November 3, 1975);
n. nurse-midwife;
o. occupational therapist;
p. ophthalmologist;
q. physical therapist;
r. physician assistant;
s. podiatrist;
t. psychiatrist;
u. psychologist;
v. registered nurse (R.N.)
w. registered nurse anesthetist; and
x. urgent care provider.

70. Outpatient – the status of a Covered Person who receives services or supplies through a Hospital, Other Facility Provider, Physician, or Other Professional Provider while not confined as an Inpatient.

71. Participating – the status of a Physician or Other Professional Provider that has an agreement with the PPO Provider about payment of Covered Services.

72. Pharmacy – any Other Professional Provider that is a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law.

73. **Physician –** a person who is licensed and legally authorized to practice medicine.

74. **Plan Clinic** – A Physician's office operated by, or on behalf of, the Plan that provides Medical Care primarily to the participants and their beneficiaries of the Plan. A Plan Clinic is also a Physician's office with which the Plan has entered into an Enhanced Clinic Access Agreement for its participants and beneficiaries to receive Medical Care. Tests and services related to Employment requirements are excluded from Plan Clinic.

75. **PPO Network Provider –** a Physician, Other Professional Provider, Contracting Hospital or Contracting Other Facility Provider that is included in a limited panel of Providers as designated by the PPO Provider and for which the greatest benefit will be payable when one of these Providers is used.

76. **Preauthorization –** a decision by your Plan, PPO Provider, or a prescription drug carrier that a health care service, treatment plan, prescription drug or Durable Medical Equipment is medically necessary. This is also referred to as "precertification" or "prior approval." The Plan requires preauthorization before you are admitted as an Inpatient in a Hospital or other Facility, before you receive certain services, except for an Emergency Medical Condition. Preauthorization is also required before you receive a non-preferred drug on the Plan's formulary list or if it is a product that has obtained FDA approval through the 510(k) Pathway Procedure established by the FDA. Preauthorization is not a promise your plan will cover the cost.

77. **PPO Network Provider –** a Physician, Other Professional Provider, Contracting Hospital, or Contracting Other Facility Provider that is included in a limited panel of Providers as designated by the PPO Provider and for which the greatest benefit will be payable when one of these Providers is used.

78. **Prescription Drug (Federal Legend Drug)** – any medication that by federal or state law may not be dispensed without a Prescription Order.

79. **Prescription Drug Coverage –** the plan that helps pay for Prescription Drugs and medications.

80. **Prescription Order** – the request for medication by a Physician appropriately licensed to make such a request in the ordinary course of professional practice.

81. **Professional Charges –** the cost of a Physician or Other Professional Provider's services before the application of the Negotiated Amount.

82. **Provider –** a Hospital, Other Facility Provider, Physician, or Other Professional Provider.

83. **Psychologist** – Other Professional Provider who is a licensed Psychologist having either a doctorate in psychology or a minimum of five years of clinical experience. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

84. **Reconstructive Surgery –** surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

85. **Rehabilitation Services –** health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

86. **Residential/Teledata/ Specialty Electrician** – as used throughout this Plan, includes all Plan participants working under a Collective Bargaining Agreement for Teledata Electricians, Residential Electricians, or any other electricians working under any Collective Bargaining Agreement except for Inside Electricians.

87. **Residential Treatment Facility –** a facility that:

a. provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders;

b. provides room and board as well as providing an individual treatment plan for the chemical, psychological and social needs of each of its residents;

c. meets all regional, state, and federal licensing requirements;

d. has a residential care treatment program that is supervised by a professional staff of qualified Physician(s), licensed nurses, counselors and social workers; and

e. is maintained for residents who do not require care in an acute or more intensive medical setting.

88. **Rider** – a document that amends or supplements your coverage.

89. **Routine Services –** services not considered Medically Necessary.

90. **Skilled Care** – care that requires the skill, knowledge or training of a physician or a registered nurse, licensed practical nurse, or physical therapist performing under the supervision of a physician. In the absence of such care, the Covered Person's health would be seriously impaired. Such care cannot be taught to or administered by a lay person.

91. **Skilled Nursing Care –** services from registered, licensed practical nurses or physical therapists in your own home or in a nursing home.

92. **Specialist –** a physician specialist who focuses on a specific area of medicine or a group of patients (other than family practice, general practice, geriatrics, internal medicine, pediatrics, neonatology, obstetrics, gynecology or advanced practice nurses) to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

93. **Spouse –** that person, if any, who is recognized under the laws of the State of Ohio or the laws of any other state in the United States which recognizes a marriage as being legally valid as being the member's lawful husband or wife and who has not been declared divorced or legally separated from the member by any judicial order. **A Spouse who is divorced or legally separated from the Eligible Employee will not be eligible for coverage under the Plan as of the date of said divorce or other termination of the marriage. However, in such an event the Spouse may elect to purchase "Continuation Coverage" for a period of time, as described elsewhere in this booklet**.

94. **Stabilize –** the provision of medical treatment given to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your Condition is not likely to result from or during any of the following:

a. your discharge from an emergency department or other care setting where Emergency Care is provided to you; or

b. your transfer from an emergency department or other care setting to another facility; or

c. your transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

95. **Surgery** – the performance of generally accepted operative and other invasive procedures, the correction of fractures and dislocations, usual and related preoperative and postoperative care, or other procedures as reasonably approved by the Plan.

96. **Total Disability -** a condition resulting from bodily injury or disease which wholly and continuously prevents the Eligible Employee from engaging in any and every gainful employment for wage or profit.

97. **Traditional Amount** – the maximum amount determined and allowed by the Plan for a Covered Service based on factors, including the following:

a. the actual amount billed by a Provider for a given service;

b. Center for Medicare and Medicaid Services (CMS)'s Resource Based Value Scale (RBRVS);

c. other fee schedules;

d. input from Participating Physicians and wholesale prices (where applicable);

e. geographic considerations; and

f. other economic and statistical indicators and applicable conversion factors.

98. **Transplant Center** – a facility approved by the Plan that is an integral part of a Hospital and which:

a. has consistent, fair and practical criteria for selecting patients for transplants;

b. has a written agreement with an organization that is legally authorized to obtain donor organs; and

c. complies with all federal and state laws and regulations that apply to transplants covered under this SPD.

99. **Trust Fund or Fund -** the International Brotherhood of Electrical Workers Local No. 38 Health and Welfare Fund.

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

101. **Union -** the International Brotherhood of Electrical Workers Local No. 38, AFL-CIO.

102. **United States –** all the states, the District of Columbia, the Virgin Islands, Puerto Rico, American Samoa, Guam and the Northern Mariana Islands.

103. **Urgent Care** – any Condition, which is not an Emergency, that requires immediate attention.

104. **Urgent Care Provider** – an Other Professional Provider that performs services for health problems that require immediate medical attention which are not Emergencies.

II. SCHEDULE OF BENEFITS

A. SCHEDULE

DEATH BENEFITS (Eligible Employees and Retirees)
Amount of Coverage $10,000.00

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
(Eligible Employees and Retirees)
Principle sum $10,000.00

WEEKLY DISABILITY BENEFITS FOR INSIDE & TELEDATA ELECTRICIANS
(Eligible Employees Only)
Weekly Benefit $350.00
($50.00 per day)

Benefits begin on the third (3rd) day of a disability caused by an accident and on the eighth (8th) day of a disability caused by sickness.

Maximum Number of Weeks Payable ..... 26 Weeks

PRESCRIPTION BENEFIT

Prescription Drug Benefit	Retail (30-day supply limit)	Mail (90-day supply limit)
Generic Copay	$10.00	$20.00
Preferred Brand Copay	$25.00	$50.00
Non-Preferred Brand Copay	$40.00	$80.00
Specialty Copay*	$50.00	Excluded

Preauthorization is necessary for Non-Preferred Brand Name drugs that are not on the Plan's Rx Formulary. For a list of Preferred Brand, Non-Preferred Brand, and Specialty medications, please contact the Pharmacy Benefit Manager.

Specialty Drugs – Participants must try the generic Specialty drug first, if available, before the Plan will cover a Brand name Specialty drug. There is no 90-day supply for Specialty drugs.

B. BENEFIT SUMMARY

See the following Benefit Summary for hospital, surgical, major medical, in-hospital, laboratory, maternity benefits for Employee or the Employee's Spouse only, and other health benefits. Please note you will receive an updated Summary of Benefit Coverage annually.

Important Information: Beginning January 1, 2021, the Plan will have two tiers for in-network care; a Wellness Tier and a Non-Wellness Tier. The Wellness Tier has lower deductibles, co-insurance rates, and out-of-pocket maximums. To be eligible for the Wellness Tier, both you and your Spouse (if applicable) must undergo an annual physical and submit a completed Physical Form to the Fund Office by November 15th.

This is an annual requirement, which means you and your Spouse (if applicable) must undergo a physical each year to be eligible for coverage under the Wellness Tier.

BENEFITS	FOR COVERED SERVICES FROM A PPO NETWORK PROVIDER		FOR COVERD SERVICES FROM A NON-PPO PROVIDER
Benefit Period	January 1st to December 31st		January 1st to December 31st
Dependent Age Limit	End of Month Dependent turns Age 26		End of Month Dependent turns Age 26
	Wellness Tier	**Non-Wellness Tier**	**Both Tiers**
Deductible for Inside Wireman CBA			
Single	$250	$500	$750
Family	$500	$1,000	$1,500
Deductible for Residential, Specialty Shop, and Teledata CBAs			
Single	$300	$550	$800
Family	$600	$1,100	$1,600
Out-of-Pocket Limit (Medical)			
For Inside Wireman CBA			
Single	$2,000	$3,000	None
Family	$4,000	$6,000	None
For Residential/Specialty Shop/Teledata CBAs			
Single	$2,500	$3,500	None
Family	$5,000	$6,000	None
Out-of-Pocket Limit (Prescription)			
For Inside Wireman CBA			
Single	$8,700	$5,700	None
Family	$13,400	$11,400	None
For Residential/Specialty Shop/Teledata CBAs			
Single	$5,650	$4,650	None
Family	$11,300	$10,300	None

Annual Limits	None		
HOSPITAL SERVICES			
Room & Board	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Ancillary Services	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Inpatient X-ray & Lab	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
BENEFITS	**FOR COVERED SERVICES FROM A PPO NETWORK PROVIDER**		**FOR COVERD SERVICES FROM A NON-PPO PROVIDER**
	Wellness Tier	**Non-Wellness Tier**	**Both Tiers**
Outpatient X-ray & Lab	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Outpatient Surgery	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Physical Therapy-Occupational Therapy-Speech Therapy-Chiropractor (combined inst. and prof. limit)	$20 copay, balance at 80% of Lesser Amount	$20 copay, balance at 70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Chemotherapy	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Physical, Occupational, and Speech Therapy are limited to the amount authorized but cannot exceed twenty-five (25) visits. Chiropractor visits are limited to ten (10).			
EMERGENCY ROOM SERVICES			
Emergency: Member & Dependents	80% of Lesser Amount ($100 copayment waived if admitted)	70% of Lesser Amount ($100 copayment waived if admitted)	80% of Lesser Amount ($100 copayment waived if admitted)
Non-Emergency: Member & Dependents	80% of Lesser Amount ($100 copayment waived if admitted)	70% of Lesser Amount ($100 copayment waived if admitted	50% of Lesser Amount ($100 copayment waived if admitted
Outpatient Cardiac Rehab	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Outpatient Respiratory Therapy	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Outpatient Dialysis	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges

PHYSICIAN SERVICES			
Access to physicians	Limited to panel providers		Unlimited
In-Hospital Physician Services	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
BENEFITS	**FOR COVERED SERVICES FROM A PPO NETWORK PROVIDER**		**FOR COVERD SERVICES FROM A NON-PPO PROVIDER**
	Wellness Tier	**Non-Wellness Tier**	**Both Tiers**
Routine Physician Exam (Limit 1 per calendar year.)	100% of Lesser Amount		50% of Lesser Amount or Covered Charges
Audiometric Testing	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Office Visits	$20 copay, then 100% of Lesser Amount $0 copay for services rendered at IBEW Fund or Laborers Fund Clinic	$20 copay, then 100% of Lesser Amount $0 copay for services rendered at IBEW Fund or Laborers Fund Clinic	50% of Lesser Amount or Covered Charges
Services at Plan Clinic	100%		Does not apply
Well Child Care Exam	100% of Lesser Amount		50% of Lesser Amount or Covered Charges
Immunizations	100% of Lesser Amount		50% of Lesser Amount or Covered Charges
Inpatient Surgery	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
COVID-19 Testing and Qualified Preventive Care	Covered at 100% (diagnostic purposes only)		
Ambulatory or Outpatient Surgery	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Inpatient Anesthesia	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Outpatient Anesthesia	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Diagnostic Services	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Allergy Treatment	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Ambulance**	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges

BENEFITS	FOR COVERED SERVICES FROM A PPO NETWORK PROVIDER		FOR COVERD SERVICES FROM A NON-PPO PROVIDER
	Wellness Tier	**Non-Wellness Tier**	**Both Tiers**
Prostate Specific Antigen	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount or Covered Charges
Skilled Nursing	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount
	(Limited to 60 Days – All Tiers)		
Private Duty Nursing	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount
Home Health Care	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount
Hospice	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount
MENTAL/NERVIOUS DISORDERS, ALCOHOL & SUBSTANCE AUBSE			
Inpatient Mental Health	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount
Outpatient Mental Health	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount
Inpatient & Outpatient Alcohol & Substance Abuse (Preauthorization is required before being admitted as an inpatient to a hospital or facility)	80% of Lesser Amount	70% of Lesser Amount	50% of Lesser Amount
HEARING AID BENEFIT			
Hearing Aid Benefit	Fund will pay up to a maximum of $500.00 per person total per 5-year period for purchase of hearing aids (not per ear)		

Please Note: Even if the Coinsurance percentage is the same for Non-Contracting Providers as Non-PPO Network providers, you may be subject to balance billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on Negotiated Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.

**Effective May 1, 2022, emergency air ambulance services will be covered at the in-network rate.

C. DENTAL BENEFIT SUMMARY

BENEFITS	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	NON-PARTICIPATING DENTIST*
Benefit Period - January 1st to December 31st			
BENEFIT MAXIMUMS			
Applied Deductible	$0		
Maximum Payment*	$1,500 per person per calendar year on Basic Services and Major Services; $3,000 per person per lifetime on Periodontal Surgery	$1,250 per person per calendar year on Basic Services and Major Services; $3,000 per person per lifetime on Periodontal Surgery	$1,000 per person per calendar year on Basic Services and Major Services; $3,000 per person per lifetime on Periodontal Surgery
***These are not Separate Maximums by Type of Dentist. *Benefit Maximums do not apply for Pediatric Oral Care for Eligible Dependents up to age 19**			
DIAGNOSTIC AND PREVENTIVE			
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	80%
Diagnostic and Preventive Services – includes exams and cleanings (4 per calendar year).	100%	100%	80%
Fluoride once per year up to age 19.			
Space maintainers payable once per area per lifetime up to age 19.			
Sealants – to prevent decay of permanent teeth (to age 9 on first molars; to age 14 on second molars)	100%	100%	80%
Radiographs – X-rays (Bitewings payable 4 times a year and full mouth x-rays are payable once per 3 year period)	100%	100%	80%
BASIC SERVICES			
Oral Surgery Services – extractions and dental surgery	85%	80%	80%
Minor Restorative Services – fillings and crown repair	85%	60%	50%
Endodontic Services – root canals	85%	60%	50%
Other Basic Services – misc. services	85%	60%	50%
Relines and Repairs – to bridges and dentures	85%	60%	50%
Periodontic Services – to treat gum disease	85%	60%	50%
Root Planning and Scaling	60%	50%	50%

Periodontal Surgical Procedures	60%	50%	50%
MAJOR SERVICES			
Major Restorative Services – crowns *crowns over implants are payable 1 per tooth per any 5 year period.	60%	50%	50%
Prosthodontic Services – includes bridges, implants (1 per tooth per any 5 year period), and dentures	60%	50%	50%
ORTHODONTIC SERVICES			
Orthodontic Services – includes braces	60%	50%	50%
Orthodontic Age Limit**	19	19	18

Payment for Orthodontic Service - When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental PPO Dentist - Delta Dental will pay 60% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental. Delta Dental Premier Dentist - Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental. Nonparticipating Dentist - Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

*A Non-Participating Dentist is a dental provider who does not participate with the Delta Dental Network. When you receive services from a Non-Participating Dentist, the percentages in this column indicate the portion of Delta Dental's Non-Participating Dentist Fee that will be paid for those services. This Non-Participating Dentist Fee may be less than what your dentist charges, which means that you will be responsible for the difference.

**Coverage is available on a pre-approved basis only for adult orthodontia solely to redress TMJ when a provider certifies that orthodontia can relieve the problem in lieu of surgery. Such coverage is subject to the same dental maximums as any other dental claim.

D. VISION BENEFIT SUMMARY

Coverage Frequency (Age 19 and Over)	
Eye Examination	Once every 24 months
Spectacle Lenses	Once every 24 months
Frames	Once every 24 months
Contact Lenses*	Once every 24 months
Coverage Frequency (Age 18 and Under)	
Eye Examination	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses*	Once every 12 months
Network Coverage	
1. Examination Including Tonometry (Glaucoma Check)	
a) Eye Exam – Optometrists	Full Coverage
b) Eye Exam – Ophthalmologist	$20
2. **Standard Spectacle Lenses**	
a) Single Vision	Full Coverage
b) Standard Bifocals	Full Coverage
c) Standard Trifocals	Full Coverage
c) Special Lenses (Aphakic & Lenticular	Full Coverage
d) Oversize Lenses	Full Coverage
2. Lens Enhancements	
a) Standard Progressive	$55
b) Premium Progressive	$95-105
c) Custom Progressive	$150-$170
3. Frames (after discount)	$150 Allowance
5. Contact Lenses (in lieu of eyeglasses)	
a) Elective Contacts	$130 Allowance
Out-of-Network Coverage	
Members may elect a non-network vision care provider. Reimbursement for coverage outside of the VSP Network will be up to the maximums listed below:	
1. Vision Examination	$45.00 Maximum
2. Standard Spectacle Lenses	
a) Single vision	$30.00 Maximum
b) Bifocal	$50.00 Maximum
c) Trifocal	$65.00 Maximum
d) Progressive	$50.00 Maximum
3. Frame Only	$70.00 Maximum
4. Contact Lenses (in lieu of eyeglasses)	
a) Elective Contacts	$105.00 Maximum
b) Therapeutic (medically necessary)	$210.00 Maximum

*Contact Lenses are in lieu of spectacle lenses and frames.

For additional information of the Vision Benefit, see Article VII hereof.

III. ELIGIBILITY RULES – COLLECTIVELY BARGAINED EMPLOYEES – ELIGIBLE EMPLOYEES (INSIDE/RESIDENTIAL/TELEDATA/SPECIALTY SHOP)

A. INITIAL ELIGIBILITY

An Employee shall become eligible on the first day of the second calendar month following the month the Employee has completed three (3) or fewer consecutive calendar months of employment with an Employer or Employers, and on whose behalf contributions have been made for not less than three hundred (300) hours during these months. For example, if a contributing Employer is required to pay total contributions on your behalf for three hundred (300) hours in December, January, and February, you would begin your coverage under the Health Plan on April 1st. Please see the table below for further clarification.

ELIGIBILITY MONTH	**BENEFIT MONTH**
300 Hours of Contributions for These 3 Consecutive Eligibility Months	**Coverage Begins This Benefit Month**
January, February, and March	May
February, March, and April	June
March, April, and May	July
April, May, and June	August
May, June, and July	September
June, July, and August	October
July, August, and September	November
August, September, and October	December
September, October, and November	January
October, November, and December	February
November, December, and January	March
December, January, and February	April

Example: Justin began working for an employer in March of 2021. Justin worked the following hours:

- March – 100 hours
- April – 145 hours
- May – 140 hours

As a result, Justin would become eligible for coverage on July 1, 2021.

Important Information: Enrolling Eligible Dependents into Plan

To enroll Eligible Dependents after initial eligibility is established, submit an Enrollment Form and required documentation to the Fund Office. To enroll a Spouse a marriage certificate and social security number must be provided. To enroll a child a birth certificate and social security number must be provided. If the Employee name does not appear on the birth certificate, documentation must be provided indicating the step-child(ren) is financially dependent on the Employee and living with him or her. Please call the Fund Office at 216-431-7738 with any questions on enrolling your Eligible Dependent.

B. CONTINUATION OF ELIGIBILITY

After satisfying the Initial Eligibility requirements, you will continue to remain eligible in the Plan so long as you receive one-hundred thirty (130) hours in contributions for the applicable month (see chart below). If you do not receive one-hundred thirty hours for an applicable month, you can use Bank Hours to fund the shortfall.

Additionally, if you are receiving weekly disability benefits from the Fund or Workers' Compensation Benefits you will be credited with up to one-hundred thirty (130) hours for a full month (or a pro-rata number of hours for any portion thereof) for a maximum of twenty-six (26) weeks of such credit.

The schedule below explains how you remain eligible in the Plan after satisfying the Initial Eligibility rules explained above:

ELIGIBILITY MONTH	**BENEFIT MONTH**
At least 130 Hours of Contribution Made on your Behalf or Banked Hours Used in this Eligibility Month	**Coverage Continues Until the End of this Benefit Month**
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Example: Brook works 100 hours in January (Eligibility Month) and is laid off. Brook has 30 Bank Hours at the end of January.

Brook meets the 130 hours requirement (see discussion on Bank Hours). Because using Brook's work hours and Bank Hours satisfy the 130 hour requirement, Brook and his Eligible Dependents will remain eligible for coverage until March 31st (Benefit Month).

If Brook did not work 130 hours in February (Eligibility Month) and does not have enough Bank Hours to cover the shortfall, Brook will have to self-pay to maintain his eligibility for April (Benefit Month) coverage.

1. BANK HOURS

Bank Hours may be used to supplement a shortfall in work hours and maintain your eligibility. Any hours received in any given month that exceed one hundred thirty (130) hours will be banked.

The maximum number of hours that you can bank is seven hundred eighty (780) hours. Bank hours are automatically applied to maintain your eligibility. In other words, if your hours are less than the continued eligibility requirements, any banked hours you have earned will automatically be applied to keep you eligible. The Board of Trustees may, in its discretion, adjust the number of Bank Hours if the hourly rate of contribution has changed.

> **Example**: An Eligible Employee has 300 hours in the Bank and receives only 100 hours of Employer contributions for the applicable eligibility month. To maintain eligibility, the Eligible Employee uses 30 Bank Hours to meet the 130-hour requirement, which will then lower the Employee's Bank to 270 hours.

2. SELF-CONTRIBUTIONS WHEN BANK FALLS BELOW 130 HRS

An Employee can make self-contributions to remain eligible if the combined hours from employer contributions and Bank Hours are less than one-hundred thirty (130). The rate will be your health and welfare contribution rate per your collective bargaining agreement (minus any HRA contribution) multiplied by the number of hours you are short of 130.

Example: Louis is an inside electrician who works under the Inside Agreement. Louis has 30 hours in his Hour Bank at the time of his January (Eligibility Month) layoff. He needs 130 hours for the March Benefit Month. Louis can self-pay the remaining 100 hours at the Health & Welfare contribution rate less the HRA contribution.

January Eligibility Month: 130 Hours required *less* 30 Bank Hours *equals* 100 Hours needed

Inside Employer H&W Contribution less HRA Contribution: For 2021 is $8.55 (i.e., $9.05-$0.50)

March Benefit Month Self-Payment: 100 Hours x $8.55 = $855.00 self-payment

You cannot make more than twelve (12) consecutive self-payments to remain eligible. After your twelfth (12^{th}) self-payment, you will no longer be eligible to participate in the Plan. You must reinstate through work hours or elect COBRA continuation coverage.

C. REINSTATEMENT OF ELIGIBILITY

An Employee who fails to be continuously eligible in accordance with the preceding section shall again become eligible on the first day of the second calendar month following three (3) or fewer consecutive months during which three hundred (300) hours of contributions have been made to the Fund on the Employee's behalf. Please refer to chart in Section A.

During any three-month period, and if the Employee had hours remaining in the bank at the time of termination, those hours may be used toward the applicable hour requirement for reinstatement. The Bank Hours will expire six months following your termination date.

Example: Omar has 40 hours remaining in his Bank after November Eligibility Month. His coverage terminates January 1, 2021. Omar returns to work in April Eligibility Month of 2021 and works 160 hours. His 40 Banked hours will be included when calculating whether he has worked enough hours to re-establish eligibility. Omar has only worked 200 hours so he will need to work 100 hours or over in the Eligibility Month of May to receive coverage in the Benefit Month of July.

D. CALCULATION OF HOURS TOWARDS ELIGIBILITY IN THE EVENT OF A DELINQUENT EMPLOYER

A participant who is employed by a contributing Employer may be granted up to three (3) work months of credit toward remaining eligible as a Participant in the Plan to receive benefits if the contributing employer has not paid its required contributions to the Plan and filed the appropriate Employer reports.

If an Employer is delinquent for more than three (3) work months, consecutive or nonconsecutive, of contributions to the Plan, whether the delinquency is for a full or partial work month, an Employee of that Employer will no longer receive credit toward allowing the Employee to maintain eligibility under the Plan.

Prior to the employee no longer receiving credit, the Trustees or their designee shall notify the Employee at least fifteen (15) days prior to the first day of the month in which the Employee will no longer receive credit.

Once the Employee is no longer granted credit, the Employee may continue to maintain his/her eligibility in the Fund by making self-payments for a period of time not to exceed twelve (12) months from the date the first self-payment is made.

An employee will lose eligibility and receive the option to elect to continue his/her health coverage under the Plan's COBRA provisions (See Section F below, entitled "COBRA Continuation Coverage") upon the earliest of (a) making twelve (12) consecutive months of self-payments, (b) failing to make the full amount of the self-payment on or before the required due date or (c) no longer being an Employee as defined herein.

Helpful Tip: Once your Employer remits the delinquent contributions, you will receive credit for the hours reported. Additionally, once the payment is received, any self-contributions that you were forced to make to maintain your eligibility will be refunded. If your Employer is delinquent, you should contact the Plan Administrator with questions.

E. ELIGIBILITY FOR BENEFITS WHEN WORKING OUTSIDE OF THE JURISDICTION

If you work outside the geographical jurisdiction of the I.B.E.W. Local No. 38 Health and Welfare Fund, you are entitled to have any fringe benefit payments returned or "reciprocated" to this Fund in order to maintain the eligibility for benefits for you and your Eligible Dependents. In order to have your contributions returned to this Fund, you must initiate the Blanket Authorization on the Electronic Reciprocal Transfer System (ERTS). Transfers of monies will be effective from the first day of the month in which the employee has initiated the Blanket Authorization and designated a home fund choice. If the Blanket Authorization is not initiated, the funds will not be remitted to your Home Local.

Important Information: If you have questions about ERTS, including registration and authorizations, please contact the Fund Office or Union Hall.

F. FREEZING ELIGIBILITY COVERAGE PERIOD

Effective January 1, 2019, you are no longer allowed to freeze the hours accrued toward any period of future eligibility described above unless in the case of Coverage During Period of Military Service – see section I below.

G. ELIGIBILITY FOR WIDOW OR WIDOWER AND TERMINATION OF COVERAGE FOR DEPENDENTS OF A DECEASED EMPLOYEE

1. The widow or widower of a deceased Active Eligible Employee who had maintained coverage under this Plan at the time of death may elect to maintain coverage for those benefit programs made available to widows or widowers under this Plan by making required self-payments, provided, however, that such election must be made in writing to the Plan Administrator by the latter of: (a) one hundred eighty (180) days after the death of the Active Eligible Employee; or (b) ninety (90) days after the expiration or cancellation of any other health care plan, program or policy in effect at the time of the death of the Active Eligible Employee which thereafter provided coverage to such widow or widower. The widow's or widower's coverage under this Plan shall commence with the first day of the month following receipt of the written election and required self-payment from the widow or widower (or such later date as the widow or widower may elect).

   If the Active Eligible Employee who provided coverage to such widow or widower had hours remaining in the bank at death, the widow or widower may apply those bank hours to reduce the amount of their self-payment necessary to continue eligibility (as described in the continuing eligibility section above). Once this bank is depleted, the widow or widower must begin making the full self-payments as described above to continue eligibility. The amount and frequency of the self-contribution payments shall be as determined from time to time by the trustees.

Your surviving spouse must request permission for such coverage in writing to the Fund Office.

2. When an Active Eligible Employee dies, the eligibility of their Eligible Dependents shall terminate on the last day of the calendar month in which the Employee dies, subject to any additional coverage that may be available. If an Active Eligible Employee had hours remaining in your Bank at death, the Eligible Dependents may apply the banked hours to continue eligibility.

   After depleting the Bank Hours, Eligible Dependents will be offered COBRA Continuation Coverage.

H. COBRA CONTINUATION COVERAGE

In compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 and related regulations and amendments ("COBRA"), the Fund offers certain Employees, dependent Spouses, and/or dependent children the opportunity to continue the health care benefits, prescription drug benefits, vision and dental benefits, where applicable, by making self-payments in certain instances where the eligibility for these benefits would otherwise terminate. This coverage, called "COBRA Continuation Coverage," applies to health care benefits, prescription drug benefits, vision benefits, and dental benefits.

Proof of good health is NOT required to obtain COBRA Continuation Coverage if the Employee or his or her Eligible Dependent meets the other qualifications for COBRA Continuation Coverage. However, the Employee or Eligible Dependent must take certain actions within certain time periods in order to effect and maintain COBRA Continuation Coverage.

Under COBRA, any Employee who loses coverage under the Plan by reason of a life event known as a "qualifying event" may elect to continue health coverage under the Plan on a temporary basis from the day the Employee's eligibility ends. Specific qualifying events are listed below. COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who loses coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Employees, Spouses of Employees, and dependent children of Employees may be Qualified Beneficiaries. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

If you are an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

1. COBRA Continuation Coverage for Employees Who Have Elected Eligible Dependent Coverage

A special rule applies if you are an Eligible Dependent of an Employee and you are covered as an Eligible Dependent under the Plan. In such cases, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

a. Your Spouse dies;

b. Your Spouse's hours of employment are reduced;

c. Your Spouse's employment ends for any reason other than his or her gross misconduct; or

d. You become divorced or legally separated from your Spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

a. The parent-Employee dies;

b. The parent-Employee's hours of employment are reduced;

c. The parent-Employee's employment ends for any reason other than his or her gross misconduct;

d. The parents become divorced or legally separated; or

e. The child stops being eligible for coverage under the Plan as a "dependent child."

2. Qualifying Event

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrative Manager has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or the death of the Employee, the employer must notify the Plan Administrative Manager of the qualifying event within thirty (30) days following the date coverage ends.

For other qualifying events (divorce or legal separation of the Employee and the Spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrative Manager. **The Plan requires you to notify the Plan Administrative Manager within sixty (60) days after the date you lose coverage.** You must send this notice to:

I.B.E.W. Local No. 38 Health and Welfare Fund
Administration Office
P.O. Box 6326
Cleveland, Ohio 44101-1326
Phone: (216) 431-7738
Fax: (216) 431-7719

The notice should include the following information:

a. Employee's name
b. Employee's Social Security number
c. name and Social Security number of individual(s) requesting continued participation
d. mailing address of individual(s) requesting continued participation
e. date and nature of the qualifying event.

Once the Plan Administrative Manager receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each Qualified Beneficiary through an election notice. The Plan Administrative Manager will send an election notice to the Qualified Beneficiary within fourteen (14) days of the date on which the Plan Administrative Manager determines that the Qualifying Event occurred. The election notice will inform the Qualified Beneficiary as to what coverage may be continued, the cost of such coverage and what the Qualified Beneficiary must do in order to obtain the COBRA Continuation Coverage. The election notice shall also contain an application form for the COBRA Continuation Coverage which must be completed and returned, along with proper payment, to the Plan Administrative Manager within the time period set forth in the election notice.

The election notice will be sent by first class mail to the Qualified Beneficiary's last known address on file in the Fund Office. In the case of multiple Qualified Beneficiaries of the same family, a single election notice will be sent to all Qualified Beneficiaries at that address. It shall be the responsibility of each Qualified Beneficiary to read the election notice; however, the parent or guardian of a minor child may read the election notice for the minor child and take action on said child's behalf.

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage. Covered Employees can elect COBRA Continuation Coverage on behalf of their Spouses, and parents can elect COBRA Continuation Coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA Continuation Coverage, COBRA Continuation Coverage will begin on the date that Plan coverage would otherwise have been lost.

If the Qualified Beneficiary or a parent or guardian acting on behalf of a minor Qualified Beneficiary elects COBRA Continuation Coverage, he/she must make sure that a completed and signed application form is returned to the Fund Office within sixty (60) days of the date on the election notice. Each qualified family member who elects Continuation Coverage must be named on the application form or a separate application form must be submitted for any person not named. If, for any reason, the completed application form is not received in the Fund Office with respect to a particular Qualified Beneficiary within the sixty (60) day period, that Qualified Beneficiary's eligibility for Continuation Coverage shall expire, and his/her benefits, if applicable, shall terminate as of the date on which he/she first became a Qualified Beneficiary. The Fund shall be held harmless in the event that a parent or guardian, acting on behalf of a minor Qualified Beneficiary, fails to inform such minor Qualified Beneficiary of his/her rights to Continuation Coverage and/or fails to elect Continuation Coverage for the minor Qualified Beneficiary within the sixty (60) day time period.

3. Duration of COBRA Continuation Coverage

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to thirty-six (36) months. Otherwise, when the qualifying event is the end of employment or the reduction of the Employee's hours of employment, COBRA Continuation Coverage generally lasts for up to a total of eighteen (18) months.

There are two (2) ways in which the 18-month period of COBRA Continuation Coverage can be extended.

(1) Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you (or anyone in your family covered under the Plan if he or she is covered as an Eligible Dependent under the Plan) are determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA Continuation Coverage and you notify the Plan Administrative Manager in a timely fashion, you (and your entire family, if applicable) can receive up to an additional eleven (11) months of COBRA Continuation Coverage, for a total maximum of twenty-nine (29) months.

You must make sure that the Plan Administrative Manager is notified of the Social Security Administration's determination within sixty (60) days after the date of the determination and before the end of the 18-month period of COBRA Continuation Coverage. This notice should be sent to:

I.B.E.W. Local No. 38 Health and Welfare Fund
Administration Office
P.O. Box 6326
Cleveland, Ohio 44101-1326
Phone: (216) 431-7738
Fax: (216) 431-7719

The notice should include the following information:

i. Employee's name
ii. Employee's Social Security number
iii. name and Social Security number of individual(s) requesting continued participation
iv. mailing address of individual(s) requesting continued participation
v. documentation of the Social Security Administration's determination.

The extended coverage terminates:

i. upon your receiving Medicare; or
ii. thirty (30) days after the month in which the Social Security Administration determines you are no longer disabled.

(2) Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

If you (or anyone in your family covered under the Plan if he or she is covered as an Eligible Dependent under the Plan) experience another qualifying event while receiving COBRA Continuation Coverage, you (or your Spouse and dependent children in your family, if applicable) can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months.

This extension is also available to a Spouse and/or dependent children of a former Employee who were covered as Eligible Dependents under the Plan if the former Employee dies or gets divorced or legally separated. Similarly, the extension is available to a dependent child when that child stops being eligible under the Plan as an Eligible Dependent.

In all of these cases, you must make sure that the Plan Administrative Manager is notified of the second qualifying event within sixty (60) days after the second qualifying event occurs. This notice must be sent to:

I.B.E.W. Local No. 38 Health and Welfare Fund
Administration Office
P.O. Box 6326
Cleveland, Ohio 44101-1326
Phone: (216) 431-7738
Fax: (216) 431-7719

The notice should include the following information:

i. Employee's name
ii. Employee's Social Security number
iii. name and Social Security number of individual(s) requesting continued participation
iv. mailing address of individual(s) requesting continued participation
v. date and nature of the qualifying event.

4. Change in Plan Coverage

If the coverage provided by the Plan is changed in any respect for Eligible Employees, those changes will apply at the same time and in the same manner for everyone whose coverage is continued, as required by COBRA. If any of those changes results in either an increase or

decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued, as required by COBRA, as of the effective date of those changes.

5. Payment for COBRA Coverage

Any Employee (or other individual) who has the right to COBRA coverage ("Qualified Beneficiary") must complete the application and make the first payment within the time limits as set forth herein. The Plan is not required to segregate any dental, vision, and other miscellaneous benefits provided by the Plan from the COBRA benefit package. The Plan will offer the same COBRA benefit package to a Qualified Beneficiary as the COBRA benefit package to which the Qualified Beneficiary was entitled on the day before the qualifying event, including dental, vision care, or any other health care benefits that were part of the Qualified Beneficiary's benefit package on the day before the qualifying event. In addition, if the Plan permits Employees to elect among different benefit packages, then after the qualifying event the Plan does not have to provide the Qualified Beneficiary with an election among the different benefit packages and will offer only the same benefit package to which the Qualified Beneficiary was entitled on the day before the qualifying event.

The Qualified Beneficiary has sixty (60) days from the date he or she loses regular coverage to elect COBRA Continuation Coverage. COBRA Continuation Coverage will be made available for the entire sixty (60) day election period if the Qualified Beneficiary elects COBRA Continuation Coverage prior to the end of the election period. A Qualified Beneficiary may reject or waive COBRA Continuation Coverage but then revoke the waiver at any point during the sixty (60) day period and elect COBRA Continuation Coverage; however, if this occurs, the COBRA Continuation Coverage will not apply retroactively to the beginning of the sixty (60) day election period but applies only back to the date on which the rejection or waiver was revoked and COBRA Continuation Coverage was elected. The Qualified Beneficiary is not covered during the election period prior to his or her election, but will have retroactive coverage if COBRA Continuation Coverage is timely elected and timely paid.

The Fund Office will inform the Qualified Beneficiary of the monthly premium to be paid. The first self-payment is due on the first day of the next calendar month following the date on which a qualifying event occurs. The first self-payment will cover the Qualified Beneficiary through the last day of the following calendar month. Subsequent self-payments shall be due on the first day of each calendar month in an amount equal to the monthly self-payment rate.

The Qualified Beneficiary has forty-five (45) days from the date he or she elects COBRA Continuation Coverage to make the first self-payment. The entire amount shown on the initial bill must be received by the Plan Administrative Manager within forty-five (45) days of the election/due date stated on the bill. COBRA Continuation Coverage shall NOT be effective and medical expenses incurred after the qualifying event will NOT be paid unless and until the full bill is paid.

Subsequent monthly self-payments are due before the first day of the month of coverage, but there is a thirty (30) day "grace period" for each such monthly payment. The Qualified Beneficiary is not covered during the forty-five (45) day grace period permitted for payment of the first COBRA premium or during the thirty (30) day grace period permitted for payment of

the monthly COBRA premium prior to his or her timely payment of the COBRA premium but will have retroactive coverage if the COBRA premium is timely paid.

It shall be the responsibility of each Qualified Beneficiary, or person acting on behalf of a Qualified Beneficiary, to ensure that correct payment is received by the Plan Administrative Manager on a timely basis. The Fund shall be held blameless by the Qualified Beneficiary in the event a parent or guardian, acting on behalf of a minor qualified beneficiary, causes such qualified beneficiary to lose COBRA Continuation Coverage through a failure to submit correct payment in a timely fashion.

The cost of COBRA Continuation Coverage will not exceed 102% of the premium applicable to Eligible Employees. However, a Qualified Beneficiary who has been determined disabled as defined by the Social Security Administration and requests coverage for an additional eleven (11) months for a total of twenty-nine (29) months of continuation coverage may be required to pay a premium which is one hundred fifty percent (150%) of the amount of the regular COBRA premium for all months of coverage after the first eighteen (18) months. In addition, the cost of COBRA Continuation Coverage may be increased at any time when the Plan is charging less than the allowable COBRA premium (i.e., less than the 102% or the 150%) or in a situation where a Qualified Beneficiary is permitted by the Plan's rules and procedures to change to a more expensive form of coverage under the Plan.

6. Cancellation of COBRA Coverage

With respect to each Qualified Beneficiary, COBRA Continuation Coverage will immediately terminate on the first day on which any one of the following events occur:

a. the date on which a Qualified Beneficiary completes the maximum period of COBRA Continuation Coverage for which he/she is eligible; or

b. the date on which a self-payment for COBRA Continuation Coverage is not made in a timely manner, or

c. the date on which a Qualified Beneficiary first becomes covered under another group health care plan after the date of the qualifying event, except that if the Employee has a pre-existing condition that is not covered under the new employer's plan, then the Employee may continue COBRA coverage under this Plan for the remainder of the continuation coverage period; or

d. the last day of the calendar month in which an Employee is reemployed and reestablishes eligibility under the Plan; or

e. the date on which the Fund terminates and no longer provides health care coverage.

7. Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan (such as a spouse's plan) through what is called a "special enrollment period." Further, you could be eligible tax credit that lowers your monthly premiums on any health insurance plan purchased through the Marketplace. Please be aware that being eligible for COBRA does not limit your eligibility for coverage for a tax through the Marketplace. Additionally, you may qualify for special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days of your Qualifying Event.

8. Can I enroll in Medicare instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

9. If You Have Questions

If you have questions about your COBRA Continuation Coverage, you should contact I.B.E.W. Local No. 38 Health and Welfare Plan at I.B.E.W. Local No. 38 Health and Welfare Fund Administration Office, P.O. Box 6326, Cleveland, Ohio 44101-1326 (Phone: (216) 431-7738; Fax: (216) 431-7719, or you may contact the nearest Regional or District Office of the United States Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at ***www.dol.gov/ebsa***.

10. Duty to Keep Plan Administrative Manager Informed of Address Changes

In order to protect your rights (and your family's rights, if applicable), you should keep the Plan Administrative Manager informed of any changes in your address (and the addresses of family Employees, if applicable). You should also keep a copy, for your records, of any notices you send to the Plan Administrative Manager.

I. COVERAGE DURING PERIOD OF MILITARY SERVICE

If you are called to military service with the United States Armed Forces, you may elect to continue coverage under the Plan for yourself, without any reduction in benefits, for a period not exceeding eighteen (18) months. In order for the Plan to properly handle your medical coverage during your period of military service, you must affirmatively elect, in writing, one of these three options. Likewise, when your military service ends, you are required to timely notify the Fund Office of the date you were discharged from military service.
You will be provided with the following three (3) options:

1. First Option. You may elect not to continue the medical coverage under the Plan for yourself, in which case your eligibility, including your continuation of eligibility [the look-back period], would freeze, and you would resume your eligibility and continuation of eligibility under the Plan when you return from military service. Any accumulated eligibility to your credit on the Plan's records will be maintained and will be made available to you when you return from military service. Upon discharge from military service, and upon written notice given within thirty-one (31) days of the discharge, your "frozen" eligibility will be reinstated effective on the first day of the then current Benefit Period. To qualify for the resumption of your eligibility under the Plan, you must satisfy the eligibility requirements set forth in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") when you return from military service.

2. Second Option. You may elect to continue medical coverage under the Plan for yourself by submitting to the Fund Office monthly premiums for a period not exceeding eighteen (18) months. The monthly premium paid by you will be at the COBRA premium rate. Your continuation of eligibility [the look-back period] would freeze, and you would resume your continuation of eligibility under the Plan when you return from military service. To qualify for the resumption of your eligibility under the Plan, you must satisfy the eligibility requirements set forth in USERRA when you return from military service.

3. Third Option. You may elect to continue medical coverage under the Plan for yourself for a period not exceeding eighteen (18) months. If you have a preexisting medical condition and/or are receiving medical treatment from a medical Provider or Physician which is not covered under the medical insurance provided by the military armed services, then you may continue your eligibility and continuation of eligibility [the look-back period] until exhausted. After you exhaust your eligibility and

continuation of eligibility, then you would submit monthly payments at the COBRA premium rate to the Fund Office for the balance of the eighteen (18) month period. When you return from military service, you would have to satisfy the Plan's initial eligibility provisions to resume coverage under the Plan.

To qualify for the protection given to those in military service under USERRA, your period of military service may not exceed five (5) continuous years, you must not have been discharged from military service under dishonorable or other punitive conditions, and you must report back to work for your Employer in a timely manner and/or contact the Union office to sign up for employment.

J. ELIGIBILITY UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

This Plan will provide benefits in accordance with the applicable requirements of the Family and Medical Leave Act of 1993 ("FMLA"). A covered Employer must grant an eligible Employee up to a total of twelve (12) work weeks of unpaid leave during any 12-month period for one or more of the following reasons:

1. for the birth or placement of a child for adoption or foster care;

2. to care for an Immediate Family member with a serious health condition;

3. to take medical leave when the Employee is unable to work because of a serious health condition; or

4. for any qualifying exigency as determined by the Secretary of Labor arising out of the fact that your Spouse, son, daughter or parent is on active duty

Moreover, an Employer must grant an eligible Employee up to a total of twenty-six (26) work weeks of unpaid leave during any 12-month period if you are caring for your Spouse, son, daughter, parent, or next of kin who is a member of the Armed Forces that is undergoing medical treatment, recuperation, or therapy, or is otherwise on the temporary disability retired list, for a serious injury or illness. A serious injury or illness is one that may render a member of the Armed Forces medically unfit to perform the duties of the member's office, grade, rank or rating.

During these periods, your Employer may be required to provide health coverage for you on the same terms and conditions that you would receive if you continued to work.

To be eligible for leave under FMLA, you must work for the same contributing Employer for at least twelve (12) months and for at least 1,250 hours during the twelve (12) month period before the leave begins. Generally, your Employer is obligated to provide family and medical leave only if it employs fifty (50) or more employees each working day during each of twenty (20) or more work weeks during the current or preceding calendar year.

To prevent a loss of eligibility to you, you and/or the Employer granting your FMLA leave must comply with the following requirements:

1. Notify the Fund Office at least fourteen (14) days before the onset of your FMLA leave, except in an Emergency, and then no later than seven (7) days after your FMLA leave begins;

2. Obtain and submit to the Fund Office a certificate of eligibility for FMLA leave; and

3. Notify the Fund Office of the beginning date and ending date of your FMLA leave.

During the FMLA leave, the Employer granting your FMLA leave will be required to make contributions to the Fund on your behalf so that your health coverage will be continued. Your eligibility will not be extended during your FMLA leave if your Employer does not make the required contributions to the Fund. The usual procedures of the Fund will be followed if the Employer does not make timely contributions, including, but not limited to, initiating collection procedures and a loss of your eligibility will result.

Upon your return from FMLA leave, you must be restored to your original job or to an equivalent job. In addition, your use of FMLA leave cannot result in the loss of any employment which you earned or to which you were entitled before using FMLA leave.

If you return to work within twelve (12) weeks (or within 26 weeks if the leave is to care for a service member), you will not lose health care coverage. If you do not return to work within twelve (12) weeks (or within 26 weeks if the leave is to care for a service member), you may nonetheless qualify for continued coverage under the Plan's extended coverage, COBRA or other self-pay provisions.

If you take a FMLA leave and you fail to return to your Employer for any reason after such absence, your Employer has the right to collect all contributions made on your behalf during such leave of absence. Thus, to ensure your continuing coverage under the Plan and to prevent possible repayment of any such contributions to your Employer, you should return to work at the end of your FMLA leave.

In addition, if you advised the Employer granting your FMLA leave that you do not intend to return to work, then the Employer must notify the Fund Office of the date you advised the Employer that you do not intend to return to work.

Please contact your Employer if you have any questions regarding your options under the FMLA.

K. ELIGIBILITY FOR TOTALLY AND PERMANENTLY DISABLED EMPLOYEES

Any Employee who has been employed in the electrical industry under the jurisdiction of I.B.E.W. Local No. 38 may become eligible for the Total and Permanent Disability Benefit Program provided all of the rules described in Subsection 1 below are satisfied.

1. Eligibility Requirements

a. The Employee is eligible to receive a Total and Permanent Disability Benefit under the I.B.E.W. Local No. 38 Pension Fund Pension Plan.

b. The Employee has received a favorable response from the Social Security Administration deeming that he or she is disabled and eligible for disability benefits.

c. The Trustees find, on the basis of medical evidence, a physical or mental condition of the Employee which completely prevents the Employee from engaging in any occupation for wage or profit, and, in the opinion of the medical examiner, the disability will be permanent and continuous during the remainder of his life. However, no Employee shall be deemed to be totally and permanently disabled for the purpose of this Health & Welfare Fund if the incapacity consists of chronic alcoholism or addiction to narcotics or if such incapacity was contracted, suffered or incurred while engaged in a felonious enterprise, or resulted from an intentionally self-inflicted injury, or from an injury, wound or disability suffered or arising out of a state of war.

d. The Employee is an Eligible Employee under the Health & Welfare Fund at the time of his/her date of application for the Total and Permanent Disability Benefit Program.

e. The Employee has elected and applied for the Total and Permanent Disability Benefit Program on a form described by the Trustees, and the Trustees shall have approved the application.

2. Self-Payments

If you qualify and elect to be covered under the Total and Permanent Disability Benefit Program, you must pay the self-payment amount on or before the first (1^{st}) day of the month before coverage will begin. For example, you must pay April's self-payment on or before March 31st. Failure to make self-payments by the due date will cause you to lose all eligibility and all benefits. The monthly self-payment rate shall be determined by the Trustees. The program is subject to revision both as to the extent of coverage provided and the amount of contributions required for coverage thereunder.

3. Termination of Eligibility

Eligibility under the Total and Permanent Disability Benefit Program will be terminated if:

a. The Employee engages in any occupation or employment for remuneration or profit; or

b. The Trustees determine on the basis of medical findings that the Employee has sufficiently recovered to resume any occupation or employment for profit or remuneration; or

c. The Employee refuses to undergo a periodic medical examination provided, however, that the Employee may not be required to undergo a medical examination more often than twice a year at the Employee's expense.

L. ELIGIBILITY FOR RETIREES

A Retired Employee who has been employed in the Electrical Industry under the jurisdiction of the I.B.E.W. Local No. 38 may be eligible for Retiree Benefits. The Retired Employee's eligibility is subject to the following:

Retiree Eligibility Requirements: (1) subsequently retires without losing eligibility; (2) is at least fifty-five (55) years of age or over; (3) is no longer actively working at the trade; and (4) is a retiree collecting a pension under the I.B.E.W. Local No. 38 Pension Fund Pension Plan.

In addition, Retired Employee's eligibility also depends on whether the Employee experienced a "Break-in-Service."

Break-in-Service: An Employee has a "Break-in-Service" if he or she is not eligible for benefits under the Plan (i.e., exhausted Contributed Hours, Bank Hours, and Self-Payments) for two consecutive plan years (i.e., May 1st to April 30th). However, an Employee that is working at a city, municipality, or other governmental entity under an agreement with I.B.E.W. Local No. 38 will not be considered to have a Break-in-Service.

1. **Municipal/Governmental Employees:** An Employee working with a city, municipality, or other governmental entity under an agreement with I.B.E.W. Local No. 38 will be eligible for Retiree Benefits if the Employee returns to covered employment, establishes eligibility under the Plan, and satisfies the conditions outlined in Section L(2) below.

2. **Employees Without a Break-in-Service:** If an Employee qualified for benefits under this Plan as an Eligible Employee and did not incur a Break-in-Service and meets eligibility requirement outlined above, the Participant may elect to be covered under the Retiree Program within ninety (90) days after the Employee retirees. Any such Retiree may use any hours remaining in their Hours Bank to continue eligibility until the Hours Bank is exhausted. After the Hours Bank is exhausted, the Retiree will be required to submit self-payments at the rate established by the Board of Trustees in order to continue eligibility under the Plan (See Section M below for a discussion on the Retiree Rates).

3. **Employees With a Break-in-Service:** If an Employee qualified for benefits under this Plan as an Eligible Employees, satisfied each of the conditions outlined in Section L(2) above, but experienced a Break-in-Service, then the Employee will only qualify for Retiree Benefits if each of the following conditions are met:

   a. he or she returns to covered employment and establishes eligibility in the Plan;

   b. works the same number of years as the previous Break-in-Service;

   c. works at least 1,000 hours in each of the years following the Break-in-Service; and;

   d. does not experience another Break-in-Service after returning to covered employment.

Example: Andre was eligible in the Plan from 2000 to 2015. However, he left the industry at the end of 2015 and did not engage in covered employment from 2016-to-2027 (i.e., 12 years). In 2028, Andre returns to covered employment and works the following hours without incurring another Break-in-Service:

Plan Year	Hours Worked	Plan Year	Hours Worked
2028	1,800	2034	1,200
2029	1,600	2035	2,000
2030	2,100	2036	1,600
2031	1,700	2037	1,110
2032	1,100	2038	1,600
2033	860	2039	1,550

Andre has worked 12 years without a Break-in-Service, but only 11 years with 1,000 hours or more. Therefore, Andre must work another year in covered employment at 1,000 hours or more to quality for Retiree Benefits.

4. If a Retired Employee qualifies and elects to be covered under the Retiree Program, the Retiree must pay the self-contribution premium required by Board of Trustees on or before the first (1^{st}) day of the month in which it is due. Failure to pay contributions by the due date shall cause the Retiree to lose all eligibility and benefits under the Plan. The monthly contributions shall be determined by the Board of Trustees and shall be subject to revision both as to extent of coverage and the amount of contributions at the commencement of any month.

5. A Retiree's coverage under the Retiree Program shall terminate on the earliest of the following dates:

   a. The date the Fund Terminates; or

b. The date the Retiree ceases to be within the classes of persons eligible for coverage under the Plan; or

c. The date the Retiree fails to make any required self-contribution.

M. COST OF RETIREE BENEFITS

Effective January 1, 2021, the Plan will calculate premiums for retirees as follows. Members who retired before January 1, 2021 will be considered "Legacy Retirees" and will have their premium calculated under the old rules. That means the Board will set the rate for Legacy Retirees each year. It also means that anyone who retired prior to January 1, 2021 will see no change in the usual procedure.

Important Information: Legacy Retirees will be notified of new monthly rates before the start of each Plan Year. This notification and the process for setting the new monthly rates will not change for Legacy Retirees.

Effective January 1, 2021, the Plan will calculate premiums for retirees as follows. Members who retired on or after January 1, 2021, will be considered "New Retirees" and will have their monthly rates based on work history, marital status (i.e., single vs. family), and whether you or your Spouse is eligible for Medicare. The Work History tiers are set forth below. The monthly rates are set annually by the Trustees. New Retirees will be notified of the new monthly rates before the start of each Plan Year.

New Retirees – (Retirement After 1/1/2021) Work History Tiers
Less than 10,000 Hours of Service
10,000 – 19,999 Hours of Service
20,000 – 29,999 Hours of Service
30,000 – 39,999 Hours of Service
40,000 – 49,999 Hours of Service
50,000 – 59,999 Hours of Service
60,000 – 69,000 Hours of Service
70,000 + Hours of Service

The surviving spouse of a retiree can continue coverage after the Participant's death. The monthly payment due will be based on the Participant's retiree category at the time of death (i.e., Legacy Retiree vs. New Retiree).

N. TERMINATION OF INDIVIDUAL BENEFITS

Except as otherwise provided herein, the coverage of any Eligible Employee under the Plan shall terminate on whichever of the following date occurs first:

1. The date the Fund terminates; or

2. The date of expiration of the period for which the last contribution payment is made to the Trustees for the Eligible Employee's coverage, together with any relevant period of extended coverage provided by COBRA or the Plan (including the self-payment provisions of the Plan); or

3. The date the Eligible Employee ceases to be within the classes of persons eligible for coverage under the Plan; or

4. Failure of the Eligible Employee to make each required self-payment by the due date. Such failure shall result in immediate termination of coverage hereunder, which coverage shall not thereafter be reinstated without the express approval of the Board of Trustees; or

5. If the Eligible Employee is an apprentice, the first day of the month following the termination of the Eligible Employee from the Cleveland Electrical Joint Apprenticeship Training Committee Program.

In addition, if a Participant fails to respond to a request for information verifying the eligibility of a Dependent of that Participant, the Plan may terminate the eligibility of any unverified Dependents for failure to cooperate with such a request.

Important Information: A Spouse who is divorced or legally separated from the Eligible Employee will not be eligible for coverage under the Plan as of the date of said divorce or other termination of the marriage. However, in such an event the Spouse may elect to purchase "Continuation Coverage" for a period of time, as described in Section H above. Failure to advise the Fund Office of termination of marriage can result in overpayment of benefits and the Eligible Employee will be subject to Section IV, subsection L, Recovery of Overpayment.

O. TERMINATION OF COVERAGE FOR WORK WITH NON-SIGNATORY CONTRACTORS

Coverage under the Plan for Employees who work for non-signatory building or construction contractors will be terminated as follows:

Any employment or self-employment by an active, inactive, or retired Employee in any capacity for, or as, a non-signatory building or construction contractor anywhere in the United States, Canada, or Mexico will be deemed to be "disqualifying employment" that will result in the termination of coverage under the Plan as provided below. For this purpose, a non-signatory building or construction contractor shall mean any such contractor who is not signatory to a collective bargaining agreement with I.B.E.W. Local No. 38 or another local union affiliated with the International Brotherhood of Electrical Workers, AFL-CIO.

When the Plan office has determined that an individual has engaged in such disqualifying employment, it will promptly notify the individual of this determination and of the Plan's provisions for termination of the person's coverage for engaging in disqualifying employment. Your coverage will be terminated in accordance with these provisions. This disqualification may result in the forfeiture of all accumulated extended eligibility rights and any hour's bank, death

benefits, and self-payments rights provided under this Plan. Notwithstanding the foregoing, you and your dependents will be offered the COBRA continuation coverage rights otherwise available for loss of coverage due to a reduction in hours in covered employment.

You may appeal this termination of coverage under the Plan's claims appeal procedure. If your coverage is terminated under these Plan provisions, you may reinstate coverage by once again meeting the Plan's initial eligibility rules.

P. CERTIFICATION OF PRIOR COVERAGE WHEN COVERAGE ENDS

When your coverage ends, the Fund Office will provide you or your Eligible Dependents with a certificate of coverage that indicates the period of time you or they were covered under the Plan. If, within sixty-three (63) days after coverage under this Plan ends, you or your Eligible Dependents become eligible for coverage under another group health plan or if you buy, for yourself or your Eligible Dependents, a health insurance policy, this certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply under that group health plan or health insurance policy. The certificate will indicate the period of time you or your Eligible Dependents were covered under this Plan, and certain additional information that is required by law. The certificate will be sent to you or your Eligible Dependents by first class mail shortly after your or their coverage under this Plan ends. If you or any of your Eligible Dependents elect COBRA Continuation Coverage, another certificate will be sent by first class mail shortly after the COBRA Continuation Coverage ends for any reason. In addition, a certificate will be provided to you or your Eligible Dependent upon receipt of a request for such a certificate if that request is received by the Fund Office within two (2) years after the later of the date coverage under this Plan ended or the date COBRA Continuation Coverage ended, if the request is addressed to the Fund Office.

Q. THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIP)

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), employees and dependents who are eligible for coverage but who are not enrolled for coverage may exercise special enrollment rights and enroll in the plan if the Employee or dependent:

1. Loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; or

2. Loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or

3. Becomes eligible for group health plan premium assistance under Medicaid or SCHIP.

If any of these circumstances arises and the Employee or dependent wishes to take advantage of these special enrollment rights, the employee or dependent must request to enroll for coverage

within 60 days from the date (1) the coverage terminates under the Medicaid or SCHIP plan, or (2) the Employee or dependent child is determined eligible for state premium assistance.

If you believe you are eligible for Special Enrollment under this provision, you must contract the Fund Office to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by the Fund Office. Requests for Special Enrollment right must be made within 60 days of an event described above that occurs on or after April 1, 2009.

R. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Plan provides the benefits required by the Women's Health and Cancer Rights Act of 1998. Under this federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits in connection with a mastectomy must also include medical and surgical benefits for breast Reconstructive Surgery as part of a mastectomy procedure.

Breast Reconstructive Surgery in connection with a mastectomy must at a minimum provide for:

1. reconstruction of the breast on which the mastectomy was performed;

2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. prostheses and physical complications for all stages of mastectomy, including lymphedemas

in a manner determined in consultation with the attending physician and the patient. As part of the Plan's schedule of benefits, this coverage is subject to the Plan's provisions regarding deductibles and coinsurance.

S. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician), after consultation with the mother, discharges the mother or newborn earlier.

In addition, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorably to the mother or newborn than any earlier portion of the stay.

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

IV. EXPLANATION OF BENEFITS

A. DEATH BENEFITS

Upon the death of an active Eligible Employee or Retiree, the Fund will pay a Death Benefit in the amount shown in the Schedule of Benefits to the designated beneficiary of the decedent. The payment of any Death Benefit will be made only after the receipt by the Trustees of proper proof of the death of the active Eligible Employee or Retiree, provided that such proof is submitted to the Fund Office within two (2) years of the date of death.

B. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If, while eligible under the Health and Welfare Plan you suffer bodily injuries solely through external, violent and accidental means as evidenced by a visible wound or contusion on the exterior of the body, on or off the job, (except in the case of drowning or internal injuries revealed by autopsy) and, within thirteen (13) weeks thereafter and directly and independently of all other causes, suffer any of the following losses, the Fund will pay:

1. For loss of life, or for loss of any two (2) or more of the members listed in 2. below, the **full amount** of the Accidental Death and Dismemberment Benefit shown in the Schedule of Benefits; or

2. For loss of a hand by severance of at least the four (4) entire fingers; or loss of a foot by severance at or above the ankle; or total and irrecoverable loss of sight of an eye, **one-half (1/2) of the full amount** shown in the Schedule of Benefits; or

3. For loss of thumb and index finger of either hand, **one fourth (1/4) of the full amount**.

In no event will the total amount payable on account of more than one (1) such loss as a result of injuries sustained in any one (1) accident exceed the full amount of the Accidental Death and Dismemberment Benefit. In no case will payment be made for death or any other loss which is caused wholly or partly, directly or indirectly by:

1. Disease or bodily or mental infirmity or medical or surgical treatment or diagnosis thereof, whether the proximate or a contributing cause of the loss; or

2. Ptomaine, any kind of poisoning, or any bacterial infection, except only infection of and through a visible wound on the exterior of the body sustained solely through external violent and accidental means; or

3. Suicide or attempted suicide or intentionally self-inflicted injury while sane or insane; or

Any injury sustained while operating or riding in any kind of aircraft or as a result of descent therefrom while in flight, if the Employee: (1) had any duties on or relating to such aircraft or flight, or (2) was being flown in such aircraft in the course of any aviation training or instruction,

or in the course of any training maneuvers or operation of any armed forces, or (3) was being flown for the purpose of descent from such aircraft while in flight.

C. BENEFICIARY PROVISION CONCERNING DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

You may designate any person or persons or legal entity as the beneficiary of any Death Benefit payable from the Plan by filing such designation in writing with the Fund Office. You may designate a new beneficiary at any time by filing, with the Fund Office, a written request for such change. Any change shall not become effective until it is entered on the Fund's records and neither the Fund nor the Trustees shall be liable for any payment made before the effective date of any change.

If you designate more than one (1) beneficiary without specifying their respective interests, the Death Benefit will be paid in equal shares to the beneficiaries.

In the event that you die without designating a beneficiary or in the event the designated beneficiary shall have predeceased you or has disclaimed any or all interest in any Death Benefits, the amount of any Death Benefits will be paid to:

1. your legal Spouse, if living;

2. if no Spouse is living, then to your living children in equal shares;

3. if no Spouse or children are living, then to your parents in equal shares, or the survivor of such parents if only one (1) is living;

4. if no Spouse, children, or parents are living, then to your living brothers and sisters in equal shares;

if no Spouse, children, parents, or brothers and sisters are living, then no Death Benefit will be paid.

D. PAYMENT PROVISION FOR DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

In the event the beneficiary is a minor or is, in the opinion of the Trustees, physically or mentally incapable of receiving or administering said benefits or acknowledging receipt thereof and the Trustees are not aware of any legal representative having been appointed for him, the Trustees may cause any benefit otherwise payable to him to be paid to such one (1) or more of the following as may be chosen by them: any institution maintaining the beneficiary; the beneficiary's Spouse, children and/or other relatives by blood or marriage; and/or any person whom the Trustees reasonably determine is caring for the beneficiary or otherwise providing the beneficiary with support and maintenance. The Trustees shall have no obligation or duty to see that the funds are used or applied for the purpose(s) for which paid and any payment so made shall be a complete discharge of any and all liability under the Plan with respect to such payment.

NOTE:	**Death and/or Accidental Death and Dismemberment Benefits provided under the Fund cannot be assigned or pledged by the Eligible Employee or the beneficiary.**

E. WEEKLY DISABILITY BENEFITS

Any Inside or Teledata Electrician only who has been employed in the electrical industry under the jurisdiction of I.B.E.W. Local No. 38 may become eligible for the Weekly Disability Benefit Program provided all of the rules described in Subsection 1 below are satisfied.

1. Eligibility Requirements

a) Wholly and continuously disabled so as to prevent you from performing **any and every duty** of your occupation as a result of (i) any sickness not entitling you to benefits under any Workers' Compensation Act or similar law; or (ii) any injury not arising out of or in the course of employment; or (iii) pregnancy, if a female Employee;

b) During the period of such disability, you are continuously under the direct care of a Physician;

c) You have submitted a completed application to Fund Office. To qualify as a completed application it must include: Physician Statement completed with return to work date, medical notes supporting diagnosis, and Physician signature.

d) You have submitted a signed Authorization for Release.

Once the rules described above are satisfied, the Fund will pay the amount of Weekly Disability Benefits set forth in the Schedule of Benefits during the period you are disabled and under the care of said Physician, beginning with the date shown in the Schedule of Benefits.

For partial weeks of disability, benefits will be paid on the basis of one-seventh (1/7th) of the applicable Weekly Disability Benefit for each day of disability for which you are entitled to receive said benefit.

Successive periods of disability will be considered one (1) continuous period unless the subsequent disability is due to causes entirely unrelated to the causes of the previous disability and commences after a return to full-time active work.

No Weekly Disability Benefits will be paid;

1. For any period in excess of the maximum payment period for any one (1) continuous period of disability as set forth in the Schedule of Benefits; or

2. To any Eligible Employee in a retired status and receiving benefits from the I.B.E.W. Local No. 38 Pension Fund;

3. To any Eligible Employee who is receiving Unemployment Compensation from a State program.

F. HEALTH CARE BENEFITS

This section describes the services and supplies covered if provided and billed by Providers. All Covered Services must be Medically Necessary unless otherwise specified.

1. Allergy Tests and Treatments

Allergy tests and treatments that are performed and related to a specific diagnosis are Covered Services. Desensitization treatments are also covered.

2. Ambulance Services

Transportation services via ambulance must be certified by your Physician and are subject to medical review to determine Medical Necessity. Ambulance services include local ground transportation by a vehicle equipped and used only to transport the sick and injured:

a. from your home, scene of an accident or Medical Emergency to a Hospital;

b. between Hospitals;

c. between a Hospital and a Skilled Nursing Facility;

d. from a Hospital or Skilled Nursing Facility to your home; or

e. from a Physician's office to a Hospital.

Trips must be to the closest facility that is medically equipped to provide the Covered Services that are appropriate for your Condition.

Transportation for Emergency Medical Conditions will also be covered when provided by a professional ambulance service for other than local ground transportation, such as air and water transportation, only when special treatment is required and the transportation is to the nearest Hospital qualified to provide the special treatment. Effective May 1, 2022, air ambulance charges for Emergency Services will be covered at the in-network rate as required by federal law. Transportation services provided by ambulate or wheelchair vans are not Covered Services.

3. Case Management

Case management is an economical, common-sense approach to managing health care benefits. The PPO Provider's case management staff evaluates opportunities to cover cost-effective alternatives to the patient's current health care needs. Case management has proven to be very effective with catastrophic cases, long-term care, and psychiatric and substance abuse treatment. In such instances, benefits not expressly covered in this Summary Plan Description/Plan Document may be approved. All case management programs are voluntary for the patient.

Coverage for these services must be approved in advance and in writing by the PPO Provider. To learn more about these services, you may contact the PPO Provider's case management staff.

4. Clinical Trial Programs

Benefits are provided for routine patient care administered to a Covered Person participating in any stage of an eligible cancer clinical trial, if that care would be covered under the Plan if the Covered Person was not participating in a clinical trial.

"Eligible cancer clinical trial" means a cancer clinical trial that meets all of the following criteria:

a. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;

b. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes;

c. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and

d. The trial does one of the following:

   i. Tests how to administer a health care service, item, or drug for the treatment of cancer;

   ii. Tests responses to a health care service, item, or drug for the treatment of cancer;

   iii. Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;

   iv. Studies new uses of a health care service, item, or drug for the treatment of cancer;

   v. The trial is approved by one of the following entities:

      1. The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;

      2. The United States Food and Drug Administration;

      3. The United States Department of Defense; or

      4. The United States Department of Veteran Affairs.

"Routine patient care" means all health care services consistent with the coverage provided under the Plan for treatment of cancer, including the type and frequency of any diagnostic modality that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

"Subject of a cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not routine patient care.

No benefits are payable for the following:

a. A health care service, item, or drug that is the subject of the cancer clinical trial;

b. A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;

c. An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;

d. Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;

e. An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; and

f. A service, item, or drug that is eligible for reimbursement by a person other than the PPO Provider, including the sponsor of the cancer clinical trial.

5. Dental Services for an Accidental Injury

Dental services will only be covered for initial injuries sustained in an accident. The accidental injury must have caused the damage to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

6. Diagnostic Services

A diagnostic service is a test or procedure performed when you have specific symptoms to detect or monitor your Condition. It must be ordered by a Physician or Other Professional Provider. Covered diagnostic services are limited to the following:

a. radiology, ultrasound and nuclear medicine;

b. laboratory and pathology services; and

c. EKG, EEG, MRI and other electronic diagnostic medical procedures.

7. Drug Abuse and Alcoholism Services

Detoxification and rehabilitation services are provided for the treatment of Drug Abuse or Alcoholism. In addition, the following services are also covered for the treatment of Drug Abuse or Alcoholism:

a. individual and group psychotherapy;

b. psychological testing; and

c. family counseling: counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Plan Document/Summary Plan Description. Charges will be applied for the Covered Person who is receiving family counseling services, not necessarily the patient receiving treatment for Drug Abuse or Alcoholism.

Inpatient care must be approved by the PPO Provider prior to admission.

Residential care rendered by a Residential Treatment Facility is NOT covered.

8. Drugs and Biologicals

You are covered for Prescription Drugs and biologicals that cannot be self-administered and are furnished as part of a Physician's professional service, such as antibiotics, joint injections and chemotherapy, in the course of the diagnosis or treatment of a Condition. Other drugs that can be self-administered or that may be obtained under drug coverage, if applicable, are not covered but the administration of the drug may be covered.

Drugs that can be covered under your supplemental Prescription Drug plan need to be obtained under your Pharmacy coverage.

9. Emergency Services

You are covered for Medically Necessary Emergency Care following an Emergency. Emergency Services are available 24 hours a day, 7 days per week. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital to obtain Emergency Services. Effective May 1, 2022, Emergency Services provided at an out-of-network hospital emergency room or Independent Freestanding Emergency Department are covered at the in-network rate. That means you will not receive a balance bill for these services **unless otherwise required by federal law care and treatment once you are Stabilized, are not Emergency Services**. Continuation of care beyond that needed to evaluate or Stabilize your Condition in an Emergency will be covered according to your Schedule of Benefits. Please refer to your Schedule of Benefits Benefit Summary for detailed coverage explanation.

10. Health Education Services

Benefits are provided for educational, vocational and training services while an Inpatient of a Hospital or Other Facility Provider.

Behavioral Counseling to Promote a Healthy Diet is covered and includes behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.

11. Home Health Care Services

The following are Covered Services when you receive them in your home from a Hospital or a Home Health Care Agency:

a. professional services of a registered or licensed practical nurse;

b. treatment by physical means, occupational therapy and speech therapy;

c. medical and surgical supplies;

d. Prescription Drugs;

e. oxygen and its administration;

f. medical social services, such as the counseling of patients; and

g. home health aide visits when you are also receiving covered nursing or therapy services.

The Plan will not cover any home health care services or supplies which are not specifically listed in this Home Health Care Services section. Examples of excluded services include but are not limited to:

i. homemaker services;

ii. food or home delivered meals; and

iii. Custodial Care, rest care or care which is only for someone's convenience.

All Home Health Care services must be certified initially by your Physician and your Physician must continue to certify that you are receiving Skilled Care and not Custodial Care as requested by the Plan. All services will be provided according to your Physician's treatment plan and as authorized as Medically Necessary by the Plan and/or the PPO Provider.

12. Hospice Services

Hospice services consist of health care services provided to a terminally ill Covered Person. Hospice services must be provided through a freestanding Hospice Facility or a hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the

Covered Person in a private residence. Benefits for hospice services are available when the prognosis of life expectancy is six months or less.

The following Covered Services are considered hospice services:

a. professional services of a registered or licensed practical nurse;

b. treatment by a physical means, occupational therapy and speech therapy;

c. medical and surgical supplies;

d. Prescription Drugs, limited to a two-week supply per Prescription Order or refill (these Prescription Drugs must be required in order to relieve the symptoms of a Condition or to provide supportive care);

e. oxygen and its administration;

f. medical social services, such as the counseling of patients;

g. home health aide visits when you are also receiving covered nursing or therapy services;

h. acute Inpatient hospice services;

i. respite care;

j. dietary guidance; counseling and training needed for a proper dietary program;

k. Durable Medical Equipment; and

l. Bereavement counseling for family members.

Non-covered hospice services include, but are not limited to:

1. volunteer services;

2. spiritual counseling;

3. homemaker services;

4. food or home delivered meals;

5. chemotherapy or radiation therapy if other than to relieve the symptoms of a Condition; and

6. Custodial Care, rest care or care which is only for someone's convenience.

13. Inpatient Hospital Services

The Covered Services listed below are benefits when services are performed in an Inpatient setting, except as specified.

The following bed, board and general nursing services are covered:

a. a semiprivate room or ward;

b. a private room, when Medically Necessary; if you request a private room, the Plan will provide benefits only for the Hospital's average semiprivate room rate;

c. newborn nursery care; and

d. a bed in a special care unit approved by the PPO Provider. The unit must have facilities, equipment, and supportive services for the intensive care of critically ill patients.

Covered ancillary Hospital services also include but are not limited to:

a. operating, delivery and treatment rooms and equipment;

b. Prescription Drugs;

c. whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded. Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;

d. anesthesia, anesthesia supplies and services;

e. oxygen and other gases;

f. medical and surgical dressings, supplies, casts and splints;

g. diagnostic services;

h. therapy services; and

i. surgically inserted prosthetics such as pacemakers and artificial joints.

Non-covered Hospital services include, but are not limited to:

i. gowns and slippers;

ii. shampoo, toothpaste, body lotions and hygiene packets;

iii. take-home drugs;

iv. telephone and television; and

v. guest meals or gourmet meals.

Coverage is not provided for an Inpatient admission, the primary purpose of which is diagnostic services; Custodial Care; rest care; environmental change; physical therapy; or residential treatment.

Coverage for Inpatient care is not provided when the services could have been performed on an Outpatient basis, and it was not Medically Necessary, as determined by the PPO Provider, the Trustees or their agent, for you to be an Inpatient to receive them.

Inpatient admissions to a Hospital must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting Hospitals in Ohio will assure this preauthorization is done; and since the Hospital is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. For Non-Contracting or Out of State Hospitals, you are responsible for obtaining the precertification. If you do not preauthorize a Hospital admission and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges. However, if your Inpatient stay is for an organ transplant, please review the requirements under the Organ and Tissue Transplant Services section.

14. Maternity Services, Including Notice Required by the Newborns' and Mothers' Protection Act

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy, miscarriage and ordinary routine nursery care for a well newborn are covered only for the Employee or the Employee's Spouse.

Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum, 48 hours for vaginal delivery and 96 hours for a caesarean section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care. Please note that neither you nor your Provider is required to obtain prior approval of an Inpatient maternity stay that falls within these time frames.

Physician-directed follow-up care services are covered after discharge, including:

a. parent education;

b. physical assessments of the mother and newborn;

c. assessment of the home support system;

d. assistance and training in breast or bottle feeding;

e. performance of any Medically Necessary and appropriate clinical tests; and

f. any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

Covered Services will be provided whether received in a medical setting or through home health care visits. Home health care visits are only covered if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

If requested by the mother, coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the attending Physician or the nurse midwife in applicable cases, determines further Inpatient postpartum care is not necessary for the mother or newborn child, provided, in the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:

a. the antepartum, intrapartum and postpartum course of the mother and infant;

b. the gestational stage, birth weight and clinical condition of the infant;

c. the demonstrated ability of the mother to care for the infant after discharge; and

d. the availability of post discharge follow-up to verify the condition of the infant after discharge.

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of Inpatient care required to be covered, at home post-delivery follow up care visits are covered for you at your residence by a Physician or nurse when performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to, parent education; physical assessments; assessment of the home support system; assistance and training in breast or bottle feeding; and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At the mother's discretion, this visit may occur at the facility of the Provider.

15. Medical Care

1. Concurrent Care – You are covered for care by two or more Physicians during one Hospital stay when you have two or more unrelated Conditions. You are also covered for care for a medical Condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.

2. Inpatient Medical Care Visits – The examinations given to you by your Physician or Other Professional Provider while you are in the Hospital are Covered Services. Benefits are provided for one visit each day you are an Inpatient. If the Trustees change your

health care benefits, causing an increase or decrease in your Inpatient Medical Care Visits allowed, the number of Inpatient Medical Care Visits already used will be deducted from the number of visits available under your new coverage.

3. **Inpatient Consultation** – A bedside examination by another Physician or Other Professional Provider is covered when requested by your attending Physician. If the consulting Physician takes charge of your care, consultation services are not covered. When this occurs, the consulting Physician is considered to be the new attending Physician. Coverage is not provided for both the new attending Physician and the Physician who was initially treating you for services rendered at the same time. Staff consultations required by Hospital rules are not covered**.**

4. **Intensive Medical Care –** Constant medical attendance and treatment is covered when your Condition requires it.

5. **Newborn Exam –** Your coverage includes the Inpatient Medical Care Visits to examine a newborn. Refer to the Eligibility section for information about enrolling for family coverage.

6. **Office Visits** – Office visits to examine, diagnose and treat a Condition are Covered Services.

7. **Removal of Cerumen –** The removal of cerumen is covered.

16. Medical Supplies and Durable Medical Equipment

This section describes supplies and equipment that are covered when prescribed by your Physician. These supplies and equipment must serve a specific therapeutic purpose in the treatment of a Condition.

a. **Medical and Surgical Supplies** – Supplies which serve a specific therapeutic purpose are covered. These include elastic and prosthetic stockings; needles; oxygen; slings; splints; surgical dressings and other similar items; and syringes. **Items usually stocked in the home for general use are not covered; these include but are not limited to elastic bandages, Jobst stockings and support or compression stockings, corn and bunion pads, and thermometers.**

b. **Durable Medical Equipment (DME)** – Equipment which serves only a medical purpose and must be able to withstand repeated use is covered. Upon request, your Physician must provide a written treatment plan that shows how the prescribed equipment is Medically Necessary for the diagnosis or treatment of a Condition or how it will improve the function of a malfunctioning body part. If you need to use this equipment for more than six months, your Physician may be required to recertify that continued use is Medically Necessary.

You may rent or purchase DME; however, for each Condition, the Plan will not cover more in total rental costs than the customary purchase price as determined by the PPO Provider. For example, if you submit claims for the monthly rental fee and by the third month the total in rental dollars meets or exceeds the customary purchase price, you will have exhausted your benefit for that piece of Durable Medical Equipment.

When it has been determined that you require DME, before you decide whether to rent or purchase, estimate what the rental cost will be for the time period during which you will use the DME. If the estimated rental cost exceeds the purchase price, then you should consider purchasing the DME. If you decide to purchase the DME, you must obtain prior approval from the PPO Provider.

Covered DME includes:

i. rental of respirators;

ii. rental of home dialysis equipment;

iii. rental of wheelchairs;

iv. rental of hospital beds;

v. rental of crutches;

vi. purchase of nebulizer;

vii. purchase of TENS unit;

viii. purchase of spinal devices; and

ix. purchase of glucometer.

Non-covered equipment includes but is not limited to:

i. rental costs if you are in a facility which provides such equipment;

ii. repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;

iii. Physician's equipment, such as a blood pressure cuff or stethoscope;

iv. deluxe equipment such as specially designed wheelchairs for use in sporting events; and

v. items not primarily medical in nature such as an exercycle, treadmill, bidet toilet seat, sauna baths, elevator and chair lifts; items for comfort and convenience; disposable supplies and hygienic equipment; and self-help

devices such as bed boards, bathtubs, over bed tables, adjustable beds, telephone arms and air conditioners.

c. **Orthotic Devices** – Rigid or semi-rigid supportive devices which limit or stop the motion of a weak or diseased body part are covered. These devices include braces for the leg, arm, neck or back; trusses; and back and special surgical corsets. Non-covered devices include but are not limited to:

i. garter belts, arch supports, corsets and corn and bunion pads;

ii. corrective shoes, except with accompanying orthopedic braces; and

iii. arch supports and other foot care or foot support devices only to improve comfort or appearance. These include but are not limited to care for flat feet and subluxations, corns, bunions, calluses and toenails.

d. **Prosthetic Appliances** – Your coverage includes the purchase, fitting, adjustments, repairs and replacement of prosthetic devices which are artificial substitutes and necessary supplies that replace all or part of a missing body organ or limb and its adjoining tissues; or replace all or part of the function of a permanently useless or malfunctioning body organ or limb. Covered prosthetic appliances include artificial hands, arms, feet, legs and eyes, including permanent lenses; and appliances needed to effectively use artificial limbs or corrective braces.

Non-covered appliances include, but are not limited to:

i. dentures, unless as a necessary part of a covered prosthesis;

ii. dental appliances, except for temporomandibular joint (TMJ) and Brusixm appliances;

iii. eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;

iv. replacement of cataract lenses unless needed because of a lens prescription change;

v. deluxe prosthetics that are specially designed for uses such as sporting events;

vi. taxes included in the purchase of a covered prosthetic appliance; and

vii. wigs and hair pieces.

17. Mental Health Care Services

The following are Covered Services for the treatment of Mental Illness.

a. individual and group psychotherapy;

b. electroshock therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;

c. psychological testing;

d. counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Plan Document/Summary Plan Description. Charges will be applied to the Covered Person who is receiving the family counseling services, not necessarily the patient.

e. In addition, as provided in the PPO Provider's medical policy guidelines, certain behavioral assessment and intervention services for individual, family and group psychotherapy will also be covered for a medical Condition.

Services for autism, developmental delay and intellectual disability, other than those necessary to evaluate or diagnose these Conditions, are not covered. Services for the treatment of attention deficit disorder are covered. **Residential care rendered by a Residential Treatment Facility is not covered.**

Inpatient admissions to a Hospital must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting Hospitals in Ohio will assure this preauthorization is done, and since the hospital is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. For Non-Contracting Hospitals or Hospitals outside of Ohio, you are responsible for obtaining preauthorization. If you do not preauthorize a Hospital admission and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges.

18. Organ and Tissue Transplant Services

Your coverage includes benefits for the following Medically Necessary human organ/tissue transplants: bone marrow; cornea; heart; heart and lung; kidney; liver; lung; pancreas; and pancreas/kidney if such services take place during a transplant benefit period. A transplant benefit period is a period of time which starts five days before the day you receive your first covered transplant and ends 12 months later. A new transplant benefit period starts only if the next covered transplant occurs more than 12 months after the last covered transplant was performed. No transplant waiting periods and/or organ transplant maximums will apply to kidney, pancreas/kidney, bone marrow, tissue or cornea transplants.

Additional organ/tissue transplants will be considered for coverage provided that the transplant is Medically Necessary, not experimental and is considered accepted medical practice for your Condition.

a. **Organ/Tissue Transplant Preauthorization** – In order to receive full benefits for an organ/tissue transplant, the proposed course of treatment must be preauthorized and approved by the PPO Provider or the Trustees. In the event you do not obtain preauthorization, and your organ transplant is determined not to be Medically Necessary or is determined to be experimental/investigational, you may be responsible for all Billed Charges for that organ transplant.

   After your Physician has examined you, he must provide the PPO Provider with:

   i. the proposed course of treatment for the transplant;

   ii. the name and location of the proposed Transplant Center; and

   iii. copies of your medical records, including diagnostic reports for the PPO Provider to determine the suitability and Medical Necessity of the transplant services. This determination will be made in accordance with uniform medical criteria that have been specifically tailored to each organ/tissue. You may also be required to undergo an examination by a Physician chosen by the PPO Provider. You and your Physician will then be notified of the PPO Provider's decision.

b. **Obtaining Donor Organs or Donor Tissue** – The following services will be Covered Services when they are necessary in order to acquire a legally obtained human organ/tissue:

   i. evaluation of the organ/tissue;

   ii. removal of the organ/tissue from the donor; and

   iii. transportation of the organ/tissue to the Transplant Center.

c. **Donor Benefits** – Benefits necessary for obtaining an organ/tissue from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions. Donor benefits include treatment of immediate post-operative complications if Medically Necessary as determined by the Trustees or the PPO Provider. Such coverage is available only so long as the recipient's coverage is in effect.

d. **Exclusions** – The Plan does not provide organ/tissue transplant benefits for services, supplies or Charges:

   i. which are not furnished through a course of treatment which has been approved by the PPO Provider;

ii. for other than a legally obtained human organ/tissue;

iii. for travel time and the travel-related expenses of a Provider, participant or donor; or

iv. that is related to other than human organ/tissue.

19. Outpatient Institutional Services

The Covered Services listed below are covered when services are performed in an Outpatient setting, except as specified:

1. **Covered Institutional Services** include, but are not limited to:

   i. operating, delivery and treatment rooms and equipment;

   ii. whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded. Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered.

   iii. Anesthesia, anesthesia supplies and services; and

   iv. Surgically inserted prosthetics such as pacemakers and artificial joints.

2. **Pre-Admission Testing** – Outpatient tests and studies required before a scheduled Inpatient Hospital admission or Outpatient surgical service are covered.

3. **Post-Discharge Testing** – Outpatient tests and studies required as a follow-up to an Inpatient Hospital stay or an Outpatient surgical service are covered.

20. Outpatient Therapy Services

Therapy services are services and supplies used to promote recovery from a Condition. Therapy services must be ordered by a Physician or Other Professional Provider to be covered. Covered Services are limited to the therapy services listed below:

a. **Cardiac Rehabilitation Services** – Benefits are provided for cardiac rehabilitation services which are Medically Necessary as the result of a cardiac event. The therapy must be reasonably expected to result in a significant improvement in the level of cardiac functioning.

b. **Chemotherapy** – The treatment of malignant disease by chemical or biological antineoplastic agents.

c. **Dialysis Treatments** – The treatment of an acute or chronic kidney ailment by dialysis methods, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine.

d. **Hyperbaric Therapy** – The provision of pressurized oxygen for treatment purposes. These services must be provided by a Hospital.

e. **Radiation Therapy** – The treatment of disease by X-ray, radium or radioactive isotopes.

f. **Respiratory/Pulmonary Therapy** – Treatment by the introduction of dry or moist gases into the lungs.

No benefits will be provided for the following therapy services once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by the PPO Provider and/or the Board of Trustees, and in no event will treatment be covered if the number of visits exceeds the limit set forth in the Schedule of Benefits, even if it is Medically Necessary.

a. **Chiropractic Visits** – The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part by a chiropractor. These Covered Services include, but are not limited to, office visits, physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. **Braces and molds are not covered under this benefit.**

b. **Physical Therapy** – The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. These Covered Services include physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. **Braces and molds are NOT covered under this benefit**. All physical therapy services must be performed by an appropriately licensed Provider.

c. **Speech Therapy –** In order to be considered a Covered Service, this therapy must be performed by a certified, licensed therapist and be Medically Necessar**y** due to a Medical Condition such as a stroke, aphasia, dysphasia, or post-laryngectomy.

21. Physical Medicine and Rehabilitation Services

Coverage is provided for acute Inpatient care from a Provider for physical rehabilitation services received in a rehabilitation facility.

22. Private Duty Nursing Services

The services of a registered nurse, licensed vocational nurse or licensed practical nurse when ordered by a Physician are covered. These services include skilled nursing services received in a patient's home or as an Inpatient. Your Physician must certify all services initially and continue

to certify that you are receiving Skilled Care and not Custodial Care as requested by the Trustees or the PPO Provider. All Covered Services will be provided according to your Physician's treatment plan and as authorized by the Trustees or the PPO Provider.

Inpatient private duty nursing services include services that the Trustees or the PPO Provider decide are of such a degree of complexity that the Provider's regular nursing staff cannot perform them. When private duty nursing services must be received in your home, nurse's notes must be sent in with your claim.

Private duty nursing services do not include care which is primarily non-medical or custodial in nature such as bathing, exercising or feeding. Also, the Plan does not cover services provided by a nurse who usually lives in your home nor is a member of your Immediate Family.

All private duty nursing services must be certified by your Physician initially and every two weeks thereafter, or more frequently if required by the Trustees or the PPO Provider, for Medical Necessity.

23. Routine and Wellness Services

a. **Immunizations** – The following immunizations are covered:

1. diphtheria toxoid;
2. Diphtheria/tetanus toxoids (DT)
3. Hepatitis B
4. herpes zoster (shingles)
5. human papillomavirus vaccine (HPV)
6. influenza (flu vaccine)
7. measles-mumps-rubella vaccine (MMR)
8. meningococcal vaccine
9. pneumococcal
10. pneumococcal polysaccharide
11. rabies vaccine
12. tetanus toxoid
13. varicella (chicken pox)

b. **Routine Gynecological Services** – The following services are covered: PAP tests and mammogram services.

c. **Routine Physical Exam** – Routine Physical Exams are covered.

d. **Routine Services** – The following services are covered:

i. Blood glucose screenings, screening for type 2 diabetes limited to asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm/Hg;

ii. Bone density screenings, limited to women ages 65 and older or beginning at age 60 for women with an increased risk for osteoporotic fractures;

iii. Chlamydia screenings, limited to pregnant and sexually active women age 24 and younger and for older women that are at an increased risk;

iv. Cholesterol screenings, limited to:

1. men ages 35 and older for lipid disorders;

2. men ages 20 to 35 for lipid disorders if they are at an increased risk for coronary heart disease;

3. women ages 20 and older for lipid disorders if they are at an increased risk for coronary heart disease;

v. Colorectal cancer screenings; using fecal occult blood testing, sigmoidoscopy or colonoscopy in adults beginning at age 40 and continuing until age 75; and

vi. hepatitis B virus screenings; limited to pregnant women in their first prenatal visit;

e. **Well Child Care Services** – Coverage for well child care services will be provided for Covered Persons under the age of 21. Coverage for immunizations is also provided for Covered Persons under the age of 21. Well child care services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination, routine newborn hearing screening and developmental assessment. Vision tests, hearing tests and the developmental assessment must be included as part of the physical examination in order to be provided as part of this benefit. This

review also includes anticipatory guidance, laboratory tests and appropriate immunizations.

f. **Women's preventative services** – These services will be provided in accordance with the age and frequency requirements of the Affordable Care Act, including, but not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; and counseling for contraceptive methods, breastfeeding and domestic violence.

g. **Additional Preventative Services** – If not shown above as a Covered Service, the following services will also be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventative Services Task Force;

2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

3. With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration.

4. With respect to medication assisted treatment for alcohol and substance abuse, prescription drugs that are prescribed as part of treatment for alcohol and substance abuse are covered with no cost sharing.

Please refer to the phone number on the back of your identification card if you have any questions or need to determine whether a service is eligible for coverage as a preventative service. For a comprehensive list of recommended preventative services, please visit www.healthcare.gov/prevention/index.html. Newly added preventative services added by the advisory entities referenced by the Affordable Care Act will start to be covered on the first plan year beginning on or after the date that is one year after the new recommendations or guidelines, went into effect.

24. Skilled Nursing Facility Services

The benefits available to an Inpatient of a Hospital listed under the Inpatient Hospital Services section are also available to an Inpatient of a Skilled Nursing Facility. These services must be Skilled Care, and your Physician must certify all services initially and continue to certify that you are receiving Skilled Care and not Custodial Care as requested by the Trustees or the PPO Provider. All Covered Services will be provided according to your Physician's treatment plan and as authorized by the Trustees or the PPO Provider.

No benefits are provided:

1. once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by the Trustees or the PPO Provider;

2. for Custodial Care, rest care or care which is only for someone's convenience; and

3. for the treatment of Mental Illness, Drug Abuse or Alcoholism.

25. Supplemental Accident Services

In addition to the emergency accident care benefit, the Plan will provide benefits for the following:

a. ambulance services to or from a Hospital;

b. crutches, splints, bandages and dressings;

c. dental services including the extraction of teeth and replacement of broken teeth;

d. diagnostic tests and services;

e. Durable Medical Equipment such as wheelchair rental or Hospital bed;

f. medical, surgical and anesthesia services;

g. Outpatient Hospital services;

h. Physical therapy services;

i. Private duty nursing services; and

j. Prosthetic appliances such as glass eye, artificial legs or fitting of these prosthetic appliances.

Services and supplies must be furnished within 90 days after the date of accident. The Plan will not provide benefits for local anesthesia.

26. Smoking Cessation Services

For Covered Persons age 18 or over, benefits are provided for the screening of tobacco use and for smoking cessation programs for those Covered Persons using tobacco.

27. Surgical Services

a. **Surgery –** Coverage is provided for Surgery. In addition, coverage is provided for the following specified services:

i. sterilization, regardless of Medical Necessity;

ii. anoscopy for all causes;

iii. direct laryngoscopy;

iv. tooth extraction related to accidental injury;

v. maxillary or mandibular frenectomy;

vi. pain control;

vii. unlimited casting applications;

viii. reconstructive Surgery following a mastectomy, including coverage for reconstructive Surgery performed on a non-diseased breast to establish symmetry as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas;

ix. Surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes as determined by the Trustees or the PPO Provider, subject to any appeal process. **Surgery to correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is NOT covered.**

b. **Diagnostic Surgical Procedures** – Coverage is provided for surgical procedures to diagnose your Condition while you are in the Hospital. The diagnostic surgical procedure and Medical Care visits except for the day the surgical procedure was performed are covered.

c. **Multiple Surgical Procedures** – When two or more Surgeries are performed through the same body opening during one operation, you are covered only for the most complex procedure. However, if

each Surgery is mutually exclusive of the other, you will be covered for each Surgery. **Incidental Surgery is NOT covered**.

When two or more surgical procedures are performed through different body openings during one operation, you are covered for the most complex procedure, and the Allowed Amount for the secondary procedures will be half the Allowed Amount for a single procedure.

If two or more foot Surgeries (podiatric surgical procedures) are performed, you are covered for the most complex procedure, and the Traditional Amount will be half of the Traditional Amount for the next two most complex procedures. For all other procedures, the Traditional Amount will be one-fourth of the full Traditional Amount.

d. **Assistant at Surgery** – Another Physician's help to your surgeon on performing covered Surgery when a Hospital staff member, intern or resident is not available is a Covered Service.

e. **Anesthesia** – Your coverage includes the administration of anesthesia, performed in connection with a Covered Service, by a Physician, Other Professional Provider, or certified registered nurse anesthetist who is not the surgeon or the assistant at Surgery or by the surgeon in connection with covered oral surgical procedures. This benefit includes care before and after the administration. The services of a stand-by anesthesiologist are only covered during coronary angioplasty Surgery.

f. **Second Surgical Opinion** – A second surgeon's opinion and related diagnostic services to help determine the need for elective covered Surgery recommended by a surgeon are covered by are not required. However, a second surgical opinion is mandatory for temporomandibular joint services (TMJ). The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the Surgery. This benefit is not covered while you are an Inpatient of a Hospital. If the first and second surgical opinions conflict, a third opinion is covered. The Surgery is a Covered Service even if the Physician's opinions conflict.

28. Hearing Aid Benefit

Hearing aid benefits shall be paid for an Eligible Employee and Eligible Dependents subject to the limitations set forth in the Schedule of Benefits. No benefits will be payable for hearing aid batteries. All claims should be submitted to the Fund Office for processing.

29. Urgent Care Services

Health problems that require immediate attention which are not Emergency Medical Conditions are considered to be Urgent Care needs. Determination as to whether or not Urgent Care Services are Medically Necessary will be made by the PPO Provider and/or the Trustees.

30. Services Not Performed In Person

When performed by a Provider with whom the PPO Provider has an agreement to perform these services, your coverage will include Providers' charges for consulting with Covered Persons by telephone, facsimile machine, electronic mail systems or online visit services. Online Covered Services include a medical consultation using the internet via a webcam, chat, or voice. Non-Covered Services include, but are not limited to, communications used for:

a. Reporting normal lab or other test results;
b. Office appointment requests;
c. Billing, insurance coverage, or payment questions;
d. Requests for referrals to doctors outside the online care panel;
e. Benefit precertification; and/or
f. Physician-to-Physician consultation.

31. Coverage for COVID-19 Testing and Qualifying Preventive Care

Effective March 18, 2020, charges related to COVID-19 Testing for diagnostic purposes only shall be provided to eligible Participants and dependents at no out-of-pocket cost and with no prior authorization. Therefore, these charges shall not be subject to any deductible, co-insurance, and co-payments. This treatment shall apply to any service or item furnished to an eligible Participant or dependent that results in the order for, or administration of, a COVID-19 Test, but only to the extent that such items and services relate to the furnishing or administration or evaluation of a COVID-19 Test.

Additionally, and effective as set forth below, Qualifying Coronavirus Preventive Services shall be provided to eligible Participants and dependents at no out-of-pocket cost and with no prior authorization.

a. For the purposes of this Subsection (F)(31), the term "COVID-19 Test" or "COVID-19 Testing" shall mean an in vitro diagnostic test defined in Section 809.3 of title 21 of the Code of Federal Regulations for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such as test that (A) is approved, cleared, or authorized under sections 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act; (B) is developed in, and authorized by, a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or (C) other test that the Secretary of Health and Human Services deems appropriate and is in accordance with effective Federal and State law.

b. Further, the term "Qualifying Coronavirus Preventive Services" shall mean an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019, and that is (A) an evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; or (B) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. Coverage for such Qualifying Coronavirus Preventive Services shall be effective fifteen (15) business days following the date on which the coronavirus preventive services recommendation is made.

G. PRESCRIPTION DRUG BENEFITS

1. Definitions

As used herein, "Legend Drugs" means drugs which have the following legend on the container: "CAUTION, FEDERAL LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION."

As used herein, "Prescription Drugs" means Legend Drugs and drugs which:

a. require a written prescription executed by a Physician according to State Law; and

b. are dispensed by a licensed pharmacist or a Hospital pharmacy for take-home use.

Prescription Drugs shall also include insulin when prescribed by a Physician, whether or not restricted by state law.

2. Payment of Benefits

Claims for benefits are processed by the prescription carrier, a claims agent specializing in pre-paid Prescription Drug Coverage. The prescription carrier recommends and covers a preferred list of medicines referred to as the Plan's "formulary." You will be responsible to pay a co-pay with your prescription. The amount of the copay depends on whether you are ordering a 30-day or 90-day supply and the type of medication, which can be Generic, Preferred Brand, Non-Preferred Brand, or Specialty. See copay chart in Section II, subsection A, Schedule of Benefits.

Important Rules: Please be aware of the following rules that affect your Rx benefits:

- Prescriptions for non-preferred drugs that are not on the Plan's formulary will not be covered unless your Physician determines that it is "Medically Necessary" (See Article I, Section (B)(55) and submits a written requirement for prior approval for the drug to be covered ("prior authorization").
- If your Physician does not follow the rules above, you will be required to pay the full cost of the non-preferred drug.
- You must try a generic equivalent or a preferred brand name Specialty drug (if available) before a Non-Preferred Specialty drug will be covered.
- If a generic equivalent drug is available, but you or your physician elects to use a name brand drug, you will be required to pay the copayment identified above along with the difference in price between the generic and brand name drug.

Benefits are available according to the following two (2) procedures:

a. Personal Identification Card. Each Eligible Employee receives a personal identification card for obtaining prescriptions at participating pharmacies. Identification cards are issued to all Employees and to new Employees as they become eligible for benefits. Prescription Drug Benefits are obtained from a participating pharmacy as follows:

    i. 30 day supply;

    ii. the identification card is presented to the pharmacist with the prescription;

    iii. the Eligible Person verifies and signs the claim voucher prepared by the pharmacist; and

    iv. the Eligible Person pays the pharmacist the Co-pay amount of $10.00 for generic drugs;

    v. The Eligible Person pay the Co-pay of $25.00 for preferred brand name drugs on the Plan's formulary;

    vi. The Eligible Person pays the Co-pay of $40.00 for non-preferred brand name drugs that are not on the formulary provided that he or she has received a pre-authorization; or

    vii. The Eligible Person pays the Co-pay of $50.00 for specialty drugs as long as the generic equivalent is tried first.

b. **Mail Order - 90 day supply**. Prescription Drug Benefits are obtained by Mail Order as follows:

    i. The Eligible Person pay a copayment of $20.00 for generic drugs;

    ii. The Eligible Person pays a copayment of $50.00 for preferred brand name drugs on the Plan's formulary; or

    iii. The Eligible Person pays a copayment of $80.00 copayment for non-preferred drugs after receiving pre-authorization.

Ninety (90) day supplies may be available at limited retail locations. Specialty drugs are not available via mail order (i.e., no 90-day supply for Specialty drugs).

3. Dispensing Limitations

The quantity of each eligible prescription is normally limited to a 30-day supply; individual prescriptions may be limited to the greater of one hundred (100) unit doses or a 30-day supply. Prescriptions may be refilled a maximum of five (5) times in any six (6) month period if authorized by the Physician. No prescription shall be refilled after six (6) months from the date of its original issue.

4. Diabetic Supplies Coverage

Prescription drug benefits shall include syringes purchased at the time of insulin purchase when accompanied by a written prescription. Diabetic test strips and lancets for use with home monitoring systems when accompanied by a written prescription shall also be covered under the prescription drug benefit.

5. Limitations

No payments will be made for charges due to:

a. Drugs which can lawfully be obtained without prescription, except insulin;

b. Therapeutic devices or appliances including hypodermic needles, support garments and other non-medical substances regardless of their intended use;

c. Administration of Prescription Drugs or Insulin;

d. Drugs labeled: "Caution - limited by Federal Law to investigational use", or experimental drugs, even though a charge is made to the individual;

e. Prescription refills in excess of the number specified by a Physician or Dentist;

f. Drugs and insulin dispensed during Hospital confinement including confinement in a rest home, sanitarium, extended care facility, skilled nursing facility, Convalescent Hospital, nursing home or similar institution which operates on its premises a facility for use as an out-patient;

g. Drugs or insulin for which no charge is made or for which charges are covered by any Workers' Compensation or Occupational Disease Laws or any State or Federal governmental agency; and/or

h. Drugs which are not approved by the FDA for the specific diagnosis for which the drug is being administered.

i. Drugs such as Kymriah and Yescarta for gene therapy treatment of cancer. Such drugs are covered as a medical benefit but not as a prescription benefit.

j. The Drug Luxturna for treatment of blindness. Luxturna is covered as a medical benefit but not as a prescription benefit.

k. Brand name drugs for the prevention of migraine headaches, unless a step therapy program, including an eight-week trial of generic drugs, has been completed and a Physician determines the generic drugs are unable to treat the condition for which the brand name drugs are prescribed.

6. Procedure for Appealing a Claim under the Prescription Drug Benefit Program

If you are not satisfied with a benefit determination decision regarding your prescription drug program, you may file an appeal. No more than two (2) appeals on one claim will be considered in accordance with the procedures explained below.

To file an appeal, you must notify the International Brotherhood of Electrical Workers Local No. 38 Health and Welfare Trust Fund (hereinafter the "Plan") in writing with the following information: full name of the person filing the appeal; patient's full name; identification number; claim number if one has been assigned; reason for the appeal; date of when you were denied your prescription benefit; any supporting information or records you would like the Trustees to consider in the appeal. Send or fax the letter to:

Board of Trustees
I.B.E.W. Local 38 Health and Welfare Fund
P.O. Box 6326
Cleveland, Ohio 44101-1326

a. First Mandatory Appeal. The Plan provides individuals with two levels of mandatory appeal with respect to Pre-Service Claims and Post-Service Claims. There is only one level of appeal with respect to Urgent Care Claims. You must complete all required levels of appeal before any action is taken in a court of law.

First level mandatory appeals related to a claim decision must be filed within one hundred eighty (180) days from your receipt of the notice of denial of prescription benefits. All requests for appeal may be made by writing as described above.

The Board of Trustees will provide you with notification of the benefit determination of your appeal orally as allowed or in writing, as follows:

i. for an appeal of an Urgent Care Claim, not later than seventy-two (72) hours after the Board of Trustees receives your request for an appeal.

ii. for an appeal of a Pre-Service Claim, not later than fifteen (15) days after the Board of Trustees receives your request for an appeal.

iii. for an appeal of a Post-Service Claim, not later than thirty (30) days after the Board of Trustees receives your request for an appeal.

Under the appeal process there will be a full and fair review of the claim. The appeal process is a review of your appeal by an Appeals Coordinator who may be the Plan's Administrative Manager, and if necessary, other health care professional(s). The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based in whole or in part on a medical judgment will be made in conjunction with health care professional(s) who have the appropriate training and experience. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

You may submit written comments, documents, records and other information relating to the claim being appealed. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that you are appealing.

The Appeals Coordinator will consider all information presented to it. The decision of the Appeals Coordinator will be made, in its sole discretion, on the basis of the medical information presented, and such decision will be final and binding.

All notices of a denial of benefit will include the following:

i. the specific reason for the denial;

ii. reference to the specific Plan provision on which the denial is based;

iii. your right to bring a civil action under federal law following the denial of a claim upon review;

iv. if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request;

v. if the claim was denied based on a medical necessity or experimental treatment or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination in applying the terms of the plan to the circumstances will be provided free of charge upon request;

vi. upon specific written request from you, provide the identification of the medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard

to whether the advice was relied upon in making the benefit determination;

vii. information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable) as well as the diagnosis code, the treatment code, and the corresponding meanings of those codes;

viii. inclusion of the denial code and its corresponding meaning in the description of the reason or reasons for the adverse benefit determination;

ix. a description of the Plan's standard, if any, that was used in denying the claim and a discussion of the decision;

x. a description of available external review processes including information regarding how to initiate an appeal;

xi. information regarding the availability of and contact information for the Consumer Affairs Division of the Ohio Department of Insurance to assist individuals with internal claims and appeals and the external review process.

b. Second Level Mandatory Appeal. If your first level mandatory appeal is denied, you must pursue a second appeal offered by the Plan for all Pre-Service Claims and Post-Service Claims. All requests for appeal may be made in writing to Board of Trustees at the address listed above. You may submit additional written comments and other information relating to the claim being appealed.

The second level appeal may be requested at the conclusion of the first level of appeal. The request for the second level appeal must be received by the Board of Trustees within sixty (60) days from your receipt of the first appeal decision. The Plan's review of the mandatory second level for Pre-Service Claims will be completed no later than fifteen (15) days after the Board of Trustees receives your request for an appeal. The Plan's review of the mandatory second level for Post-Service Claims will be completed at the next regularly scheduled Board of Trustees meeting, provided your appeal is received at least 30 days prior to the scheduled date of the Board of Trustees' meeting. If your appeal is received within 30 days preceding such meeting, then your benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. You may request to be present at the Board of Trustees' meeting to present your appeal.

The second level appeal provides a full and fair review of the claim. There will be a review of your appeal by the Board of Trustees and, if determined to be needed, other licensed health care professional(s). The appeal will take into account all comments, documents, records and other information submitted by you and the provider relating to the claim, without regard to whether such

information was submitted or considered in the first level mandatory appeal. All determinations of medical necessity that are based in whole or in part on a medical judgment will be made in conjunction with health care professionals. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

In order to process your appeal, you agree that:

i. any person claiming benefits will furnish the Plan with any information the Plan needs; and

ii. the Plan may, without the consent of or notice to any person, release to or obtain from any source any necessary information.

c. External Review Procedure. After exhausting the internal review process described above, you may appeal an adverse benefit determination through an external review process. For more information regarding this process, contact the Plan Administrator.

d. Facility of Payment. If payment which the Plan should have made under this provision is made under any other health care plan, then the Plan has the right to pay whoever paid under the other health care plan. The Plan will determine the necessary amount under this provision. Amounts so paid are benefits under this booklet, and the Plan is discharged from liability to the extent of such amounts paid for Covered Services.

e. Right of Recovery. If the Plan pays more for covered services than this provision requires, the Plan has the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure the Plan's right to recover the excess payment.

Upon receipt of notice of the Board of Trustees' denial of your claim in connection with your second level appeal, you or your personal representative may, within sixty (60) days after receipt of such notice, request in writing, delivered to the Board of Trustees at the address provided above, if this information has not already been provided, a final decision in writing, stating the specific reasons for the decision and the Plan's pertinent provisions on which the decision is based. The decision of the Board of Trustees will be final.

The Board of Trustees will consider all information presented to it. The Board of Trustees, in its sole discretion, will make its decision on the basis of the medical information presented to it, and such decision will be final and binding.

If the Board of Trustees denies your appeal and you are dissatisfied with the Board's decision, you may initiate legal action by filing suit in state or federal court. No action, at law or in equity, may be brought against the Plan to recover benefits within sixty (60) days after the Plan receives written proof in accordance

with this appeal process that the covered services about which you are appealing have been given to you. No such action may be brought later than two (2) years after you receive notice of the denial of your appeal.

H. GENERAL EXCLUSIONS AND LIMITATIONS APPLICABLE TO ALL BENEFITS

In addition to any exclusion or limitation listed in the previous sections of this booklet, no benefits will be paid under any section of the Plan for services and supplies:

1. Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider;

2. Not performed within the Provider's license;

3. Not Medically Necessary;

4. Received from other than a Provider;

5. For Experimental or Investigational drugs, devices, medical treatments or procedures provided, however, the sole exception to this exclusion is that the Board of Trustees has determined to cover use of Viagra for treatment of Reynaud's Syndrome;

6. To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual;

7. For a Condition that occurs as a result of any act of war, declared or undeclared;

8. For which you have no legal obligation to pay in the absence of this or like coverage;

9. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;

10. Received from a member of your Immediate Family;

11. Incurred after you stop being a Covered Person except as specified in the Benefits After Termination of Coverage section;

12. For the following:

    a. Physical examinations or services required by an insurance company to obtain insurance;

    b. Physical examinations or services required by a governmental agency such as the FAA and DOT;

c. Physical examinations, services, and testing, required by an employer in order to begin or to continue working; or

d. Premarital examinations.

13. For X-ray examinations with no preserved film image or digital record;

14. For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work or wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage;

15. For which benefits are payable under Medicare Parts A, B and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in the SPD/Plan Document or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part B, the Plan will calculate benefits as if he or she had enrolled;

16. Received in a military facility for a military service related Condition;

17. For Residential Care rendered by a Residential Treatment Facility;

18. For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), except as specified elsewhere;

19. For Surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment;

20. For the removal of tattoos;

21. For dietary and/or nutritional guidance or training, except as specified or required by the Affordable Care Act;

22. For Outpatient educational, vocational or training purposes except as may be required by the Affordable Care Act;

23. For treatment of Conditions related to an autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndrome, behavioral problems or intellectual disability, except as specified elsewhere;

24. For routine minor non-operative endoscopic procedures, other than coverage for colonoscopy and sigmoidoscopy required by the Affordable Care Act;

25. For treatment, by methods such as dietary supplements, vitamins, and any care which is primarily dieting or exercise for weight loss, except as specified elsewhere;

26. For weight loss Surgery and any repairs, revisions, or modifications of such Surgery, including weight loss device removal, unless determined by the PPO Provider or the Trustees to be a Covered Service in accordance with the PPO Provider's corporate medical policy;

27. For marital counseling;

28. For the medical treatment of sexual problems not caused by a biological Condition;

29. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery;

30. For male Contraceptives and over-the-counter birth control without a prescription;

31. For reverse sterilization;

32. For the treatment of infertility, including, but not limited to, artificial insemination, in vitro fertilization, Gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT). This exclusion does not apply to prescription drugs for treatment of infertility, which are still covered under the prescription drug benefit above;

33. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent;

34. For oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic except when due to trauma, accident or as deemed Medically Necessary by the PPO Provider and/or the Trustees;

35. For treatment associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified elsewhere;

36. For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension;

37. For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis;

38. For personal hygiene and convenience items;

39. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except as specified otherwise and except those for aphakic patients, keratoconus,

and soft lenses or sclera shells for use as corneal bandages when needed as a result of Surgery;

40. For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis);

41. For all services related to hearing loss including examinations for prescribing or fitting hearing aids, except as specified otherwise (other than newborn screening for hearing loss, as required by the Affordable Care Act);

42. For immunizations other than those specified as covered in the Routine and Wellness Services section of the SPD/Plan Document;

43. For massotherapy or message therapy;

44. For hypnosis and acupuncture;

45. For blood which is available without charge. For Outpatient blood storage services;

46. For Prescription Drugs, except as specified elsewhere;

47. For over the counter drugs, vitamins or herbal remedies, except for certain preventive drugs written with a Physician's prescription and required by PPACA;

48. For topical anesthetics;

49. For Outpatient occupational therapy services;

50. For routine services, except as specified elsewhere and in accordance with the Affordable Care Act;

51. For arch supports and other foot care or foot support devices only to improve comfort or appearance which include, but are not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses, and toenails;

52. For specialized camps;

53. For water aerobics;

54. For After Hours Care;

55. For missed appointments, completion of claim forms or copies of medical records;

56. For any oral, written or electronic communications or consultations by a Provider with a Covered Person or another Provider that do not involve in-person contact with the Covered Person;

57. For fraudulent or misrepresented claims;

58. For a particular health service in the event that a Non-PPO Network Provider waives Copayments, Coinsurance (and/or the Deductible per Benefit Period), no benefits are provided for the health service for which the Copayments, Coinsurance (and/or the Deductible per Benefit Period) are waived;

59. For non-covered services or services specifically excluded in the text of this SPD/Plan Document.

60. For telephone consultations or consultations via electronic mail, facsimile or internet/web site, except as required by law, authorized by the Plan in writing, or as otherwise described in this SPD/Plan document.

61. For the prescription drug Spinraza.

I. NOTICE OF CLAIM

Written notice of an injury or sickness upon which a claim may be based must be filed with six (6) months of the occurrence of the illness or accident, or within a reasonable time if it has not been possible for the employee or his dependent to file the notice of claim within six (6) months of the occurrence for the illness or accident.

Written proof of an injury or sickness must be furnished to the Trustees within ninety (90) days after the termination of the period of disability for which a claim is made. Written proof of loss for all other expenses must be furnished to the Trustees within ninety (90) days after the date of the loss. In the event of an accidental death, written notice must be given to the Trustees within two (2) years after the date of death.

J. PAYMENT OF BENEFITS

Subject to due proof of loss, Weekly Disability Benefits will be paid each week during any period for which benefits are payable. Any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of due proof. Benefits for loss of life are payable to the beneficiary designated by the Eligible Employee.

If you designate more than one (1) beneficiary without specifying their respective interest, the Death Benefit will be paid in equal shares to the beneficiaries.

If any benefits of this Plan shall be payable to an Eligible Dependent or beneficiary who is a minor or is otherwise not competent to give a valid release, the Trustees may pay to the Hospital or Physician on whose charge or fee claim is based, any sums due for Hospital Expense Benefits, Surgical Expense Benefits or Medical Expense Benefits toward satisfaction of any amounts still

owed such Hospital or Physician. Any balance of such sums and any sums due for Weekly Disability Benefits may be paid, up to an amount not exceeding $1,000.00, to any relative by blood or marriage of the Eligible Dependent or beneficiary who is deemed by the Trustees to be equitably entitled thereto. Any payment made by the Trustees in good faith pursuant to this provision shall fully discharge the Fund and the Trustees to the extent of such payment.

K. MEDICAL EXAMINATION

The Trustees shall have the right, through its medical examiner, to examine the Eligible Person as often as they may reasonably require during the pendency of a claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

L. RECOVERY OF OVERPAYMENT

Any misrepresentation or error by an Eligible Employee, beneficiary, plan administrator, or any Trustee which results in any benefit or other payments to, for or on behalf of an Eligible Employee or beneficiary to which such Employee was not entitled (in whole or in part), or any failure on the part of an Eligible Employee or beneficiary to repay to the Fund any or all amounts due under a reimbursement, subrogation or similar provision or agreement, shall constitute grounds for recovery of such payments or amounts made in reliance thereon. The Trustees may recover such benefit payments or amounts by any method they deem necessary or appropriate, including the retention or withholding of future benefit payments or other amounts or portions thereof which may be payable to, for, or on behalf of such Eligible Employee or beneficiary.

M. HEALTH CARE FRAUD

Health care fraud is not only unethical, immoral and illegal, it is costly to the Health & Welfare Fund and each and every Participant pays for the dishonesty of the person who commits health care fraud. Any Participant who engages in an activity intending to defraud this Fund, as determined by the Board of Trustees, that Participant and his/her Dependents will immediately lose health care coverage along with all banked and/or reserved hours at the end of the month in which it is determined the activity was intended to defraud this Fund and remain suspended until such time as the Board of Trustees determines eligibility should be reinstated. The Participant and/or Dependent who engages in such activity will face disciplinary action and/or prosecution. Furthermore, any Participant or Dependent who receives money from the Fund or has benefits paid on his/her behalf to which he/she is not entitled will be required to fully reimburse the Fund. If not fully reimbursed the Trustees have the right to: offset the unpaid amount against (a) any future medical claims for which the Participant and/or Dependent(s) may be entitled to have paid by the Fund and/or (b) retain Employer contributions to the Fund made on behalf of the Participant while said Participant and/or Dependent(s) are suspended.

N. DIRECT PAYMENTS

Any benefits for Covered Services which have been assigned will be paid to the appropriate assignee Hospital, Physician or other service provider. Notwithstanding the foregoing and subject to proof of prior payment by the Eligible Person, all or a portion of any Covered

Expenses for Hospital, Physician or other service providers will be paid directly to such service providers.

Except as may be otherwise provided herein, any other benefits will be paid to the Eligible Person except that benefits unpaid at the Eligible Person's death may be paid, at the Trustees' option, to:

1. the Eligible Person's beneficiary;

2. the Eligible Person's estate; or

3. as otherwise provided in the Plan.

Any payment of benefits made in good faith will discharge the Fund and the Trustees fully to the extent of the payment.

O. TERMINATION OF COVERAGE

Benefits for Eligible Persons will terminate when they are no longer able to fulfill the Plan's eligibility requirements for coverage.

- The benefits for a Dependent child will terminate on the first (1^{st}) day of the month next following the date of his or her attainment of his or her twenty-sixth (26^{th}) birthday, or when such child otherwise ceases to meet the definition of an Eligible Dependent.

- The benefits for dependent Spouse will terminate on the date in which the Spouse and Eligible Employee become divorced by way of a divorce decree, dissolution, or legal separation agreement. Failure to advise the Fund Office of termination of marriage can result in overpayment of benefits and will be subject to Section IV, subsection L, Recovery of Overpayment.

Any such termination is subject to the individual's right to obtain COBRA Continuation Coverage or other self-payment rights under the Plan.

P. CLAIMS APPEAL AND REVIEW PROCEDURE

Claims for benefits shall be made in writing to the Trustees by delivery to the Plan administrator within the time period specified by the Plan. A claimant must furnish any information or proof reasonably required to determine his benefit rights. Unless and until the claimant makes proper application in accordance with the rules and procedures established by the Trustees, he shall have no right to receive benefit payments under the Plan. Any misrepresentation or error by the claimant, Plan Administrator or Trustees which results in benefit payments to which the claimant is not entitled (in whole or in part) will constitute grounds for the recovery of such benefit payments made in reliance thereon. The Trustees may recover such benefit payments by retention or withholding of future benefits payments or portions thereof.

1. Health Care Claims

Many health care providers will submit claims for you. Health care claims include Hospital, surgical and other medical claims, as well as prescription drug, dental, vision and hearing aid benefits. Be sure to show your ID card so your provider knows where to submit your claim. If your provider does not submit your claim for you, it is then your responsibility to do so.

If you or an Eligible Dependent has coverage under two or more health care plans, be sure to include the name of the other health care plan(s) on your claim form. In addition, if you have had benefits paid by another plan, attach a copy of the itemized bill relating to the health care service provided and a copy of any explanation of benefits. Both the bill and explanation of benefits must be submitted.

Types of Health Care Claims

How you file a claim for benefits depends on the type of claim it is. There are four basic types of health care claims:

a. **Urgent Care.** An urgent care claim is a claim for medical care or treatment that:

   i. Would seriously jeopardize your life, health, or ability to regain maximum function if normal preservice standards were applied; or

   ii. Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a doctor with knowledge of your condition.

b. **Pre-Service.** A pre-service claim is a claim for benefits where pre-certification is required. The Plan will not deny benefits for these procedures or services if:

   i. It is not possible for you to obtain pre-certification; or

   ii. The pre-certification process would jeopardize your life or health.

c. **Post-Service.** A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim.

d. **Concurrent Care.** A concurrent care claim is a claim that is reconsidered after it is initially approved (such as re-certification of the number of days of a Hospital stay) and the reconsideration results in:

   i. Reduced benefits; or

ii. A termination of benefits.

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, the Fund Office or the appropriate third-party administrator will notify you as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment.

A. Weekly Disability Benefit Claims

Be sure to notify the Fund Office if you are an Inside or Teledata Electrician and are sick or injured and are unable to work and entitled to weekly disability benefits. The Fund Office will send you a claim form for weekly disability benefits. Send the completed form to the Fund Office as soon as possible. Benefits are not payable until you apply for and submit the required information.

B. Death and AD&D Benefit Claims

In the event of your death, your beneficiary should call the Fund Office for help in filing a claim. If you have an injury covered under the AD&D benefit, you should file the claim and any benefits will be paid to you.

C. Claim Decisions and Benefit Payment

When you submit benefit claims, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. In some situations, the Fund has the right to request a physical exam by a doctor of its choice (at the Fund's expense).

D. Health Care Claims

Generally, all health care benefits will be paid as soon as administratively possible. The Fund or appropriate third-party administrator will notify you of its initial decision within certain timeframes. If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Fund or appropriate third-party administrator will give you written notice of its decision about your claim.

The deadlines differ for the different types of claims as shown in the following information:

a. ***Urgent Care Claims.*** An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will

then have up to 48 hours to respond. The initial 72-hour deadline is suspended for up to 48 hours or until the information is received, if sooner.

b. ***Pre-Service and Post-Service Claims***. An initial determination will be made within 15 calendar days from receipt of your claim for pre-service claims and 30 calendar days from receipt of your claim for post-service claims. If additional time is necessary, up to 15 additional calendar days, due to matters beyond the control of the Plan, you will be informed of the extension within the 15-day timeframe with respect to pre-service claims or within the 30-day extension with respect to post-service claims. In addition, if additional information is needed to process your claim, you will be notified within the 15 day timeframe (with respect to pre-service claims) or within the 30 day timeframe (with respect to post-service claims) and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

When Contracting or Network Providers submit the claims, payment is made directly to the Provider. Providers may handle all the paperwork for you. Even if you submit the claim, payment will be made to the Provider pursuant to the Fund's contracts with its Providers and/or Provider network.

2. Weekly Disability Benefit Claims (Benefit Available for Inside and Teledata Employees)

In the event your claim for weekly disability benefits is denied, you will be notified in writing of the reasons why your claim was denied by the Fund Office. Notification of a decision on a weekly disability claim shall occur within forty-five (45) days of the receipt of your approved claim form by the Fund Office. If the Fund Office determines that more time is needed to process the claim due to matters beyond its control, the Fund Office will notify you of a thirty (30) day extension. No further extensions shall occur. Any notice of an extension shall include the standards on which an entitlement to weekly disability benefits is based, the unresolved issues preventing a decision, and any additional information that is needed to resolve the claim.

All claims and appeals for weekly disability benefits will be adjusted in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decision regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claim adjudicator or medical or vocational expert) will not be made based on the likelihood that the individual will support a denial of benefits.

3. Death And AD&D Benefit Claims

Generally, you will receive written notice on a decision on your claim within 90 days after the Plan receives your claim. If circumstances require an extension of time for processing your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

4. If A Claim Is Denied

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

If your claim is denied (in whole or in part), the Plan will:

a. Provide you with certain information about your claim; and

b. Notify you of its denial of your claim within certain timeframes.

5. Information Requirements

When the Plan notifies you of its initial denial on your claim, it will provide:

a. The specific reason(s) for the decision;

b. Reference to the Plan provisions on which the decision was based;

c. A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed; and

d. A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim.

In addition, for ***health care, weekly disability and supplemental unemployment benefits*** claims, the notice will include:

a. A copy of any internal rule, guideline, protocols, standards, or other similar criteria that was relied upon in making the decision or, alternatively a statement that such rules, guidelines, protocols, standards, or similar criteria of the Plan do not exist; and

b. A copy of the medical or clinical judgment or statement that is available to you at no cost upon request if your claim is denied due to medical necessity, experimental treatment, or similar exclusion or limit.

For ***weekly disability benefit*** claims, the notice will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to your claim for benefits. In addition, in the event the determination disagrees with the views of (1) a health care professional treating you; (2) vocational professionals who have evaluated you; (3) a medical or vocational expert whose advice was obtained on behalf of the Plan in connection with your claim; or (4) a disability determination regarding you made by the Social Security Administration; then the decision to deny shall set forth an explanation of the basis for disagreeing with those views or opinions. If the decision to deny was based on a medical necessity, experimental treatment, or similar

exclusion or limit, the decision will set forth either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

If your appeal is due to the denial of an urgent care claim, the notice will also include a description of the expedited review process.

6. Appealing A Denied Claim

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Board of Trustees at the Fund Office or to the appropriate third-party administrator as soon as possible. For urgent care claims, your appeal may be made orally. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

a. 180 days from the date of a decision for health care, weekly disability or supplemental unemployment benefit claims; or

b. 60 days from the date of a decision for death or AD&D benefit claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office or third-party administrator authorizing this representative. A health care provider that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim, and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

a. Submit additional materials, including comments, statements or documents; and

b. Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:

   i. Was relied upon by the Plan in making the decision;

   ii. Was submitted, considered or generated (regardless of whether it was relied upon); or

   iii. Demonstrates compliance with the claims processing requirements.

In addition, if your claim is for ***health care*** or ***weekly disability or supplemental unemployment benefits*** and is denied based on:

a. An internal rule, guideline or other similar criteria, you have the right to request a free copy of such information; and

b. A medical necessity, experimental treatment or similar exclusion or limit, you have the right to request a free copy of an explanation of the medical or clinical judgment for the determination.

For claim appeals that are handled by the Board of Trustees, you may request an opportunity to appear before the Board of Trustees in person or by representative. If you do not request to appear before the Trustees, your failure to request such appearance will be considered a waiver of your right to do so, and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing, by certified mail (return receipt requested) of the date, time and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

7. Appeal Decisions

If you file your appeal on time and follow any applicable required procedures, a new, full and independent review of your claim will be made, and the decision will not be deferred to the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review, and the decision will be based on all information used in the initial determination as well as any additional information submitted. The review of your appeal of a denial of a weekly disability benefits will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor a subordinate of such individual. If the appeal of a weekly disability benefit decision is based, in whole or in part, on medical judgement, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

If the appeal of a weekly disability benefit decision is based, in whole or in part, on medical judgment, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. The reviewer will also identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial adverse benefit determination, without regard to whether the advice was relied upon by the initial determination.

Prior to making a decision to deny a weekly disability benefit appeal, you will be provided, free of charge, with any additional evidence considered, relied upon, or generated by the Plan, the

disability insurer, or other person making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse weekly disability benefit determination on review is provided so as to give you a reasonable opportunity to respond prior to that date. If the determination is based on new or additional rationale, the Plan Administrator shall provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse weekly disability benefit determination on review is provided so as to give you a reasonable opportunity to respond prior to that date.

Benefits provided or administered by the PPO Provider, Prescription Benefit Manager, Vision Provider or any insurance company or other third-party may be subject to initial review of and decision upon denied claims by that organization.

8. Appeal Decision Timeframes

The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

a. Health Care Claims:

i. **Urgent Care Claims.** A determination will be made within 72 hours from receipt of your appeal.

ii. **Pre-Service Claims**. A determination will be made within 30 calendar days from receipt of your appeal. If the appeal process has two mandatory levels, the determination will be made within 15 calendar days from receipt of your appeal for each level.

iii. **Post-Service Claims**. A determination will be made within 60 calendar days from receipt of your appeal. If the appeal process has two levels, the determination will be made within 30 calendar days from receipt of your appeal for the first level. The second level determination will be made at the Fund's next quarterly meeting unless the appeal is received within 30 days of that meeting, in which case the appeal may be heard at the quarterly meeting following the next quarterly meeting.

iv. **Concurrent Care Claims**. A determination will be made before termination of your benefit.

b. ***Weekly Disability and Supplemental Unemployment Benefits***. A determination will be made within 45 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 45 days), a decision will be made within 90 days after the date the Plan receives your request for review. However, the Plan may:

i. Make its decision at the next quarterly Board of Trustees meeting; or

ii. If your appeal is received within 30 days of the meeting, the decision will be made at the following quarterly meeting.

c. ***Death and AD&D Benefits***. A determination will be made within 60 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 60 days), a decision will be made within 120 days after the date the Plan receives your request for review. However, the Plan may:

i. Make its decision at the next quarterly Board of Trustees meeting; or

ii. If your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

9. Medical Judgments

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional who:

a. Has appropriate training and experience in the field of medicine involved in the medical judgment; and

b. Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right, upon request, to be advised of the identity of any medical experts consulted in making a determination of your appeal.

10. Official Plan Records

You may submit whatever records and evidence you believe are appropriate in support of your claim for benefits. However, the Trustees shall rely upon the records of the Plan ("Official Plan Records") in determining your eligibility for benefits and, if you are eligible, the amount of your benefits. In the event of a discrepancy between the Official Plan Records and the records or other evidence supporting the claim asserted by you or your beneficiary, the Trustees shall rely upon the Official Plan Records unless shown to their satisfaction that the additional or other records/evidence you submitted are valid and that the Trustees should rely upon those records/evidence. The burden of proving a claim for benefits which differs from the Official Plan Records shall be upon you or your beneficiary.

11. **Information Requirements**

When the Plan notifies you of its determination on your appeal, the Plan will provide the following:

a. The specific reason or reasons for the decision, including reference to the Plan provision on which the decision is based;

b. A statement notifying you that you have the right to request a free copy of all documents, records, and relevant information;

c. Information relating to any additional voluntary appeal procedures offered by the Plan; and A statement that you may bring a civil action suit under Section 502(a) of ERISA;

d. The applicable contractual limitations period that applies to your right to bring such an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim;

e. For Health Care Claims, information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable) as well as the diagnosis code, the treatment code, and the corresponding meanings of those codes;

f. For Health Care Claims, inclusion of the denial code and its corresponding meaning in the description of the reason or reasons for the adverse benefit determination;

g. A description of the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination, or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do exist;

h. For Health Care Claims, a description of available external review processes including information regarding how to initiate an appeal;

i. For Health Care Claims, information regarding the availability of, and contact information for, the Consumer Affairs Division of the Ohio Department of Insurance to assist individuals with internal claims and appeals and the external review process; and

j. For weekly disability claims, a discussion of the decision, including an explanation for disagreeing with or not following any of the following:

   i. The views of health care professionals treating the claimant; or

   ii. The views of vocational professionals who evaluated the claimant; or

   iii. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the appeal, without regard to whether the advice was relied upon in making the benefit determination; or

   iv. A disability determination made by the Social Security Administration.

   If the adverse benefit determination is based on medical necessity, experimental treatment, or a similar exclusion or limit, you will be provided either with an

explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request.

All notices to you shall be made in a culturally and linguistically appropriate manner. The Plan will provide oral language services such as a telephone customer assistance hotline that include answering questions in any "applicable non-English language" and provided assistance with filing claims and appeals in "any applicable non-English language." In addition, the Plan will provide, upon request, a notice in any "applicable non-English language" and will include in the English version of all notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. "Applicable non-English languages" including, with respect to an address in any United States county to which a notice is sent, a non-English language in which ten percent (10%) or more of the population residing the county is literate only in that language.

The Trustees shall have full authority to interpret the provisions of this Plan and it is within the sole and absolute discretion of the Trustees to determine if you are entitled to receive a benefit and the amount of the benefit. The decision shall be final and binding upon you.

12. External Review Process

After exhausting the internal review process described above, you may appeal an adverse benefit determination through an external review process. For more information regarding this process, contact the Plan Administrator.

13. Legal Actions

You may not begin any legal action, including proceedings before administrative agencies, until you have followed the Plan's claims and review procedures and exhausted the opportunities described in this section. You may, at your own expense, have legal representation at any stage of these review procedures. These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined in this section, you are not satisfied with the result, then you must file any legal action within two years of receiving the final review notice under these procedures. Accordingly, if the Trustees deny your appeal and you are still dissatisfied with the Trustee's decision, you may initiate legal action by filing suit in state or federal court, but you must do so not more than two years after you receive notice of the Trustees' decision.

Q. COORDINATION AND NON-DUPLICATION OF BENEFITS

If any individual covered under this Plan is also covered under one (1) or more other group plans or individual medical expense policies, the determination of benefits payable with respect to the individual under this Plan for any claim determination period will be coordinated with the benefits payable with respect to the individual under all other group plans or individual medical expenses policies.

A. Order of Benefit Determination:

The order of benefit determination is as follows:

a. The plan that covers the person as an employee is the plan that pays first.

b. When the claim is for a dependent child, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year.

c. When the parents are separated or divorced: if there is a court decree which establishes responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits are determined in agreement with the court decree (see the provisions of the Plan below entitled "Qualified Medical Child Support Orders") Otherwise, if the parent with custody has not remarried, the plan of the parent with custody is primary; if the parent with custody has remarried, the plan of the parent with custody is primary, the stepparent's plan is secondary, and the plan of the parent without custody pays third.

d. If the above rules do not establish an order of benefit determination, the plan which has covered the person for the longer period of time shall be primary, with the following exception:

   The benefits of a plan covering the person as a laid-off or retired employee, or a dependent of such person, shall be determined after the benefits of any other plan covering the person as an employee.

e. Any plan that does not contain a Coordination of Benefits provision is automatically primary.

In no event shall benefits provided under this Plan, together with benefits provided under any Other Group Plan or Individual Medical Expense Policies, exceed one hundred percent (100%) of total incurred Eligible Expenses.

Whenever payments which should have been made under this Plan in accordance with the coordination of benefits provisions have been made by some other contract carrier, the Administrative Manager shall have the right to pay over to any organization making such payments any amount on a "first dollar recovered basis" determined to be warranted in order to satisfy the intent of the coordination of benefit provisions and amounts so paid shall be a discharge of the Plan's liability for the applicable benefits.

R. RIGHT OF SUBROGATION, RESTITUTION, AND REIMBURSEMENT

The Plan's right of subrogation, restitution, and reimbursement arises and will be exercised when any benefits, including Hospital, surgical and/or medical benefits, are paid to or on behalf of an Employee or dependent (hereinafter, the "Covered Person") due to a loss, injury or illness for which another person or entity is or may be legally responsible. This right includes, but is not be

limited to, a loss, injury or illness compensable under the workers' compensation system, and/or due to medical malpractice, negligence, tortuous and/or criminal conduct of a third party, or any other situation. In consideration for the Plan's advancement of benefits in this context, the Covered Person is subject to the Plan's right of subrogation, restitution, and reimbursement, as follows:

1. Definitions

a. "Constructive Trust" shall mean a trust in which any amount, compensation and/or money You recover shall be deemed to be held for Your exclusive benefit and not commingled with other funds. Any such Constructive Trust shall be subject to an equitable lien by the Plan and any other equitable remedies available to the Plan under ERISA Section 502(a)(3) for the purpose of preserving the Plan's right to restitution for benefits paid by the Plan on Your behalf.

b. "Reimbursement" shall mean repayment to the Plan for, any benefit, including but not limited to medical, dental or vision that the Plan paid toward care and/or treatment for an injury or illness.

c. "Restitution" shall mean the return or restoration to the Plan of any benefit, including but not limited to medical, dental, prescription or vision benefits, the Plan paid toward care and/or treatment for an injury, disease or illness.

d. "Subrogation" shall mean the Plan's right to recover any benefit payment:

   i. because of injury or illness to You or Your dependent caused by either You or a third party's conduct; and

   ii. You or Your dependent later recover from a third party's insurer or Your own insurer.

e. "Third party" shall mean another person, entity, or organization.

f. "You" or "Your" shall mean the following: You, Your dependents and/or Your or Your dependent's heirs, estate or assigns. Therefore, all references herein to "You" shall also include Your dependents and/or Your or Your dependents heirs, estate and assigns.

2. Subrogation, Restitution, and Reimbursement Rights

a. To the extent of any payment made under the Plan, the Plan shall be subrogated to Your rights of recovery, which rights arise from any claim or cause of action which may occur because of Your or a third party's conduct. This right of subrogation, restitution, and reimbursement extends to any recovery received by You, regardless of how it is characterized,

such as for pain and suffering, regardless of who makes the payment, for any type of third-party injury. This also includes, but is not limited to:

i. payments made directly by a third party, or any insurance company on behalf of a third party or any other payments on behalf of a third party;

ii. any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on your behalf or other persons;

iii. any other payments from any source designed or intended to compensate you for injuries sustained as the result of negligence or alleged negligence of a third party;

iv. any worker's compensation award or settlement;

v. any recovery made pursuant to no-fault insurance; or

vi. any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

b. The Plan has a first priority lien on any recovery. You and Your attorney are deemed to hold any recovery in Constructive Trust on behalf of the Plan. The Plan is entitled to repayment in full, without reduction for attorney's fees and costs, and regardless of whether You are made whole or fully compensated. The Plan will not pay future claims to the extent of any recovery You received in the past in connection with an accident, unless the Plan's claim for subrogation, restitution, or reimbursement has been satisfied.

c. The Plan shall automatically have a first lien upon any recovery that You receive, or may be entitled to receive, from a third party. The Lien shall be in the amount of the benefits paid under this Plan for the treatment of any illness, disease, injury or condition for which the Responsible Third Party may be liable to You. The Participant or Beneficiary hereby consents to this lien and agrees to cooperate with the Plan to enforce any rights of Subrogation, Restitution, or Reimbursement that the Plan may have.

d. The Plan shall be entitled to equitable relief, including without limitation the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and to obtain (or to preclude the transfer or dissipation of) any recovery. The Plan shall be entitled to enforce its lien even if the recovery is less than the actual loss suffered by You.

e. The Plan shall have a specific and first right of reimbursement, up to the amount of the Plan's lien, out of the proceeds of any recovery that You may receive from a Responsible Third Party.

f. You and Your representatives are required to provide all assistance and cooperation requested by the Plan so that the Plan can exercise its subrogation, restitution, and reimbursement rights**.** If You or Your representative fail to cooperate with the Plan, the Plan has the right to stop benefit payments and/or deny all future applications for the payment of benefit of whatever kind including, but not limited to, recovery from any full or partial recovery of revenue/money including, but not limited to, full or partial recovery for pain and suffering, loss of wages and punitive damages until You cooperate to the satisfaction of the Plan. In addition, if You fail to cooperate and/or pay the Plan the full amount owed, the Plan shall have the right to withhold Your payment(s) for future or different claims on behalf of Yourself or Your Dependents until the amount owed in the subrogation, restitution, or reimbursement claim, in the estimation of the Plan, has been obtained through the withholding of the claims.

g. You and Your attorney may be required to sign the Plan's subrogation, restitution, and reimbursement agreement prior to the Plan's payment of any benefits on Your behalf for any injury, disease or illness resulting from the actual or alleged negligent conduct of a third party. This Plan's subrogation, restitution, and reimbursement agreement may be obtained from the Fund Office or the Plan Administrative Manager and may include terms and conditions beyond the scope of provisions listed in the Summary Plan Description. The Plan's subrogation, restitution, and reimbursement agreement You sign will obligate You, among other things, to reimburse the Plan for any benefits paid by the Plan from any moneys or other property recovered from a third party as the result of a judgment, settlement or other recovery against or with a third party or if You recover under Your own insurance coverage, including uninsured or underinsured coverage. If You are represented by an attorney, Your attorney may also be required to sign the subrogation, restitution, and reimbursement agreement. If You do not have an attorney at the time of signing the subrogation, restitution, and reimbursement agreement but You subsequently are represented by an attorney, You may also be required to have Your attorney sign a subrogation, restitution, and reimbursement agreement at the time Your attorney begins representing You.

h. If You and Your attorney do not sign a subrogation, restitution, and reimbursement agreement**,** and the Plan Administrator later learns that benefits were paid to You or on Your behalf because of medical treatment which was rendered due to the negligent (actual or alleged) conduct of a third party or You, the Plan has the right to stop benefit payments and/or

deny all future applications for the payment of benefits of whatever kind until You sign a subrogation, restitution, and reimbursement agreement. In addition, You and Your attorney are obligated to avoid doing anything that would prejudice the Plan's right of subrogation, restitution, and reimbursement.

i. If litigation is commenced, the Plan may cause to be recorded a Notice of Payment of Benefits, and such notice will constitute a first lien on any judgment recovered less a pro rata of court costs. Further, if litigation is commenced, You and Your attorney are required to deliver to the Plan a copy of the complaint filed in court, the name of the insurance company for the defendant(s) and any other instruments, documents or information for which the Plan requests to insure the Plan's subrogation, restitution, and reimbursement rights. The Plan shall have the right to intervene in any litigation involving You to protect its subrogation and reimbursement rights. Any action taken by the Plan to protect its subrogation, restitution, and reimbursement rights shall be without any charge or cost to You. However, the Plan shall not be liable to pay Your attorney fees or costs or Your attorney or his/her costs.

j. You are required to segregate any recovery received by You (up to the amount of the Plan's first lien) in a separate account, and You must preserve such recovery so that the Plan may enforce its lien and any disputes as to entitlement may be resolved.

k. You may not assign any right, claim or cause of action against a Responsible Third Party to recover for any illness, disease, injury or condition on account of which benefits were paid by the Plan.

l. The Plan's rights of reimbursement, restitution, and subrogation shall not be affected, reduced or eliminated by the make whole doctrine, comparative or contributory fault, or the common fund doctrine, or payment of Your attorney fees or court costs. The Plan expressly disavows such doctrines.

m. If You fail to make a claim or file a lawsuit against the responsible party or parties or insurance company or any other entity, the Plan may sue, compromise or settle in Your name all claims and may execute and sign releases and endorse checks or drafts given in settlement of such claims in Your name with the same force and effect as if You had executed and endorsed them. You and Your attorney agree to cooperate fully with the Plan in the prosecution of such claims and to attend court and testify if the Plan, in its sole discretion, deems Your attendance and testimony to be necessary.

S. MEDICARE REDUCTION

Persons eligible for benefits under the Plan are required to enroll in Parts A and B of Title XVIII of the Social Security Amendments of 1965 (more commonly known and described as "Medicare") when they become eligible for coverage by reason of age or a qualifying disability. In the event that an Eligible Person or dependent is also eligible for Medicare, the Fund will be the primary payer and Medicare will become the secondary payer of benefits if and to the extent required by law. Failure to timely enroll in both Medicare Part A and Medicare Part B when eligible will result in suspension of coverage under this Plan until the participant becomes eligible for both Medicare Part A and Medicare Part B.

T. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

This Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order ("QMCSO"), as required by ERISA Section 609. For this purpose, a "medical child support order" is a judgment, decree, or order (including approval of a settlement agreement) entered by a court or administrative agency of competent jurisdiction that:

1. Provides for child support with respect to your child under a group health plan or provides for health benefit coverage to your child; and

2. Is made pursuant to a state domestic relations law.

A medical child support order is a QMCSO if it creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, specifies required information, and does not alter the amount or form of plan benefits. An "alternate recipient" means any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. If a QMCSO provides health benefit coverage under the Plan to an alternate recipient, the Trustees are required to comply with the QMCSO.

A QMCSO may require the Plan to provide coverage to an alternate recipient who might not otherwise be eligible for coverage, but generally may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan. This Plan will provide benefits according to the requirements of a proper QMCSO. The Fund will promptly notify affected participants and alternate recipients if a QMCSO is received. The Fund will notify these individuals of its procedures for determining whether medical child support orders are qualified. Within a reasonable time after receipt of such order, the Fund will determine whether the order is qualified and notify each affected participant and alternate recipient of its determination.

U. COMPLIANCE WITH THE HEALTH INSURANCE AND PORTABILITY ACCOUNTABILITY ACT OF 1996 (HIPAA)

1. Definition of Protected Health Information.

The Board of Trustees of the Plan is the Plan's designated Plan Sponsor. The Plan's administrative staff and other professionals service providers to the Plan may create, receive, maintain or transmit individually identifiable health information of Plan participants, required for the Plan's administrative functions. When this health information is provided by the Plan to the Plan Sponsor, Business Associates, subcontractors, and other service providers to the Plan, such information is Protected Health Information ("PHI").

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA, as amended.
On January 25, 2013, HIPAA's Privacy, Security, Enforcement and Breach Notification rules were modified by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act") and the Genetic Information Nondiscrimination Act of 2008 ("GINA") (collectively referred to as the "HIPAA Omnibus Rules" or "HIPAA Rules"). These modifications were effective on or after March 26, 2013.

The following definition of PHI shall apply for purposes of compliance with all HIPAA Omnibus Rules and HIPAA regulations:

a. PHI is information that is created or received by the Plan and relates to the past, present, or future:

   i. physical or mental health condition of a Covered Person;

   ii. provision of health care to a Covered Person;

   iii. payment for the provision of health care to a Covered Person;

   iv. identification of the Covered Person; or

   v. belief that the information can be used to identify the Covered Person.

b. PHI may be created, received, maintained, or transmitted to or from the Plan according to the following methods:

   i. by electronic media;

   ii. in electronic media; or

   iii. in any other written or oral form or medium.

c. PHI excludes individually identifiable health information contained in:

i. education records covered by the Family Educational Rights and Privacy Act, as amended;

ii. medical records described at 20 U.S.C. 1232g(a)(4)(B)(iv);

iii. employment records held by a covered entity in its role as Employer; and

iv. records of a Covered Person who has been deceased for more than 50 years.

2. Permitted Uses of Protected Health Information-Payment

The Plan will use and disclose PHI for purposes related to payment, health care treatment, and health care operations. For this purpose, payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These payment activities include, but are not limited to, the following:

a. determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, plan maximums, and co-payments as determined for an individual's claim);

b. coordination of benefits;

c. adjudication of health benefit claims (including appeals and other payment disputes);

d. subrogation of health benefit claims;

e. establishing employee contributions;

f. calculation of amounts due to risk adjustments or other factors;

g. billing, collection activities, and related health care data processing;

h. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participants' (and their authorized representatives') inquiries about payments;

i. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if necessary, in the future;

j. medical necessity reviews, or reviews of appropriateness of care or justification of charges;

k. utilization review, including pre-certification, preauthorization, concurrent review, and retrospective review; and

l. reimbursements to the Plan.

3. Health Care Operations

For purposes of determining uses or disclosures of PHI relating to health care operations, the term "health care operations" includes, but is not limited to, the following activities:

a. quality assessment;

b. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives; and related functions;

c. rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities;

d. underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

e. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

f. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

g. the Plan's management and general administrative activities, including, but not limited to:

i. management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;

ii. participant and provider service, including the provision of data analysis;

iii. resolution of internal grievances; and

iv. filing of governmental forms, including Internal Revenue Service Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code.

v. For "research" purposes, defined by current HIPAA Omnibus Rules and regulations as a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge. An Employer may use or disclose PHI which has been appropriately de-identified according to HIPAA regulations for research purposes.

The Plan will use and disclose PHI for administrative purposes, only as required by law and permitted by authorization of Covered Persons or their beneficiaries. The Plan will disclose PHI to other related benefit plans which may provide retirement and/or disability benefits to a Covered Person or beneficiary, but only upon written authorization from such Covered Person and the execution of a Business Associate Agreement by such benefit plan. Such uses and disclosures will be made for purposes solely related to administration of the Plan.

4. Permitted Uses and Disclosure of Summary Health Information.

The Plan (or a health insurance issuer) may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of:

a. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

b. modifying, amending, interpreting, or terminating the Plan.

For this purpose, the term "Summary Health Information" means information that:

i. summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan; and

ii. has been de-identified in accordance with the HIPAA Omnibus Rules.

5. Activities That Require Permission for Use or Disclosure of Protected Health Information.

In accordance with rules promulgated by the HIPAA Omnibus Rules, the Plan must have the express written permission/authorization of any Covered Persons (or their beneficiaries) to use or disclose PHI to engage in the following activities:

i. the use or transmission of psychotherapy notes related to the treatment of any Covered Person;

ii. the use of PHI when the Plan receives financial remuneration from a third party for communications regarding treatment and health care, when that third party is marketing its product or service to the Plan or Eligible Employees;

iii. the sale of PHI for any reason; or

iv. activities which are not specified or described in the Plan.

Covered Persons who wish to provide written permission/authorization to the Plan to use or disclose PHI for such activities may obtain permission/authorization forms from the Fund Office. In addition, Covered Persons may revoke such express written permission/authorization at any time by contacting the Fund Office and executing an updated form.

6. Use of Genetic Protected Health Information Prohibited.

In accordance with regulations under GINA, the Plan is prohibited from using any Covered Person's "genetic information" for any underwriting purposes. Genetic information includes manifestations of diseases or disorders that have appeared in a Covered Person's family history but have not appeared in the Covered Person's health record.

7. Disclosure Restrictions on Protected Health Information for Health Care Expenses Paid in Full by Covered Persons.

In accordance with regulations under HITECH, a Covered Person has the right to restrict disclosures of his or her PHI to the Plan when the Covered Person pays out of pocket, in full, for any health care item or service.

8. Opting Out of Fundraising Activities Involving Protected Health Information.

All Covered Persons have the right to opt out of fundraising activities sponsored by, or engaged in, by the Plan Sponsor which involve the use of PHI. However, the Plan Sponsor may include the use of demographic information, health insurance status, or dates of health care for Covered Persons in order to raise money for a non-profit organization or charity.

The Plan Sponsor shall include a reminder of a Covered Person's rights and methods to opt out fundraising activities whenever the Plan Sponsor sends fundraising communications.

9. Protected Health Information Breaches Required to be Disclosed under HIPAA Regulations.

The Board of Trustees shall report to the Plan any breach of PHI of which it becomes aware. All Covered Persons will receive a detailed written explanation whenever an event occurs that results in a breach of unsecured PHI. For this purpose, the term "breach" means the acquisition, access, use, or disclosure of PHI in a manner which is prohibited by HIPAA regulations and

which compromises the security or privacy of PHI. The impermissible use or disclosure of PHI is presumed to be a breach unless the Plan Sponsor or Business Associate specifically demonstrates that there is a low probability that PHI has been comprised.

10. Covered Person's Right to Receive Protected Health Information from the Plan Sponsor.

All Covered Persons have the right to obtain a copy of their PHI from the Plan Sponsor in electronic or hardcopy format. To obtain this information, a Covered Person must make a written request to the Fund Office.

11. Conditions of Disclosure for Plan Administration Purposes.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions, provided that such information has been de-identified in accordance with the HIPAA Omnibus Rules) disclosed to it by the Plan (or a health insurance issuer), the Plan Sponsor shall:

a. not use or further disclose PHI, other than as permitted or required by plan documents, privacy notices, Business Associate Agreements, or as required by current laws and regulations;

b. ensure that any Business Associates, providers, agents or plan representatives, to whom the Board of Trustees provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information by executing written Business Associate Agreements;

c. not use or disclose PHI for employment-related actions and decisions unless authorized by Covered Persons or their beneficiaries;

d. not use or disclose PHI in connection with any other benefit or employee benefit plan unless authorized by the Covered Persons or as otherwise specifically provided herein;

e. report to the Plan and Covered Persons any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Omnibus Rules of which it becomes aware;

f. make PHI available to a Covered Person in accordance with the current access requirements of the HIPAA Omnibus Rules;

g. make PHI available to a Covered Persons to permit the individual affected by such information to make amendments to such PHI in accordance with the HIPAA Omnibus Rule;

h. make available the PHI required to provide an accounting of PHI disclosures in accordance with the HIPAA Omnibus Rules;

i. make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the United States Department of Health and Human Services ("HHS") for the purposes of determining compliance by the Plan with the HIPAA Omnibus Rules and regulations;

j. if feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which permissible disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

k. implement administrative, physical, and technical safeguards that reasonably de-identifies and appropriately protects the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan; and provide for adequate separation, which is supported by reasonable and appropriate security measures between the Plan and the Board of Trustees, as set forth below.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions, provided that such information has been de-identified accordance with the HIPAA Omnibus Rules) on behalf of the covered entity, the Board of Trustees shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. Further, the Plan Sponsor shall ensure that any agents, Business Associates (including subcontractors) to whom it provides such electronic PHI agree to implement similar safeguards, using reasonable and appropriate security measures to de-identify or otherwise protect the information. For these purposes, "electronic PHI" means any PHI that is transmitted by, or maintained in, electronic media.

12. Business Associate Agreements

Any contract between the Plan and a Business Associate must be set forth in a Business Associate Agreement that complies with the requirements of the HIPAA Omnibus Rules. For this purpose, the term "Business Associate" means a person or entity that performs certain functions or activities on behalf of, or that provides certain services to, the Plan involving access by the Business Associate to PHI. The term "Business Associate" also includes a subcontractor that creates, receives, maintains, or transmits PHI on behalf of another Business Associate.

Functions and activities that are performed by a Business Associate include the following:

1. claims processing or administration;
2. data analysis, processing, or administration;

3. utilization review;
4. quality assurance; billing;
5. benefit management;
6. practice management; and
7. repricing.

Services that are performed by a Business Associate include the following:

1. legal services;
2. actuarial services;
3. accounting services;
4. consulting services;
5. data aggregation;
6. management;
7. administrative services;
8. accreditation; and
9. financial services.

For purposes of compliance with the HIPAA Omnibus Rules, the term "Business Associate Agreement" means a contract between the Plan and a Business Associate that satisfies the requirements of the HIPAA Omnibus Rules, including the following:

1. establishes the permitted and required uses of PHI by the Business Associate;

2. provides that the Business Associate will not use or further disclose the PHI other than as permitted or required by the Business Associate Agreement or as required by law;

3. requires the Business Associate to use appropriate safeguards to prevent a use or disclosure of PHI other than as provided for by the Business Associate Agreement;

4. requires the Business Associate to report to the Plan any use or disclosure of the information not provided for by its Business Associate Agreement, including incidents that constitute breaches of unsecured PHI;

5. requires the Business Associate to disclose PHI as specified in its contract to satisfy a Plan's obligation with respect to individuals' requests for copies of their PHI, as well as make available PHI for amendments (and incorporate any amendments, if required) and accountings;

6. to the extent the Business Associate is to carry out a Plan's obligation under HIPAA, requires the Business Associate to comply with the requirements applicable to the obligation;

7. requires the Business Associate to make available to HHS the Business Associate's internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, the Plan for purposes of allowing HHS to assess the Plan's compliance with the HIPAA's privacy requirements;

8. at termination of the contract, if feasible, requires the Business Associate to return or destroy all PHI received from, or created or received by the Business Associate on behalf of, the Plan;

9. requires the Business Associate to ensure that any subcontractors it may engage on its behalf that will have access to PHI agree to the same restrictions and conditions that apply to the Business Associate with respect to such information; and

10. authorizes termination of the contract by the Plan if the Business Associate violates a material term of the contract.

Contracts between Business Associates and Business Associates that are subcontractors are subject to the same requirements under the HIPAA Omnibus Rules as contracts between the Plan and Business Associates.

13. Persons Entitled to Access to Protected Health Information.

In accordance with the HIPAA Omnibus Rules, only the following employees or classes of employees may be given access to PHI:

1. the Plan's Administrative Manager;

2. staff designated by the Plan's Administrative Manager, Investment Manager, or other approved Business Associates; and

3. members of the Board of Trustees and the Plan's legal counsel.

These persons may have access to and use and disclose PHI only for plan administration functions that are performed on behalf of the Plan. If these persons do not comply with the Plan's limitation on the use of PHI, the Board of Trustees shall provide for the resolution of issues of noncompliance, including notifying Covered Persons in writing and imposing disciplinary sanctions.

14. Adequate Separation between Plan and Plan Sponsor.

The Plan Sponsor will allow third party service providers' access to PHI, subject to the Business Associate Agreement restrictions under Section K. above. No other persons shall have access to PHI. These specified individuals or entities shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these service providers fail to comply with the Business Associate

Agreement restrictions under Section K. above, such service provider shall be subject to termination pursuant to the Business Associate Agreement in place.

The Plan Sponsor shall ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

15. Certification of Plan Sponsor.

The Plan (or a health insurance issuer) will disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate applicable provisions of HIPAA, and that the Plan Sponsor agrees to the conditions of disclosure set forth in J. above.

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA, 45 C.F.R. 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 (a) that it receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (b) that qualifies as Summary Health Information and that it receives for the purpose of either (i) obtaining premium bids for providing health insurance coverage under the Plan, or (ii) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated in this Summary 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 will, in accordance with the Security Regulations, take the following measures:

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 that the Plan Sponsor will use ePHI only for activities related to the Plan's administration and not for employment-related actions or for any purpose unrelated to the Plan's 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 or the Plan's provisions regarding such policies and procedures is subject to the Plan's disciplinary procedure.

3. Ensure that 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.

Effective February 17, 2010, the Plan and the Plan Sponsor will take the measures necessary to comply with the requirements of the HITECH Act and regulations issued by HHS implementing the HITECH Act. These measures include the following:

1. Modify and expand existing HIPAA privacy and security rules to protect PHI.

2. Comply with breach notification procedures that require the Plan Sponsor to notify an individual and HHS (and a prominent media outlet in any breach affecting more than500 individuals in a state or jurisdiction) when there is a breach of unsecured PHI that affects such individual. For this purpose, "unsecured PHI" is PHI that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technology or methodology specified in guidance issued by HHS.

3. Disclose expanded information to any individual who requests an accounting of PHI disclosures.

V. DENTAL CARE BENEFITS

A. ELIGIBLE PERSONS

Dental Care Benefits are payable for Eligible Persons and dependents, subject to the conditions of this section.

B. ELIGIBILITY

In order to become eligible for Dental Benefits, a person must qualify under the eligibility requirements as set forth in this Health and Welfare Plan.

C. TERMINATION OF COVERAGE

Upon termination of eligibility, benefits will cease on the last day of the month in which eligibility terminated. Eligibility and benefits shall terminate immediately in the event of termination of this Dental Care Benefit Program.

D. DENTAL DEFINITIONS

1. "Active Treatment" means the treatment of adjusting an Orthodontic appliance to apply effective force to the teeth or jaws.

2. "Benefit Verification" means the method by which the Plan determines Covered Services and benefits that will be provided for a proposed service or Course of Treatment. For further information see How Claims are Paid section.

3. "Billed Charges" means charges for all services and supplies that the Covered Person has received from the Dental Provider, whether they are a Covered Service or not.

4. "Calendar Year" means, with respect to the Plan and the Trustees, the period commencing at 12:01 a.m., standard time on January 1, and terminating on December 31 at 12:00 midnight. The Individual Calendar Year means any year (as described in the preceding sentence), or any portion thereof, during which the person has satisfied the eligibility requirements.

5. "Clinically Necessary" (Clinical Necessity) means a service or supply that is required to diagnose or treat a Condition and which the Plan determines is:

   a. Appropriate with regard to the standards of good dental practice;

   b. Not primarily for your convenience or the convenience of a Dental Provider; and

   c. The most appropriate supply or level of service which can be safely provided to you.

6. "Coinsurance" means a percentage of the Fee Schedule amount for Covered Services for which you are responsible after you have met your Deductible.

7. "Complex Services" means inlays, onlays, crowns, dentures and prosthetics.

8. "Course of Treatment" means a planned series of procedures or treatments

9. "Dentist" means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry and who treats diseases and injuries to the teeth and oral cavity.

10. "Dental Hygienist" means a person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene, and who works under the supervision and direction of a Dentist.

11. "Eligible Dental Expenses" means those reasonable expenses actually incurred commencing after the effective date of eligibility of the Eligible Person that are covered by the Plan and are incurred for treatment of any dental disease or defect. Such treatment must be rendered by a Dentist and reported by him on a Treatment Plan.

12. "Emergency Palliative Treatment" means treatment given in response to painful or dangerous situation to relive pain and remove a person from immediate danger without rendering definitive treatment (such as a filling).

13. "Essential Services" means x-rays such as panoramic/full mouth, periapical, cephalometric, occlusal and extraoral, fillings, periodontal services, endodontic services, extractions, impactions and root removals, oral or dental Surgery and related anesthesia, alveolectomy, vestibuloplasty and repairing and relining or prosthetics.

14. "Excess Charges" means the amount of Billed Charges less Non-Covered Charges in excess of the Fee Schedule Amount for a Non-PPO Network Provider (also referred to as patient liability).

15. "Fee Schedule Amount" means the maximum dollar allowance for Covered Services that PPO Network Providers have agreed to accept as payment in full. Non-PPO Network Providers will also be reimbursed based on the Fee Schedule Amount.

16. "Incurred" means rendered to you by a Dental Provider.

17. "Lesser Amount" means for PPO Network Providers, the Lesser of the Negotiated Amount or the Covered Charges and for Non-PPO Network Providers, the Fee Schedule Amount.

18. "Maximum Amount Payable" means the aggregate amount payable for Eligible Dental Expenses incurred during any one (1) calendar year for Routine Oral Examination Benefits, Basic Dental Benefits, or any combination thereof, while coverage under the Plan is in effect for the Eligible Person. In no event shall the Maximum Amount Payable for all benefits for any one (1) calendar year be in excess of the applicable "Per Person" amount as stated in the Schedule of Benefits.

19. "Negotiated Amount" – means the amount the Provider has agreed with the Plan to accept as payment in full for Covered Services.

20. "Non-PPO Network Provider" means a Dentist which is not designated by the Plan as a PPO Network Provider.

21. "Orthodontics" means the specialty and practice of preventing and correcting irregularities of the teeth, as by braces.

22. "Pediatric Oral Care" means oral care and services provided to Eligible Dependents from birth to age nineteen.

23. "Periodontal Services" means procedures including examination, diagnosis and treatment (including Surgery) of disease affecting the surrounding and supporting tissues of the teeth.

24. "Plan Month" means any calendar month.

25. "PPO Network Provider" means a Dentist designated by the Plan as a PPO Network Provider.

26. "Retention Treatment" means the period of Orthodontic treatment during which the individual is wearing an appliance to maintain the teeth in position.

27. "Routine Preventive Services" means oral evaluations, bitewing x-rays, topical fluoride applications, prophylaxis, and space maintainers.

28. "Surgery" means:

    a. The performance of generally accepted operative and other invasive procedures of the teeth, bone, and soft tissue of the oral structures;

b. Referring specifically to the operative/cutting procedure of the teeth, bone and soft tissue of the oral structures, which are considered within the scope or practice by the provider's license and specialty and/or as determined by the State Dental Board;

c. Utilized to correct pathology as a result of decay, fracture, damage, loss, and infection that would necessitate tissue removal, prosthesis placement, placement of dental materials and/or tissue architecture modifications;

d. Usual and related preoperative and postoperative care; or

e. Other procedure as reasonably approved by the Plan.

29. "Treatment Plan" means a written report showing the recommended treatment of any dental disease or defect prepared by a Dentist for the Eligible Person as a result of any examination made by such Dentist while coverage under the Plan is in effect for such Eligible Person.

E. CARRY-OVER PROVISION

There shall be no carry-over provision under the Dental Care Plan and claims will only be paid based on the date of service as rendered.

F. DESCRIPTION OF DENTAL PLAN BENEFITS

Subject to the Exclusions and Limitations described below, the following is a description of dental services covered by the Plan when rendered by a Dentist and when necessary and customary, as determined by the standards of generally accepted dental practice.

a. **Preventative**. Procedures to prevent the occurrence of oral disease. These services include: oral examinations, prophylaxis (cleaning) four (4) times per calendar year; Topical application of fluoride solutions, diagnostic casts, Emergency (Palliative) treatment, space maintainers, and sealants when necessary.

b. **Diagnostic**. Procedures to assist the Dentist in evaluating the existing condition to determine the required covered dental treatment. Such procedures under this Plan shall mean x-rays, tests, and laboratory examinations.

c. **Oral Surgery.** Procedures for extractions, including pre- and post-operative care.

d. **Restorative Fillings**. Procedures to restore the teeth with amalgam and composite restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay); including fillings placed after a nerve is removed from a tooth.

e. **Cast Restorations**. Cast restorations which include crowns, jackets, inlays, onlays and other cast restorations when fillings cannot be used to restore teeth satisfactorily.

f. **Endodontics**. Procedures for pulpal therapy and root canal filling (treatment of non-vital teeth).

g. **Periodontics**. Procedures for treatment of the tissues supporting the teeth.

h. **Prosthodontics**. Includes bridges, partials and complete dentures.

i. **Orthodontics**. The necessary procedures for the correction of malposed teeth.

G. EXCLUSIONS

No benefits will be paid for:

1. Services for injuries or conditions which are compensable under any Workers' Compensation or Employer's Liability Laws or which are provided the covered person by any Federal or State government agency or are provided without cost to the covered person by any municipality, or county or other political subdivision, or community agency.

2. Services with respect to hereditary, congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons including, but not limited to: cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, facings posterior to first molar, and bleaching of teeth.

3. General anesthesia, or analgesia other than when administered in conjunction with oral surgery.

4. Prescribed drugs or premedication.

5. Oral hygiene instruction, dietary instruction, and sterilization fees.

6. Plaque control programs.

7. Myofunctional therapy.

8. Treatment for disturbances of the Temporomandibular Joint (jaw joint).

9. Experimental procedures.

10. Procedures, appliances or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, restoration of tooth structure lost from attrition, occlusal and anesthesia charges.

11. Hospital costs and any additional fees charged by the Dentist for Hospital treatment.

12. Extra oral grafts (grafting of tissues from outside the mouth to the oral tissues).

13. Services, treatment or supplies received from a dental or medical department maintained by the Trustees, a mutual benefit association, labor union, Trustee or other similar group.

14. Services, treatment or supplies which are payable or furnished under any other group or individual insurance coverage with this Fund or any other insurance company, or Hospital, surgical or medical benefit plan or service plan, for which the Trustees shall directly or indirectly, have paid for all or a portion of the cost or made payroll deductions, or any federal or state government plan or law.

15. Services or treatment rendered or supplies furnished primarily for cosmetic purposes.

H. LIMITATIONS

1. **Preventative:** Prophylaxis, including periodontal prophylaxis, is a covered benefit no more than four (4) times per person in each calendar year.

2. **Diagnostic X-Rays and Examinations:** Panoramic and/or complete mouth x-rays are covered benefits only once in a three (3) year period, unless special need is shown. Supplementary bitewing x-rays and examinations are covered benefits not more often than four (4) times per person in each calendar year, unless special need is shown. Periodic oral examinations are covered benefits no more than four (4) times per person in a calendar year.

   Subject to the Exclusions and Limitations set forth, the following benefits are provided:

   a. **Diagnostic Services**

      If you receive Covered Services from a Delta Dental PPO Dentist or a Delta Dental Premier Dentist, 100% is paid for by the Plan.

      If you receive Covered Services from a Non-Participating Dentist, 80% of Delta Dental's Non-Participating Dentist Fee that will be paid for those services. The Non-Participating Dentist Fee may be less than what your dentist charges, which means you, will be responsible for the difference.

b. **Preventive Services**

If you receive Covered Services from a Delta Dental PPO Dentist or a Delta Dental Premier Dentist, 100% is paid for by the Plan.

If you receive Covered Services from a Non-Participating Dentist, 80% of Delta Dental's Non-Participating Dentist Fee will be paid for those services. The Non-Participating Dentist Fee may be less than what your dentist charges, which means you, will be responsible for the difference.

3. Oral Surgery

If you receive oral surgery services from a Delta Dental PPO Dentist, 85% is paid for by the Plan

If you receive oral surgery services from a Delta Dental Premier Dentist, 80% is paid for by the Plan.

If you receive oral surgery services from a Non-Participating Dentist, 80% of Delta Dental's Non-Participating Dentist Fee will be paid for those services. The Non-Participating Dentist Fee may be less than what your dentist charges, which means you, will be responsible for the difference.

4. Restorative, Endodontic, And Periodontic Services

If you receive restorative, endodontic, or periodontic services from a Delta Dental PPO Dentist, 85% is paid for by the Plan

If you receive restorative, endodontic, or periodontic services from a Delta Dental Premier Dentist, 60% is paid for by the Plan.

If you receive restorative, endodontic, or periodontic services from a Non-Participating Dentist, 50% of Delta Dental's Non-Participating Dentist Fee will be paid for those services. The Non-Participating Dentist Fee may be less than what your dentist charges, which means you, will be responsible for the difference.

5. Prosthodontic Services

If you receive prosthodontic services from a Delta Dental PPO Dentist, 60% is paid for by the Plan.

If you receive prosthodontic services from a Delta Dental Premier Dentist, 50% is paid for by the Plan.

If you receive prosthodontic services from a Non-Participating Dentist, 50% of Delta Dental's Non-Participating Dentist Fee will be paid for those services. The Non-Participating Dentist Fee may be less than what your dentist charges, which means you, will be responsible for the difference.

6. Annual Maximum

The maximum amount payable by the Plan for covered services received from a Delta Dental PPO Dentist is $1,500 per person total per calendar year on Basic and Major Services

The maximum amount payable by the Plan for covered services received from a Delta Dental Premier Dentist is $1,250 per person total per calendar year on Basic and Major Services.

The maximum amount payable by the Plan for covered services received from a Non-Participating Dentist is $1,000 per person total per calendar year on Basic and Major Services.

However, no annual maximum applies to Pediatric Oral Care covered under the Plan.

7. Lifetime Maximum on Periodontal Surgery

The maximum amount payable by the Plan for covered services for Periodontal Surgery is $3,000 per person.

8. Orthodontic Benefits

Orthodontic benefits are limited to Eligible Dependent children from birth to age 19 for those receiving services from a Delta Dental PPO Dentist or a Delta Dental Premier Dentist and from birth to age 18 for those receiving services from a Non-Participating Dentist.

I. ALTERNATE COURSES OF TREATMENT

Due to the element of choice involved in the utilization of many dental services, situations frequently arise where there are two (2) or more alternate methods of treatment for a dental condition. In these situations, the amount included as Covered Dental Expenses will be determined in the following manner:

If alternate services may be used to treat a dental condition, covered Dental Expenses will be limited to the reasonable and customary charge for that service which is customarily employed nationwide in the treatment of the condition, and is recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice taking into account the total current oral condition of the Eligible Person.

The purpose of this provision is to define the level of dental care which benefits are based when alternate methods of treatment may be used. The Eligible Person and his dentist may choose a more expensive level of care, but benefits will be payable in accordance with the above provision regardless of the method of treatment used.

J. PRE-TREATMENT REVIEW

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of $100.00 or more, a description of the procedures to be performed, including x-rays and an estimate of the dentist's charges can be filed with Delta Dental, prior to the commencement of the course of treatment.

Delta Dental will notify the dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desires result. The amount included as certified dental expenses will be the appropriate amount as provided herein, determined in accordance with the limitations set forth herein.

K. COORDINATION AND NON-DUPLICATION OF BENEFITS

All Coordination and Non-Duplication of Benefits provisions of the Plan shall apply to the Dental Care Benefits Program.

VI. VISION CARE PROGRAM

A. ADMINISTRATOR:

Vision Service Providers (VSP)

B. PLAN DESCRIPTION:

See the Vision Benefit Summary in Article II, Section B above for a description of Plan benefits.

C. COVERED VISION SERVICES

1. **Vision Examination** - The examination includes a determination of the need for correction of visual acuity, prescribing the lenses, if needed, and confirmation of the appropriateness of any visual aids obtained from the prescription. The vision examination includes the following procedures:
   a. History
   b. Evaluation of visual acuity for eyeglasses
   c. External examination of the eyes
   d. Binocular measure
   e. Ophthalmoscopic examination
   f. Tonometry (glaucoma check)
   g. Summary and findings

h. Dilation when indicated

2. **Contact Lens Examination** - Up to $40. Contact lenses are in lieu of spectacle lenses and frame

D. SERVICES PERFORMED

If you need an examination, please call a provider within the VSP Network. To find a provider, visit www.vsp.com or call 1-800-877-7195.

a. Eye Doctors. Eye doctors are available at each location to serve a wide range of your needs, from standard eyeglass exams and glaucoma checks to specialized contact lens examination and fittings. Please call for an appointment.

b. Opticians. Licensed opticians fill all your eyewear prescription needs. They are trained for expert fitting of eyeglasses and contact lenses. No appointment is necessary if you have a prescription.

E. HOW TO OBTAIN REIMBURSEMENT CLAIM FORM

Members may elect to receive services outside the network. Members will be reimbursed up to the maximums listed, in accordance with the OUTSIDE AREA or OUT-OF-NETWORK provisions of the agreement. Please call or write VSP to obtain a reimbursement claim form. The claim form must be completed and signed by the employee and/or dependent. Have your doctor and/or optician sign in the appropriate area of the form and attach originals of all receipts and submit to the VSP office listed below. Please make photocopies of all documents for your records.

F. PROGRAM EXCLUSIONS

No benefits are payable for:

1. Lenses not requiring a prescription.
2. Anti-reflection or CRT coated lenses.
3. Medical surgical treatment of eyes.
4. Drugs or medication not administered for the purpose of a vision testing examination.
5. Special or unusual procedures, such as orthoptics, perimetry, tonography, vision training, sub-normal vision aids, aniseikonic lenses, disease or injury of the eye.
6. Replacement of lost eyewear.

7. Payment to medical doctors.

8. Charges for rimless mounting, faceting or edge polishing.

9. Lenses of a type or style not listed.

10. Contact lens examination fees to the extent that they exceed the plan's benefit allowance.

11. All sales taxes on materials or services not covered by this program.

G. NON-COVERED OPTIONS

1. Because of the cosmetic nature of eyewear, the Eligible Person may select lenses and/or frames that include options not provided for under "Covered Vision Services". Frames or contact lenses exceeding the maximum allowance are considered an option. The Eligible Person will pay the difference between the actual cost and the maximum allowable benefit.

2. Additional vision examination services; i.e., contact lens examinations and follow-up care, are not covered and are the responsibility of the Eligible Person.

H. I.B.E.W. LOCAL NO. 38 H&W FUND AUTHORIZATION

All VSP network providers will maintain the Union member and dependent eligibility details necessary for administering optical services and products pertinent to the Vision Care Plan.

Plan participants seeking services from a VSP provider need to identify themselves as the principal subscriber (Union Member) or as a dependent of the subscriber. A driver's license or Social Security card can be used for identification.

If you need an examination, please call a network provider for an appointment.

VII. VEBA BENEFITS FOR INSIDE & TELEDATA ELECTRICIANS ONLY

A. VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION BENEFIT

The Voluntary Employee Beneficiary Association (VEBA) Benefit, established effective May 1, 2014, creates a Health Reimbursement Account (HRA) for eligible participants. The following participants are eligible for the VEBA Benefit:

- participants working under the Inside Electricians Collective Bargaining Agreement;

- participants working under the Teledata Collective Bargaining Agreement;
- participants working under another collective bargaining agreement providing additional hourly contributions into the Health & Welfare Plan for the purposes of funding the VEBA Benefit; or
- participant working under another participant agreement with the Fund providing for additional hourly contribution into the Health & Welfare Plan for purposes of funding the VEBA Benefit.

Participants working under the Residential Electricians Collective Bargaining Agreement are not eligible for the VEBA benefit. The individual VEBA Account will be maintained for the purpose of providing reimbursement for medical expenses not covered elsewhere under the Health & Welfare Plan, and the payment of employee self-contributions and retiree premiums for continued healthcare coverage under the Plan. The VEBA is funded through Employer Contributions.

B. ELIGIBILITY FOR EMPLOYEES

1. Initial Eligibility: You are eligible to participate in the VEBA Plan if you meet all the following:

   a. You are an Employee receiving contributions under the Collective Bargaining Agreement for Inside Electricians, receiving contributions under the Collective Bargaining Agreement for Teledata Electricians (Residential Electricians are not eligible for this VEBA benefit), or working as an Employee under a Participation Agreement with the Plan Collective Bargaining Agreement with the Union that provides for the additional contribution necessary to fund the VEBA Benefit; and

   b. You have an individual VEBA Account balance; and

   c. You become eligible for medical coverage benefits under Article II, Section B of the Plan as of the time of the VEBA contribution or thereafter. If VEBA contributions are made to your VEBA Account prior to you becoming eligible for major medical coverage, you will not able to use such contributions until you do become eligible for major medical coverage under the Plan.

2. Continuation of Eligibility: You will continue to remain eligible for participation in the VEBA Plan so long as you have a balance in your individual VEBA Account and are an Employee. Once you become eligible for major medical coverage, you may use your VEBA Account for VEBA Account Benefits even if you subsequently lose eligibility for major medical coverage under the Plan. Once your individual VEBA Account is exhausted, no further benefits are payable.

3. Termination of Coverage: Your coverage under the VEBA Plan will end on the earlier of the following:

   a. The first day of the month following the twelve (12) consecutive month period during which your individual VEBA Account begins as $0 and remains to $0 for the duration of such period; or

   b. The day the VEBA Plan is terminated.

4. Reinstatement of Eligibility after Termination: If you terminate your coverage pursuant to subsection 3 above, your coverage will be reinstated when you again satisfy the requirements for initial eligibility in the same manner as a new Employee.

5. Military Service: Your eligibility to participate in the VEBA Plan will end on the day in which you are inducted, enrolled, or enlisted into the military services of this country other than for temporary service. However, any balance in your individual VEBA Account will be kept on the VEBA Plan's records and will be made available when you return from military service, provided you notify the Fund Office in writing that you are entering military service. You may, by written notice, request the Board of Trustees to freeze your eligibility and any balance in your individual VEBA Account at the end of the month you are inducted, enrolled, or enlisted into the military service of this country. Upon discharge from the military service and upon written notice to the Administrator within thirty (30) days of the discharge, your frozen eligibility will be reinstated, and the balance in your individual VEBA Account restored effective on the first (1^{st}) day of the month following the month in which you are discharged from military service. Your account will not be subject to forfeiture as set forth in paragraph 8 below while on Military Service.

6. Change of Eligibility Rules and Removal of VEBA Plan: The VEBA benefits set forth in this Article are not a vested benefit and are subject to change at any time and for any reason. You never have any vested right to the money accounted for in your VEBA Account. The Trustees in their sole discretion are empowered to change or amend the foregoing rules of eligibility or the benefits provided by the VEBA Plan at any time and for any reason, including the right to eliminate the VEBA Plan altogether.

7. Continuation of Group Health Insurance Coverage through Self-Payments: If you or an Eligible Dependent loses coverage by reason of a "qualifying event" under COBRA, including related regulations and amendments, you may use the funds in you individual VEBA Account to make self-payments to the Health & Welfare Plan in order to continue health coverage on a temporary basis. The rules governing the continuation of

your health insurance coverage are more fully described in Article III, Section F hereof.

8. Forfeiture of VEBA Account: If your VEBA Account balance is less than five hundred dollars ($500), your individual VEBA Account balance will be terminated and the fund absorbed by the Plan upon thirty-six (36) consecutive months of individual Account inactivity. For these purposes, inactivity occurs when you fail to receive contributions to the Plan on your behalf for any given month and also fail to seek any benefits under the Plan for that month.

9. Right to Opt-Out of VEBA Account: After termination of your medical coverage, you may not be entitled to a premium tax credit from the government for the purchase of health insurance from a health insurance exchange unless you permanently opt out of and waiver further reimbursements from your VEBA Account. Accordingly, upon termination of your coverage under the major medical Plan sponsored by the IBEW Local 38 Health and Welfare Fund, you are permitted to permanently opt-out and waiver future reimbursements from your VEBA Account. Please contact the Fund Administrator to obtain the necessary waiver form.

C. ELIGIBILITY FOR RETIRED EMPLOYEES

1. Eligibility Requirements for Retired Employees: If you retire, you may use the VEBA Account to pay for self-payments required to maintain coverage under this Plan or the IBEW Local No. 38 Health and Welfare Fund Medicare Advantage Plan for Retirees, Widows, and the Totally & Permanently Disabled ('the Medicare Advantage Plan"). Coverage under the VEBA Plan will continue until the amount of money in your individual VEBA Account is exhausted. If you exhaust the amount of money in your individual VEBA Account before retirement, you will not be eligible to participate unless you again satisfy the Employee eligibility requirements. You will be considered an Eligible Retiree and entitled to coverage under the VEBA Plan only if you meet the following requirements:

   a. You are retired from active employment; and

   b. You were eligible for Employee coverage under the VEBA Plan on the date you retired.

2. Retiree Benefits: The benefits provided to Eligible Retirees under the VEBA Plan shall be the same as the benefits provided to Eligible Employees. In addition to the benefits provided active Employees, Eligible Retirees can use their VEBA account to pay for continued self-pay coverage under the retiree plan.

3. No Vested Right to Retiree VEBA Benefits: The Trustees reserve the right, in their sole discretion, to change or eliminate retiree coverage including, but not limited to, the medical and/or VEBA Account benefits available to participants at any time and for any reason. Retired Employees do not have any vested rights in their individual VEBA Account or for continued coverage under the Plan.

4. Cancellation of Coverage: Coverage for Eligible Retirees shall be cancelled as of the earliest of:

   a. The date the Eligible Retiree's individual VEBA Account is reduced to zero;

   b. The date the VEBA Plan is terminated; or

   c. The date coverage for Eligible Retirees under the VEBA Plan is cancelled.

D. SURVIVING SPOUSE/ELIGIBLE DEPENDENT CONTINUATION

If you have any balance remaining in your individual Account, it shall be used, until such balance is depleted, to provide medical reimbursement benefits for your Surviving Spouse or, if no Surviving Spouse, your surviving Eligible Dependents at the time of your death. In order to your spouse to qualify for survivorship benefits under the VEBA Account, you must have been married to your Surviving Spouse for at least one (1) year prior to the date of your death.

Important Rules: Your Surviving Spouse or Eligible Dependents must apply to continue coverage within one-hundred eighty (180) days after your death! Therefore, make sure your Spouse and Eligible Dependents are aware of this benefit. Surviving Spouses can continue to seek reimbursement until he or she is deceased. If the Surviving Spouse remarries, reimbursements are limited to medical expenses for your Surviving Spouse and your Eligible Dependents.

An Eligible Dependent can continue to seek reimbursement from the funds remaining in your VEBA account after your death until either (a) the account is depleted, or (b) the individual no longer qualifies as an Eligible Dependent.

E. VEBA BENEFIT (REIMBURSABLE EXPENSES)

1. VEBA Account: Your VEBA Account balance will be funded by excess contributions to the Plan that commence with work hours on or after May 1, 2014. If a participant is traveling and working in another jurisdiction which reciprocates contributions back to the Plan, VEBA credit to a participant's individual VEBA Account will not be given for such hours worked unless the total contributed to the Plan is at least the amount set forth for contributions to the Health & Welfare Plan in the applicable

current IBEW Local 38 Inside Electricians or Teledata Electricians collective bargaining agreement.

2. Reimbursable Expenses: You are entitled to reimbursement from your individual VEBA Account for any expenses that (1) satisfy the definition of an eligible medical expense under Section 213(d) of the Internal Revenue Code and (2) are not eligible for reimbursement from any other health insurance plan or other insurance under which you, your Spouse, or Eligible Dependents are covered. The following is a list of common reimbursable medical expenses:

- Co-payments and co-insurance;
- Prescription drug co-payments;
- Expenses for Medical devices and equipment
- Feminine products

Helpful Tip: Each year the IRS produces a document called IRS Publication 502. This Publication lists medical expenses which qualify for the "medical expense" deduction under IRS Code Section 213(d). All the expenses listed in the Publication are eligible for reimbursement under this Plan. Some examples include medical, vision, dental, or prescription drug copayments, self-payments (both active and retiree), COBRA payments, and amounts that are applied to your deductible.

VIII. ADDITIONAL INFORMATION

A. NO GUARANTEE OF BENEFITS

All benefits under the Plan shall be payable through employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Fund can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for any other benefits against I.B.E.W. Local No. 38, NECA, any Employer or the Trustees.

B. AUTHORITY OF THE BOARD OF TRUSTEES

The Trustees have exclusive authority and discretion to determine an individual's eligibility for benefits under the Plan and the amount of such benefits; to require of participants, beneficiaries, dependents, service providers and other interested parties such information as may be necessary or appropriate to establish or confirm eligibility for benefits or the amount thereof or for the determination of any other matter that the Trustees may have before them; to determine or find facts that are relevant to any claim for benefits or to any other matter; to interpret all the provisions of the Plan, its related Trust Agreement, any applicable collective bargaining agreement, and any other document or instrument involving or impacting the Plan or its administration; and to amend or terminate the Plan and Fund, in whole or in part, at any time and

for any reason as they deem necessary to carry out the purposes and objectives of the Plan and its related Trust Agreement. Subject to the rights of appeal and review provided for in the Plan or in any policy, plan or program of an insurance carrier or company, health maintenance organization or similar entity or organization providing benefits under the Plan, all such determinations and interpretations made by the Trustees will be final and binding upon any person claiming benefits or other relief from or under the Plan and upon any other interested or affected party.

No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or the Trust Agreement. Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the claimant's right to legal action, be final and binding on all parties. No provision of this Plan shall be construed to conflict with any Treasury Department, Department of Labor or Internal Revenue Service regulation, ruling, release or proposed regulation or other legal authority which affects or could affect the terms of this Plan, and this Plan shall be deemed to be amended to such extent necessary to resolve any such conflict.

C. AMENDMENT OR TERMINATION OF PLAN

If the Plan is amended or terminated, active or retired participants or their Eligible Dependents may not receive benefits as described in this document. Participants or Eligible Dependents may be entitled to receive different benefits, or benefits under different conditions.

It is also possible that participants or Eligible Dependents will lose all benefit coverage. Loss of coverage may happen at any time, even after retirement, if the Trustees decide to terminate the Plan or the coverage of participants or Eligible Dependents under the Plan. In no event will any participant or retiree or Eligible Dependent become entitled to any vested rights under this Plan.

D. LEGAL ACTIONS

No action, at law or in equity, to recover benefits may be commenced or maintained against the Plan or the Trustees within sixty (60) days after the Plan Administrative Manager receives written proof in accordance with this Summary Plan Description that covered services or supplies have been given to you. Subject to the rules governing legal actions after the Trustees' decision on review under the Plan's appeal procedure, no action, at law or in equity, may be commenced or maintained against the Plan or the Trustees more than two (2) years after the Trustees' decision on review under the Plan's appeal procedure.

E. YOUR RIGHTS UNDER ERISA

As a participant in the I.B.E.W. Local No. 38 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a. Examine without charge, at the Fund Office and union hall, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as annual reports and plan descriptions.

b. Obtain copies of all plan documents and other plan information upon written request to the Fund Office. The Fund Office may make a reasonable charge for the copies.

c. Receive a summary of the Plan's financial report. The Fund Office is required by law to furnish each participant with a copy of the summary financial report each year.

d. File suit in federal court, if any materials requested are not received within 30 days of your request, unless the materials are not sent because of matters beyond the control of the Fund Office. The court may require the Fund Office to pay a fine for each day's delay until the materials are received.

2. Continue Group Health Coverage

You may continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan and the rules governing your COBRA continuation coverage rights.

You may qualify for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for twelve (12) months (18 months for late enrollees) after your enrollment date in your coverage.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union,

or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (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 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 United States 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.

5. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Office at (216) 431-7338. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. The nearest Area Office of the Employee Benefits Security Administration is the Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Fort Wright, Kentucky 41011 at (606) 578-4680.

F. NAME OF PLAN

I.B.E.W. Local No. 38 Health and Welfare Fund

G. NAMES AND ADDRESSES OF THE TRUSTEES

Union Trustees:

Michael Muzic
I.B.E.W. Local No. 38
1590 East 23rd Street
Cleveland, Ohio 44114

Dan Gallagher
I.B.E.W. Local No. 38
1590 East 23rd Street
Cleveland, Ohio 44114

Dan O'Connell
I.B.E.W. Local No. 38
1590 East 23rd Street
Cleveland, Ohio 44114

Management Trustees:

Thomas Shreves
N.E.C.A.
9050 Sweet Valley Drive
Valley View, Ohio 44125

Brian Arthur
G&B Electric Company
10343 Brecksville Road
Brecksville, Ohio 44141

David Haines
London Road Electric Company
16109 St. Clair Avenue
Cleveland, Ohio 44110-3097

H. TYPE OF WELFARE PLAN

The Plan is a self-funded employee welfare benefit plan administered by the Board of Trustees. The purpose of the Plan is to provide Hospitalization, surgical, medical, weekly disability, dental, vision, prescription drug supplemental unemployment, death and accidental death and dismemberment benefits, all as set forth in the Plan.

I. PLAN ADMINISTRATOR

Office Address:
I.B.E.W. Local No. 38 Health and Welfare Fund
3250 Euclid Ave. Rm #270
Cleveland, OH 44115

Mailing Address:
P.O. Box 6326
Cleveland, OH 44101-1326
Tel: (216) 431-7338
Fax: (216) 431-7719

J. AGENT FOR SERVICE OF LEGAL PROCESS

Board of Trustees
I.B.E.W. Local No. 38 Health and Welfare Fund
3250 Euclid Ave.
Cleveland, Ohio 44115

Service of legal process may also be made upon any individual Trustee or the Fund's administrative manager at the Fund Office.

K. LEGAL COUNSEL

Allotta | Farley Co., LPA
Preston Building
3240 Levis Commons Blvd.
Perrysburg, OH 43551

L. ELIGIBILITY

The Plan's requirements respecting eligibility for participation and the conditions pertaining to eligibility to receive benefits are contained in the "Eligibility Rules" provisions of this booklet.

M. SOURCE OF CONTRIBUTIONS TO THE PLAN

Contributions to the Plan are made by participating employers, working within the jurisdiction of the I.B.E.W. Local No. 38/NECA collective bargaining agreement on behalf of their covered employees or through reciprocity for work in other jurisdictions and in some instances by contributions made to the Plan by employees on their own behalf. The contribution rate is negotiated and set forth in the I.B.E.W. Local No. 38/NECA collective bargaining agreement. A copy of the collective bargaining agreement may be obtained from I.B.E.W. Local No. 38 or may be examined at the Fund Office during normal business hours. The name and address of any contributing employers is available from the Fund Office.

N. APPLICABLE LAWS

The provisions of the Plan are to be construed, administered, and enforced according to applicable federal laws and the laws of the State of Ohio.

O. MEDIUM FOR PROVIDING BENEFITS

The I.B.E.W. Local No. 38 Health and Welfare Fund is a self-insured Plan. Assets are accumulated and held in a trust account and benefits are provided from the assets of this trust account.

P. FISCAL YEAR

The Fund's fiscal year is May 1 of each year through April 30 of the following year.

Q. PLAN RECORDKEEPING METHOD

The records of the Plan are maintained on an accrual basis method of accounting, and marketable securities are carried at market value

R. EMPLOYER IDENTIFICATION NUMBER/PLAN NUMBER

EIN: 34-6529234

Plan No.: 501

This Summary Plan Description/Plan Document has been executed this ____ day of _____ 2022, to be effective May 1, 2022.

BOARD OF TRUSTEES
I.B.E.W. LOCAL 38 HEALTH AND WELFARE FUND

ON BEHALF OF UNION TRUSTEES:	**ON BEHALF OF EMPLOYER TRUSTEES:**
_____	_____
Michael Muzic, Chair	Thomas Shreves, Secretary