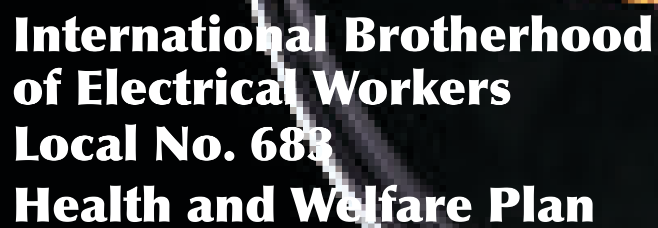

International Brotherhood of Electrical Workers Local No. 683 Health and Welfare Plan

SUMMARY PLAN DESCRIPTION 2020 EDITION

For Inside Journeyman Wireman

International Brotherhood of Electrical Workers
Local No. 683 Health and Welfare Plan
6525 Centurion Drive
Lansing, MI 48917-9275

Third Party Administrator – Fund Office
TIC International Corporation

Fund Counsel
Allotta Farley Company, L.P.A.

Fund Auditor
Bodine Perry LLC

Consultant and Actuary
Segal Consulting

Only the full Board of Trustees is authorized to interpret the Health and Welfare Plan. No other individual or organization, such as your Union or Employer, nor any Employee or representative of any individual or organization is authorized to interpret this Health and Welfare Plan or act as an agent of the Board of Trustees. Should you have any questions regarding the Health and Welfare Plan, please direct them to the Third Party Administrator.

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TO OUR PARTICIPANTS

The International Brotherhood of Electrical Workers Local No. 683 Health and Welfare Plan (hereinafter referred to as the "Health and Welfare Plan" or "Plan") is a welfare benefit plan that offers a wide range of benefits, including:

- Medical
- Prescription Drug
- Vision
- Dental
- Death
- Accidental Death and Dismemberment (AD&D)
- Weekly Disability

This Summary Plan Description (SPD) outlines the benefits available to you and your Eligible Dependents, effective as of January 1, 2020, based on your status under the Plan (Active Employee, Disabled Employee, Retired Employee, Surviving Spouse, or Eligible Dependent). This booklet replaces and supersedes any prior booklet.

The Plan is funded by Employer contributions and, under certain circumstances, self-payment contributions. It is not insured by an insurance company. In some instances, the Board of Trustees of the Plan has delegated administrative responsibilities to other organizations, but all benefits are paid from the Fund's assets.

In this booklet, we have tried to describe your benefits as completely as possible and in everyday language. We have also tried to organize the booklet in a way that will be useful to you. This booklet includes:

- A summary of the coverages provided by the Plan for Actives, Disabled Employees and Pre-Medicare-eligible Retirees (see the *Summary of Benefits* insert)
- A summary of the coverages provided by the Plan for Medicare-eligible Retired Employees (see the *Summary of Benefits* insert)
- A listing of important contact information (see the **Important Contact Information** insert)
- A **life events section** designed to show you how your benefits work and how they fit into the different stages of your life
- **Eligibility information** about when you and your dependents, if applicable, are eligible for coverage under the Plan
- An **explanation about your coverage** under each benefit program
- Information about **how to file claims**
- General **Plan administrative information**
- A **glossary** of important terms

We urge you to read the booklet and, if you are married, to share it with your Spouse. We recommend that you keep this booklet with your important papers so you can refer to it when needed.

Sincerely,

Board of Trustees

ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

ACTIVE BENEFIT PROGRAM

This section describes the eligibility requirements for Active Employees and defines dependents who are eligible for coverage under the Plan. For information on:

- Disabled Employee eligibility (see page 17)
- Retired Employee eligibility (see page 8)
- Surviving Spouse eligibility (see page 18)
- COBRA continuation coverage (see page 19)

Generally, you are eligible for benefits from the Fund if you work for an Employer that contributes on your behalf. Your eligibility (initial and continued) for coverage is based on a month system and is determined as described below.

When you become initially eligible for benefits, you will need to complete an enrollment form for you and your Eligible Dependents in order for your coverage to be effective. You may also be asked to provide appropriate documentation, such as a marriage certificate, birth certificate, or divorce decree, as applicable. If you fail to enroll your Eligible Dependents when you are initially eligible or fail to enroll them within 30 days of when they become eligible, they will not receive insurance cards, and their coverage may not be retroactively effective.

Initial Eligibility

You will be initially eligible and your coverage will begin on the first day of the second month following the month in which $1,329 in contributions have been received by the Third Party Administrator on your behalf from one or more participating Employers during a three consecutive month period.

Initial Eligibility Example: Pat began working for an Employer on April 1. By June 30, the Third Party Administrator had received $1,500 in Employer contributions on his behalf. Since Pat's contributions exceed $1,329, Pat is eligible for coverage as of August 1 (the first day of the second month following the month in which sufficient contributions were received by the Third Party Administrator on his behalf). The additional $171 ($1,500 - $1,329 = $171) of contributions received by the Fund is credited to Pat's Dollar Bank (see page 4).

Your Eligible Dependents who have enrolled will become covered on the same date as your initial eligibility of coverage, or on the date that you acquire a new Eligible Dependent, provided that you notify the Third Party Administrator within 30 days of your dependent's eligibility, whichever is later.

Continuing Eligibility

Your eligibility for coverage will continue on a month-by-month basis. As long as you are working in Covered Employment and have sufficient contributions made on your behalf to cover the monthly cost of coverage, your coverage will continue.

Your continuing eligibility is based on **Work Months** and **Benefit Months**, as follows:

Work Month Work performed during:	**Benefit Month** Determines your eligibility for:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Work Month

A calendar month during which Employer contributions are made to the Fund on your behalf for the hours you worked in that month.

Benefit Month

A calendar month during which you are eligible for benefits based on the Employer contributions made on your behalf during the corresponding Work Month.

In order for your coverage to continue for the next Benefit Month, you must continue to work in Covered Employment and your Employer must make sufficient contributions on your behalf in the corresponding Work Month to cover the monthly cost of coverage.

As of June 1, 2020, the monthly cost of coverage is $1,329 for Inside Journeyman Wireman. The monthly cost of coverage is determined by the Trustees based on the actual cost of providing benefits. The Trustees, in their sole discretion, reserve the right to modify this amount periodically. You will be notified in advance of any change in the monthly cost of coverage.

If contributions made on your behalf in a Work Month are:

- **Less than the monthly cost of coverage for the corresponding Benefit Month,** the additional amount needed will be deducted from your Dollar Bank, if available.
- **More than the monthly cost of coverage for the corresponding Benefit Month,** the additional amount will be credited to your Dollar Bank.

Continuing Eligibility Example: In June, Joe, who is currently eligible for coverage under the Plan, has only $835 in Employer contributions made on his behalf and, therefore, needs $494 more to be eligible for coverage in August. Because Joe has a credit of $1,500 in his Dollar Bank, he can maintain coverage by drawing on his Dollar Bank balance. To maintain Joe's coverage, the additional amount is deducted from his Dollar Bank, leaving him with a Dollar Bank balance of $1,006 ($1,500 - $494 = $1,006).

Dollar Bank

The Dollar Bank program is designed to help you accumulate contribution dollars. The more you work, the more your Dollar Bank may grow. Contributions that your Employer makes on your behalf are based on the number of hours you work each month and are credited to your Dollar Bank. You may accumulate a maximum balance of 12 months of coverage in your Dollar Bank (currently $15,948, based on a monthly cost of coverage of $1,329).

Note that if you have insufficient hours to maintain coverage under the Plan and an insufficient balance in your Dollar Bank, you must make self-payments to the Plan in order for you and your Eligible Dependents to remain covered. In such cases, your Eligible Dependent's coverage will end on the last day of the **Benefit Month** for which the last self-payments were made to the Plan on account of such Eligible Dependent to continue his or her eligibility for participation in the Plan in the next successive **Benefit Month** (except in situations in which the Participant dies).

Reciprocal Hours

If you are a Participant in this Plan and you are working in a jurisdiction other than the jurisdiction of IBEW Local 683, then you may be able to transfer the hourly contributions received on your behalf.

In order to have contributions transferred, you must enroll in the Electronic Reciprocal Transfer System ("ERTS") by completing an ERTS enrollment form at the IBEW Local 683 union hiring hall. Monies are transferred at a rate equal to the lesser of:

- The other local's rate of contribution for health and welfare benefits; or
- This Plan's hourly contribution rate.

For more information about ERTS, you may contact your Local Union or the Third Party Administrator.

You will be credited with contribution hours by dividing the amount of money received from the other local's fund by our Plan's current hourly contribution rate.

Self-Payment Contributions

If you are eligible to make self-payments to maintain coverage under the Plan, the amount of your payment will be the monthly cost of coverage minus the amount in your Dollar Bank plus any Employer Contributions made on your behalf. You will be allowed to make self-payments to the Plan in order to maintain coverage if:

- You have a permanent residence within the jurisdiction of the Fund, or are available for work in the jurisdiction by signing the Union's work referral list;
- You were eligible under the Plan, but you have not received sufficient Employer contributions to cover the monthly cost of coverage; and
- The amount credited to your Dollar Bank is insufficient to cover the monthly cost of coverage.

Self-pay Example: In September, Tom, who is currently eligible for coverage under the Plan, has only $435 in Employer contributions made on his behalf and, therefore, needs $894 more ($1,329 - $435 = $894) to remain eligible for coverage in November. His current Dollar Bank credit is $500, which leaves him $394 short ($1,329 - [$435 + $500] = $394) of the amount needed to maintain monthly coverage. To maintain coverage for November, Tom can make a self-payment of $394.

The maximum number of months for which you are allowed to make self-payments to maintain coverage is 24 consecutive months. This period includes any months during which you draw upon your Dollar Bank to maintain coverage.

Continuing Self-pay Example: In January 2019, Mike, who is currently eligible for coverage under the Plan, has only $235 in Employer contributions made on his behalf and thus needs $1,094 more ($1,329 - $235 = $1,094) to remain eligible for coverage. His current Dollar Bank credit is $14,384. To maintain Mike's coverage, the additional $1,094 is deducted from his Dollar Bank, leaving him with a Dollar Bank credit of $13,290 ($14,384 - $1,094 = $13,290). At the end of January 2019, Mike is laid off, and no Employer contributions are made on Mike's behalf until April 2020, when Mike returns to Covered Employment. Mike may maintain coverage for 10 additional months, from February 2019 through November 2019, by drawing down his Dollar Bank balance to $0 ($13,290/$1,329 = 10). Beginning in December 2019, he may continue to maintain coverage for up to 13 additional months, from December 2019 through December 2020, by timely making monthly self-payments of $1,329. His self-payment in December 2020 will be the last of his payments over 24 consecutive months, whether from his Dollar Bank or self-payments, aimed at providing him with continuing coverage. Beginning in January 2021, having reached the end of this 24 consecutive-month period, he will no longer be permitted to make monthly self-payments to maintain coverage.

Dependent Eligibility

Your Eligible Dependents become eligible for coverage on the same date you become eligible, or if later, on the date you acquire an Eligible Dependent. However, your Eligible Dependents are not eligible for Weekly Disability, Death, and AD&D Benefits.

Your Eligible Dependents are:

- Your Spouse, who is not divorced or legally separated from you.
- Your biological child(ren), through the end of the month in which the child turns age 26.
- Your adopted children as of—
  - the date of placement for adoption, or
  - the date of actual adoption,

  whichever occurs first, through the end of the month in which the child turns age 26. The Trustees may request a statement to verify a claim that an adopted child is an Eligible Dependent.
- Your stepchild who has been placed under your legal guardianship, through the end of the month in which the child turns age 26. To qualify as an Eligible Dependent, the stepchild must:
  - physically live in the same household as you on a daily basis at the time a claim is incurred and for at least six months prior to the date a claim is incurred; and
  - primarily rely on you for basic everyday needs.
- Any child for whom you have been ordered by a United States court or administrative agency of competent jurisdiction to provide medical coverage in accordance with the provisions of a Qualified Medical Child Support Order (QMCSO), even if the child is not in your custody or primarily relying on you for basic everyday needs.

- A child who has reached age 26 but is unmarried and incapable of self-sustaining employment because of intellectual disability or physical handicap is covered provided:
  - the incapacity began before the child attained age 26;
  - the child resides with you and is permanently and regularly dependent upon you for support; and
  - you provide satisfactory proof of the child's incapacity no later than 31 days after the child turns age 26.

The Trustees have the sole discretion to determine whether your Spouse or your child qualifies as an Eligible Dependent and to interpret the definition of the term "Eligible Dependent" under circumstances in which there is a possible ambiguity. The Trustees' determination concerning an individual's status as an Eligible Dependent will be final, binding and conclusive. If the Trustees, in their sole discretion, determine that a Dependent is fraudulently covered by this Plan, then the Plan will hold the Participant responsible for reimbursement of all benefits paid on that Dependent's behalf. The Trustees may request documentation as proof of eligibility.

When Eligibility Ends

When your coverage or your Eligible Dependent's coverage ends, you or they may be eligible to continue coverage by making monthly payments for COBRA continuation coverage (see page 19). In general, your and/or your Eligible Dependent's eligibility for coverage will end at midnight, 30 days after the Plan informs you, in writing, of your termination of coverage.

For You

Your eligibility for coverage will end at the earliest of the following events:

- The Plan's termination;
- Your entrance into military service on active duty (except for temporary active duty of four weeks or less);
- The cessation of your eligibility under the Plan; or
- Your employment by an Employer who is not obligated to make contributions to the Plan on your behalf.

For Your Eligible Dependent(s)

Your Eligible Dependent's eligibility for coverage will end at the earliest of the following events:

- The Plan's termination;
- Last day of the month in which your Eligible Dependent child reaches age 26;
- Their entrance into military service on active duty, unless you have elected continuation of coverage for them or coverage is otherwise required by the Uniformed Services Employment and Reemployment Rights Act of 1994; or
- The cessation of your eligibility under the Plan.

In the event of your death, your surviving Spouse may continue coverage for himself/herself and any Eligible Dependents under COBRA continuation coverage (see page 19).

Reinstating Your Eligibility

If your coverage ends, you may reinstate eligibility by again meeting the Plan's initial eligibility requirements (see page 2).

CHANGE IN COVERAGE DUE TO A CHANGE IN EMPLOYMENT CLASSIFICATION

If your employment classification changes to a classification which provides coverage that is different from the coverage in your current employment classification, the change in coverage becomes effective as of the first day of the calendar month immediately following the date on which contributions for 100 or more hours are paid on your behalf and are received by the Third Party Administrator after the change in your employment classification, provided that the Third Party Administrator is notified of the change in employment classification by the 15th day of the month prior to the month in which the change in coverage becomes effective.

If the Third Party Administrator is notified of the change in employment classification after the 15th day of the month prior to the month in which the change in coverage is to become effective, the change in coverage will be effective as of the first day of the second calendar month immediately following the date on which contributions for 100 or more hours are paid on your behalf and are received by the Third Party Administrator after the change in your employment classification.

RESCISSION OF COVERAGE

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact or material omission after the Plan provides you with 30 days' advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact or a material omission.

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan.

If your Spouse and/or Dependent(s) are covered under another group medical plan, you must report such other coverage to the Third Party Administrator, unless you decline coverage under this Plan. The amount of benefits payable under this Plan will be coordinated with such other coverage.

SPECIAL ENROLLMENT RIGHTS

Federal law requires that you be eligible to enroll if:

- You and/or your Eligible Dependent(s) decline coverage under this Plan because you have other health coverage and then you and/or your Eligible Dependents later lose the other health coverage;
- You and/or your Eligible Dependent(s) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you and/or your Eligible Dependent(s) lose eligibility for that coverage or become eligible for premium assistance through Medicaid or CHIP; or
- You acquire an Eligible Dependent through marriage, birth, legal guardianship/ custody/conservatorship, adoption, or placement for adoption.

To enroll, you must submit an enrollment form and request enrollment within 31 days after the qualifying event.

CHANGE OF ELIGIBILITY RULES AND BENEFITS

Over time, it may be necessary to change the eligibility rules and the benefits provided under the Plan. The Trustees, at their discretion, have the right to interpret, change, modify, or discontinue all or part of the eligibility rules or benefits provided, at any time, by written amendment to this SPD. Whenever policies (such as self-payment contribution rates, benefits provided, etc.) change, you will be notified of the changes and copies of the changes will be on file at the office of the Third Party Administrator.

RETIRED EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

Depending on your age and your Eligible Dependents' ages when you retire, you may have different options for coverage under the Plan.

THE RETIREE PROGRAM

When you retire, you remain eligible to receive the same benefits as when you were an Active Employee, except you are not eligible for a Weekly Disability benefit and your Death Benefit is reduced. Refer to the *Summary of Benefits* insert.

Eligibility Requirements for the Retiree Program

Early and Normal Retired Employee means an Employee who:

- Is at least age fifty-five (55) but under age sixty-five (65);
- Is not eligible for Medicare; and
- Is retired from the electrical industry.

You must meet **all** of the following rules of eligibility to participate in the Retiree Program:

- You are retired from the electrical industry and are no longer actively working;
- Your coverage under the Active Benefit Program has terminated;
- You were eligible under the Active Benefit Program at the time of your retirement;
- You had:
  - at least five years of continuous service immediately preceding your retirement; or
  - at least 30 years of service under the I.B.E.W. Local 683 Pension Fund Pension Plan or at least 30 years of participation in the I.B.E.W. Local 683 Profit Sharing Annuity Plan prior to your retirement, and you are a member in good standing with the Union.

Continuous Service Year

After the date you become a Participant in the Plan, the term "Continuous Service year" will mean any year after you become initially eligible in the Active program in which you work a minimum of 400 hours.

To participate in the Retiree Program, you must make monthly self-payments. The monthly self-payment amount will be determined by the Board of Trustees and can be obtained from the Third Party Administrator.

Electing Coverage Under the Retiree Program

If you qualify to participate in the Retiree Program, then you must elect coverage and make the required self-payments, within the first 60 days after the last month in which you were covered for benefits under the Plan. If you fail to do so, you **will not** be eligible for coverage at any time in the future.

If you elect to participate in the Retiree Program and your coverage in the Retiree Program is continuous, then you will be eligible for the Senior Retiree Program at the current premium established by the Plan upon reaching the age of 65.

THE DISABLED RETIREE PROGRAM

Eligibility Requirements for the Disabled Retiree Program

You will be eligible to participate in the Disabled Retiree Program if:

- You are retired from the electrical industry and are no longer actively working;
- Your coverage under the Active Benefit Program has terminated;
- You were eligible under the Plan's Active program at the time of your retirement;
- You had at least five years of continuous service immediately preceding your retirement;
- You were eligible to receive Social Security benefits, or you submit other proof of disability satisfactory to the Trustees; and
- At the 25th month of your disability, you enroll in and obtain coverage under Medicare Parts A and B.

If an application for Social Security benefits has been filed before the 25th month of disability but the claim is still pending at the Social Security Administration after the 25th month of disability, you may still be eligible to participate in the Disabled Retiree Program, so long as your claim is still pending a final determination. If the final determination on the application for Social Security Benefits is a denial of the claim by the Social Security Administration, then you will no longer be eligible to participate in the Disabled Retiree Program, and you will be notified that you may continue coverage at your own expense under the Plan's COBRA continuation coverage.

Disabled Retired Employee

An Employee who is Totally Disabled and receiving disability benefits under the Social Security System and receiving a pension benefit from a retirement plan in which Union members participate.

Disabled Retired Employees and their Eligible Dependents are eligible for benefits to the same extent as Active Employees except they are not entitled to Weekly Disability benefits and only receive reduced death benefits. Refer to the *Summary of Benefits* insert.

Electing Coverage Under the Disabled Retiree Program

If you qualify to participate in the Disabled Retiree Program, then you must:

- Elect coverage within the first 60 days after the last month in which you were covered for benefits under the Plan; and
- Make the required self-payments.

If you fail to do so, you **will not** be eligible for coverage in the Disabled Retiree Program or the Retiree Program at any time in the future.

If you elect to participate in the Disabled Retiree Program and your coverage is continuous, you will be eligible for the Senior Retiree Program at the current premium established by the Plan upon reaching age 65.

THE SENIOR RETIREE PROGRAM

Eligibility Requirements for the Senior Retiree Program

You will be eligible to participate in the Senior Retiree Program if:

- You are retired from the electrical industry and are no longer actively working;
- Your coverage under the Plan's Active Benefit Program has terminated;
- You were eligible under the Plan's Active program at the time of your retirement;
- You had at least five years of continuous service immediately preceding your retirement; and
- You are eligible to receive Medicare benefits and have submitted proof satisfactory to the Trustees that you have enrolled in and obtained coverage under Medicare Parts A and B.

Upon reaching the age of 65 and becoming eligible for Medicare, Retired Employees who participated in the Retiree Program and maintained continuous coverage in the Retiree Program will become eligible to participate in the Senior Retiree Program at the current premium established by the Plan. You and your dependent will be eligible for the same benefits applicable under the Retiree Program (see page 8)—and the same benefit exceptions will apply.

Electing Coverage Under the Senior Retiree Program

If you qualify to participate in the Senior Retiree Program, then you must:

- Elect coverage within the first 60 days after the last month in which you were covered for benefits under the Plan; and
- Make the required self-payments.

If you fail to elect coverage in the Senior Retiree Program within the applicable 60-day period or you do not timely make the required self-payments, you will not be eligible for coverage at any time in the future. In that event, you may continue coverage at your own expense under COBRA continuation coverage.

IF YOU ACTIVELY WORK

It is a condition to your coverage under the Retiree Programs that you not engage in or perform employment in the trade jurisdiction. The Board of Trustees, in its sole discretion, will determine if you are engaging in or performing employment in the trade jurisdiction.

If you return to active employment and become eligible for benefits under the Active Benefit Program, your coverage under any applicable Retiree Program will be terminated and you may again be entitled for coverage as an Active Participant.

CONTINUING YOUR COVERAGE

You will remain eligible to participate in the Retiree Programs as long as you:

- Remain in retired status;
- Make the necessary self-payments;
- Sign up for Medicare Part B (when you become eligible); or
- Until such time as the Trustees revoke the Retiree Programs.

If you are participating in the Disabled Retiree Program, you must continue to receive Social Security Benefits in order to continue your coverage under the Disabled Retiree Program.

RETIREE BENEFITS (FOR RETIREES ELIGIBLE FOR MEDICARE BENEFITS)

The Plan serves as gap coverage for expenses allowable but not paid by Medicare when those expenses are incurred by a retiree who is—

- Under age 65 and enrolled in Medicare Parts A and B; or
- Age 65 or older and enrolled in Medicare Parts A and B.

Under Medicare Part A, an individual is entitled to receive basic hospital insurance benefits. Under Medicare Part B, an individual is entitled to receive surgical and medical benefits. Regardless of your age, you will not be eligible to receive benefits under this Plan that supplement your Medicare benefits unless you have enrolled in Medicare Parts A and B.

If you are age 65 or older and are enrolled in Medicare Parts A and B, the Plan provides benefits as shown on the *Summary of Benefits*. If you are age 65 or older, you are no longer eligible for vision or dental benefits under the Plan. However, you are still eligible for prescription drug benefits, which are not subject to out-of-pocket maximums.

LIFE EVENTS

Certain life events can affect your benefit coverage, including:

- Marriage;
- Divorce;
- Birth of a child;
- Death; and
- Retirement.

Keep Your Records Up to Date

It is important that you keep the Third Party Administrator advised of your current address *at all times* to ensure that you receive all information regarding your benefits.

It is also your obligation to notify the Third Party Administrator of any change in beneficiary you want to make. Failure to do so will result in the payment of the Death Benefit to the person or persons that you previously designated.

To update your records, contact the Third Party Administrator and they will send you the appropriate form.

GETTING MARRIED

If you get married, your Spouse is automatically eligible for coverage effective as of the date of your marriage, **but only if** you submit a completed enrollment form and provide a marriage certificate to the Third Party Administrator within 31 days of the date of your marriage. If you fail to do so, your spouse may not be eligible for retroactive coverage. In that event, your spouse's coverage would be effective on the first day of the month following your notification to the Third Party Administrator.

If your Spouse is enrolled under another group medical plan, you must report such other coverage to the Third Party Administrator. The amount of benefits payable under this Plan will be coordinated with your Spouse's other coverage, which means benefits for your Spouse under this Plan will be paid after any benefits are payable from your Spouse's plan.

If you get married, you may want to consider updating your beneficiary information.

ADDING A CHILD

To ensure their coverage under the Plan, you should contact the Third Party Administrator immediately after:

- A child is born;
- A child becomes your legal responsibility; or
- Adoption proceedings begin.

When Coverage Will Begin

- Generally, your biological child will be eligible for coverage on the date of his or her birth.
- If you adopt a child or have a child placed with you for adoption, coverage will become effective on the date of their placement with you as long as you are responsible for the child's health care coverage and the child meets the Plan's definition of an Eligible Dependent.
- Stepchildren are eligible for coverage on the date of your marriage, provided they are dependent on you for care.

How to Add a Child

You must notify the Third Party Administrator within 60 days after the date of the child's birth, adoption or placement with you for adoption. The Trustees may accept a later notification, as they deem appropriate, but not later than 12 months after the date of the child's birth, adoption or placement with you for adoption.

If you provide notification after 12 months, the child will not be covered retroactive to the date on which the Third Party Administrator receives notice, unless the child is a newborn. If the child is a newborn, the Trustees may, for good cause, provide coverage for him or her retroactive to the date that you acquire the child.

In order for the Third Party Administrator to determine a child's eligibility, you must provide legal documentation of dependent status to the Third Party Administrator within 60 days, such as:

- A birth certificate;
- Adoption papers;
- The legal guardianship/custody/conservatorship order signed by a judge;
- A marriage certificate;
- Guardianship documents; or
- A divorce decree or paternity order.

Contact the Third Party Administrator within 60 days if you:

- **Have a child;**
- **Become legally responsible for a child; or**
- **Adopt a child or one is placed with you for adoption.**

Any applicable information regarding other coverage will also be required.

Receipt of a valid Qualified Medical Child Support Order (QMCSO) by the Third Party Administrator will automatically result in the enrollment of that person.

GETTING LEGALLY SEPARATED OR DIVORCED

If you and your Spouse legally separate or divorce, your Spouse and your stepchildren from your former marriage will no longer be eligible for coverage as Eligible Dependents under the Plan effective as of the date the legal separation or divorce is final. However, they may be eligible for COBRA continuation coverage. See page 19.

If you and your Spouse legally separate or divorce, your Spouse and your stepchildren from your former marriage will no longer be eligible for coverage under the Plan.

You or your Spouse must notify the Third Party Administrator within 30 days of the legal separation or divorce date in order for your Spouse and your stepchildren to obtain COBRA continuation coverage. At this time, you may also want to review your beneficiary designation under the Plan. If you legally separate or divorce and you want to change your beneficiary, you need to complete a new enrollment form.

CHILD LOSING ELIGIBILITY

In general, your child is no longer eligible for coverage on the last day of the month in which he or she reaches age 26. However, if your child is mentally or physically disabled, you may be able to continue coverage for that child (refer to page 6). Once your child is no longer eligible for coverage under the Plan, he or she may elect to continue coverage under COBRA for up to 36 months.

You should notify the Third Party Administrator within 31 days of when your child is no longer eligible for coverage.

If your child is no longer eligible for coverage under the Plan, he or she can elect to continue coverage under COBRA for up to 36 months.

TAKING A LEAVE OF ABSENCE (ACTIVE EMPLOYEES ONLY)

Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for benefits must be extended to Active Participants and their Eligible Dependents if the Active Participant is eligible for and has been granted leave by his or her Employer pursuant to FMLA, and if the Participant's Employer makes the required contributions to the Fund.

FMLA Provisions

FMLA allows you to take up to 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- The birth, adoption, or placement with you for adoption of a child;
- To care for a seriously ill Spouse, parent, or child;
- You are unable to work because of a serious Illness; or
- You have a qualifying exigency because your Spouse, child, or parent is on active duty or notified of an impending call to active duty status in support of a contingency military operation as either a member of the Reserves component of the Armed Forces of the U.S. or as a retired member of the regular U.S. Armed Forces.

You may be eligible for up to 26 weeks of leave within a single 12-month period to care for a Spouse, child, parent, or next of kin who is a covered service member suffering from a serious Illness or Injury sustained in the line of duty, and which renders him or her unfit to perform the duties of his or her office, grade, rank, or rating.

In some circumstances, if you and your Spouse both work for the same Employer, you and your Spouse are eligible for a combined total of 12 weeks of leave during a 12-month period.

If the need for qualifying exigency leave is foreseeable, you must provide your Employer with notice that is "reasonable and practicable."

Maintenance of Plan Benefits

You are eligible for a leave under FMLA if you:

- Have worked for a covered Employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 Employees are working each day during each of 20 or more work weeks during the current or preceding calendar year.

How FMLA Works With COBRA Continuation Coverage

If you return from leave within 12 or 26 weeks, you will not experience a loss of coverage, as long as your Employer remits the required contributions. If you do not return from leave and lose coverage, it will be considered a qualifying event under COBRA continuation coverage. In such an instance, you will have up to 12 weeks (or 26 weeks, if applicable) of maintained health care coverage during FMLA leave and an additional 18 months of continued coverage if you elect COBRA continuation coverage, which requires a self-payment.

TAKING A MILITARY LEAVE (ACTIVE EMPLOYEES ONLY)

If you are called to military service, you may elect to continue coverage under the Plan for yourself and/or your dependent(s), without any reduction in benefits, for a period not exceeding 18 months. You will be provided with the following three (3) options:

1. **First Option – Opt-Out from Coverage Under the Plan:** You may elect not to continue the health care coverage under the Plan for yourself and/or your Eligible Dependent(s), in which case your eligibility would freeze and you would resume your eligibility under the Plan when you return from military service.
2. **Second Option – Uniformed Services Employment and Reemployment Rights Act ("USERRA") of 1994 Election:** You may elect to continue health care coverage under the Plan for yourself and/or your Eligible Dependent(s) by drawing on your Dollar Bank balance and, upon exhaustion of your Dollar Bank, by timely submitting to the Third Party Administrator monthly premiums for a period not exceeding the lesser of (i) 24 months; or (2) the duration of your military service.
3. **Third Option – COBRA Election:** You may elect to continue health care coverage under the Plan for yourself and/or your Eligible Dependent(s) by timely submitting to the Third Party Administrator monthly premiums for a period not exceeding 18 months (29 months if you are disabled).

Upon discharge from military service, and upon your giving timely written notice to your Employer after discharge, you have the right to have your coverage under the Plan reinstated, generally without any waiting periods or exclusions (except for service connected Illnesses or Injuries), in accordance with the Plan's eligibility rules.

You must affirmatively elect one of the listed three options, in writing. When your military service ends, you are required to notify the Third Party Administrator of the date you are discharged from military service.

Your period of military service may not exceed five continuous years, you must not have been discharged from military service under dishonorable or other punitive conditions, and you must report back for work or apply for reemployment with your Employer within a specified period of time. See the *Plan Document* for further information on these time restrictions.

Reemployment

Following your discharge from military service, you may be eligible to apply for reemployment with your former Employer. Such reemployment includes your right to elect reinstatement in any existing health care coverage provided by your Employer.

If you are seeking work in the jurisdiction of the Fund, but are unable to find work, be sure to notify the Third Party Administrator. You may be allowed to make self-payment contributions for coverage.

How USERRA Works With COBRA Continuation Coverage

Continuation coverage under USERRA will run concurrently with COBRA continuation coverage. The cost of continuation coverage under USERRA will be the same cost as that for COBRA continuation coverage. The procedures for electing coverage under USERRA will be the same procedures described for COBRA continuation coverage, except that only you (the Participant) have the right to elect USERRA coverage for yourself and your Dependents.

Your coverage under USERRA will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after your coverage would have otherwise ended.

However, your coverage will end at midnight on the earliest of the day:

- Your coverage would otherwise end as described directly above;
- You lose your rights under USERRA (for instance, for a dishonorable discharge);
- Your self-payment contribution is due and unpaid; or
- You again become covered under the Plan.

If you voluntarily or involuntarily leave your employment position to undertake military service, USERRA requires your Employer to grant you unpaid military leave for up to five years and to continue to subsidize your health care coverage for up to 31 days from the first day of your military leave.

If your military service exceeds 31 days, you should receive military health care coverage from the U.S. Government at no cost. However, you may also elect to continue your coverage under this Plan for you and your Eligible Dependents for a maximum period of 24 months from the first day of your military leave. You must notify the Third Party Administrator at the beginning of your military leave and fill out an election form in order to receive this continuation of coverage.

Once the Plan Administrator receives notice that you have been called to active duty, the Plan will offer the right to elect USERRA coverage for you and any eligible dependents covered under the Plan on the day the leave started. The cost, election periods, and grace periods for USERRA coverage are the same as COBRA continuation coverage. However, unlike COBRA continuation coverage, if you do not elect USERRA for eligible dependents, those dependents cannot elect USERRA separately.

USERRA is an alternative to COBRA continuation coverage.

Additionally, you and any eligible dependents covered under the Plan on the day the leave started may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA—therefore either COBRA continuation coverage or USERRA coverage can be elected and that coverage will run consecutively. Contact the Third Party Administrator to obtain a copy of the COBRA/USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA. See the COBRA continuation coverage section for details.

Paying for USERRA Coverage

You and any eligible dependents covered under the Plan on the day the leave started can continue health care coverage under this Plan during that leave period if you continues to pay the appropriate contributions for that coverage during the period of that leave. If you elect USERRA temporary continuation coverage, you and any eligible dependents covered under the Plan on the day the leave started may continue Plan coverage for up to twenty-four (24) months, measured from the date you stopped working. USERRA continuation coverage operates in the same way as COBRA continuation coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA continuation coverage. See the COBRA section for more details.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your Eligible Dependents may also have COBRA rights. See the COBRA section of this document for details. In addition, your Dependent(s) may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected disabilities.

USERRA allows you to use your accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA Continuation Coverage. When your accumulated eligibility is exhausted, you may pay for USERRA coverage under the self-pay rules of the Plan. If you do not want to use your accumulated eligibility to pay for USERRA coverage, you may choose to freeze it and instead proceed to pay for the USERRA coverage under the self-pay rules of this Plan as described above.

When you are discharged (not less than honorably) from military service, your full eligibility will be reinstated on the day you return to employment with a Contributing Employer, provided that you return to employment within:

- 90 days from the date of discharge if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was at least 31 days, but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The Employer must notify the Third Party Administrator in writing within the time periods listed above. Upon reinstatement, your coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated. If you have any questions about taking a leave of absence, please speak directly with your Employer. If you have any questions about how a leave of absence affects your coverage, please contact the Third Party Administrator. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

If your coverage ends while you are on an approved USERRA military service leave, your coverage will be reinstated on the day you return to active employment, subject to any annual and lifetime plan benefit maximums that were incurred prior to the leave of absence.

IF YOU BECOME DISABLED (ACTIVE EMPLOYEES ONLY)

If you become disabled due to a non-occupational Illness or Injury, you may be allowed to make self-payment contributions to continue your eligibility. You will be required to submit written proof of application for disability benefits from the Social Security Administration.

Refer to page 9 for information regarding disability benefits for Retired Disabled Participants.

> **Active Participants**
>
> **If you become disabled, you may be eligible for an AD&D benefit or a Weekly Disability Benefit.**
>
> **Benefits under the Plan's Weekly Disability provisions are available for a non-occupational disability only.**

Temporary Disability

If you are out of work due to a non-work-related disability, you may receive a Weekly Disability benefit (note that retirees are not eligible to receive a Weekly Disability benefit). See page 39.

If you become temporarily disabled due to a non-occupational Illness or Injury and are entitled to Weekly Disability Benefit payments under this Plan **or** if you receive payments under a Workers' Compensation or Occupational Disease law, then beginning with the first paid date of your disability, you will be given credits to remain eligible for up to 26 weeks, provided you continue to meet the requirements for Continuing Eligibility. Usually, the disability credits will be enough to continue eligibility so a self-payment will not be required. However, sometimes you may need to make some self-payments even while receiving the credits when, for example, you may not have been working full-time prior to the disability occurring. You must provide the Third Party Administrator with proper documentation to verify your eligibility for contribution credit.

Total Disability

If you become Totally Disabled, you may be eligible to continue coverage for yourself and your Eligible Dependents under the Plan by making self-payments. The Trustees determine the benefits provided under retiree coverage, which may not necessarily be the same as those provided to Active Participants. See page 9 for information regarding disability benefits for Retired Participants.

If, in the opinion of the Trustees, within their sole discretion, you become able to work in the trade, then the disability coverage will terminate at the end of the calendar month in which you are no longer disabled. You will then be eligible to continue as a Participant.

WHEN YOU RETIRE

When you retire, you may be eligible to continue retiree coverage under the Plan. See the section beginning on page 8 for more information on continuing coverage as a retiree.

IN THE EVENT OF YOUR DEATH WHILE AN ACTIVE PARTICIPANT

If you die while eligible for coverage under the Plan, your beneficiary will receive a Death Benefit (and an AD&D Benefit if your death is caused by an accident). See page 38. In addition, your dependents' eligibility for coverage will continue, without cost, for the balance of the remaining Benefit Month and the following two Benefit Months. Afterwards, your Eligible Dependents may elect to exhaust the balance of your Dollar Bank to continue coverage. Once the balance of your Dollar Bank is exhausted, your Eligible Dependents may elect to continue their coverage for a period of 36 months by electing COBRA continuation coverage and making the necessary self-payments for such coverage (see page 20).

In the event of your death, your Spouse or beneficiary must:

- **Notify the Third Party Administrator;**
- **Provide the Third Party Administrator with a copy of your death certificate; and**
- **Apply for your Death Benefit (and AD&D Benefit, if applicable).**

IN THE EVENT OF YOUR DEATH WHILE RETIRED

If you die after the date that you start receiving pension benefits, your beneficiary will receive a Death Benefit (and an AD&D Benefit if your death is caused by an accident). In addition, your surviving Spouse and surviving Eligible Dependents may continue their Plan coverage by making self-payments until their eligibility for coverage ends. Your Spouse's eligibility for coverage will end if he or she remarries, and your Eligible Dependent child's coverage will end if your Spouse remarries and/or once he or she ceases to qualify as an Eligible Dependent, as defined on page 5. In order to maintain their coverage by making self-payments, your surviving Spouse or Eligible Dependents must pay for single coverage at the contribution rate that corresponds to the "years of service" category you fit in prior to your death.

Example: If Doug retires beginning January 1, 2020 with 22 years of service and is not eligible for Medicare, then Doug and his Spouse will be in the "20 to 25" tier for years of service designated by the Plan and would be required to pay a non-Medicare "individual plus Spouse" premium in the amount of $730. After Doug's death, his surviving Spouse's rate will still be based on the "20 to 25" tier for years of service, but it will decrease to $365 per month because Doug's Spouse would be paying for individual coverage

Contact the Third Party Administrator for additional information regarding the contribution rates based on years of service.

COBRA CONTINUATION COVERAGE

You may elect to continue coverage for medical, prescription drug, vision and dental benefits. Death, Accidental Death and Dismemberment, and Weekly Disability Benefits cannot be continued.

COBRA allows you to pay to continue your coverage when it would otherwise end.

QUALIFYING FOR COBRA

To qualify for COBRA continuation coverage, you or your Eligible Dependent must experience a qualifying event that would cause your coverage to end.

A qualifying event for you is:

- A reduction in the number of hours worked; or
- A termination of employment for any reason (including retirement) other than gross misconduct.

To ensure that you do not suffer a gap in coverage, you or a family member must notify the Third Party Administrator of any qualifying events as soon as the qualifying event occurs.

For an Eligible Dependent, a qualifying event may be:

- Your death;
- A reduction in the number of hours you work;
- Termination of your employment (including retirement) for any reason other than gross misconduct;
- Your divorce or legal separation;
- Your entitlement to Medicare; or
- The loss of dependent status.

If you or your Eligible Dependent have a qualifying event, you need to notify the Third Party Administrator in writing within 30 days of the loss of coverage. Even though a notice is required from your Employer, the Plan recommends you contact the Third Party Administrator as soon as possible if you (or a dependent) have a qualifying event.

If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA continuation coverage is in effect, you may add this child to your coverage if they would have been eligible for coverage under the Plan when you elected COBRA continuation coverage. Any dependent child added to your coverage during a period of COBRA continuation coverage will have his or her own right to elect COBRA continuation coverage. Appropriate documentation of birth/adoption will be required.

If you get married while your COBRA continuation coverage is in effect, you may add your Spouse to your coverage. A copy of your marriage license may be required by the Third Party Administrator. A Spouse added to your coverage during a period of COBRA continuation coverage will not have his or her own right to elect COBRA continuation coverage.

COBRA CONTINUATION COVERAGE PERIOD

The COBRA continuation coverage period depends on the type of qualifying event that caused loss of eligibility under the Plan.

Generally, COBRA continuation coverage will remain in effect for a period of 18 months (or up to 29 months for disabled individuals, as described below) if the qualifying event is:

- A reduction in the number of hours you work; or
- Termination of your employment (including retirement) for any reason other than gross misconduct.

COBRA continuation coverage will continue for a maximum period of 36 months if the qualifying event is:

- Your death;
- Divorce or legal separation;
- Your entitlement to Medicare; or
- The loss of dependent status.

EXTENSION OF COVERAGE PERIOD FOR A SECOND QUALIFYING EVENT

If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage because of a reduction in the number of hours you work or termination of employment, your Eligible Dependents can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Third Party Administrator.

This extension is available to your Eligible Dependents if one of the following events occurs:

- Your death;
- Divorce or legal separation;
- Your entitlement to Medicare; or
- The loss of dependent status.

COVERAGE FOR DISABLED INDIVIDUALS

If you or any of your Eligible Dependents are disabled (as determined by the Social Security Administration) at the time or within 60 days of the date your employment ends or your hours are reduced, COBRA continuation coverage can be extended an additional 11 months, to a maximum period of 29 months. The extension applies to the disabled person and any other covered family members. The Third Party Administrator must be notified:

- Before the 18-month period ends; and
- Within 60 days of the date of disability.

TERMINATION OF COBRA COVERAGE

Once COBRA continuation coverage is elected, it will stay in effect until the earliest of the following:

- The date you or your Eligible Dependent complete the maximum period of COBRA continuation coverage for which you or your Eligible Dependent are eligible;
- The date a self-payment is not paid on time;
- The date after your COBRA election date that you or your Eligible Dependent become covered under any other group health plan;
- The date after your COBRA election date that you or your Eligible Dependent(s) become entitled to Medicare;
- The date the Plan terminates; or
- The date your Employer ceases to provide any group health plan to any Employee.

COBRA PREMIUM PAYMENTS

After the Third Party Administrator receives your form electing COBRA continuation coverage, you will be mailed a statement showing the amount due. You will then have 45 days from the date of election to pay the full amount due. COBRA continuation coverage will not be effective until full payment is made. After your effective date, your coverage will be terminated if you are late making future payments.

COBRA NOTICE PROCEDURES

An initial general notice describing COBRA rights will be given to you (and your Spouse, if you are married) when you become covered under the Plan and will contain the information required by COBRA.

If the qualifying event that occurs is the termination of employment or reduction of hours of employment, your death or entitlement to Medicare benefits, the Employer must notify the Third Party Administrator of the qualifying event. However, you or another family member should notify the Third Party Administrator if any of these qualifying events occurs to ensure that you receive COBRA election materials as soon as possible.

If you or your Eligible Dependent have a qualifying event or second qualifying event that is a divorce or legal separation or a dependent child's loss of eligibility for coverage as a dependent, you need to notify the Third Party Administrator in writing within 60 days. You may be asked to provide verification in the form of a copy of your divorce decree, certified copy of your marriage certificate, etc. You or your Eligible Dependent will be ineligible for COBRA continuation coverage or extended COBRA continuation coverage (in the case of a second qualifying event) if you or your dependent fail to timely notify the Third Party Administrator.

You must promptly notify the Third Party Administrator if you and your Spouse become divorced. If you fail to do so and your former Spouse continues to claim or receive benefits under the Plan, you and your Spouse can be subject to loss of benefits, lawsuits and criminal charges. In addition, it is your responsibility to understand your marital status and to inform the Third Party Administrator when a qualifying event has occurred.

You must also notify the Third Party Administrator of a disability determination before the 18-month period ends and within 60 days of the date of disability. In addition, you must notify the Third Party Administrator within 30 days of any subsequent determination by the Social Security Administration that the disabled individual is no longer disabled.

The notice of a qualifying event or disability determination must be in writing and must include sufficient information to enable the Plan Administrator to determine the following information:

- The covered Participant and qualified beneficiaries;
- The type of qualifying event or disability determination; and
- The date on which the qualifying event occurred or the disability determination was made.

A notice that does not contain all of the required information will not be considered notice of a qualifying event. If you do not timely provide all of the information necessary to meet the content requirements, you will lose the right to elect or extend continuation coverage.

Failure to provide notice within the form and timeframe described in that notice may prevent you and/or your Eligible Dependents from obtaining or extending the COBRA continuation coverage.

To protect your family's rights, you should keep the Third Party Administrator informed of any changes in your address or those of your family members.

Notice of Right to Elect COBRA Coverage. Once notified, the Third Party Administrator will mail you the necessary forms to enable you to elect the COBRA continuation coverage. When you receive the forms, you will have 60 days from the date of the Third Party Administrator's notification letter in which to elect or decline COBRA continuation coverage. You or your Eligible Dependent will be ineligible for COBRA continuation coverage if you do not timely elect COBRA continuation coverage.

MAJOR MEDICAL BENEFITS

The medical program pays benefits for a wide range of services and supplies that are Medically Necessary to treat Illness and/or Injury. Refer to the *Summary of Benefits* insert.

HOW THE PLAN WORKS

The decisions about how and when you receive medical care are up to you and your Physician—not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

Deductible

The annual Deductible is the dollar amount you pay each year before the Plan pays benefits. The annual Deductible applies to each Covered Person each calendar year. However, once the total amount of Deductible expenses paid by all family members meets the overall family Deductible, no further Deductibles are required for that year.

Expenses applied to your individual Deductible during the last three months of the calendar year (October 1 through December 31) will also count toward next year's Deductible, regardless of whether the prior year's Deductible is met.

Coinsurance

Coinsurance, generally expressed as a percentage, is the amount you pay for covered services after you meet the Deductible, if applicable. For most covered expenses, once you meet your Deductible:

- The Plan pays 80% of the In-Network Allowed Amount. You pay the remaining 20%; and
- The Plan pays 60% of the Non-Network charges. You pay the remaining 40%.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum limits the amount you pay out of your pocket in a calendar year for covered medical expenses. Once you meet the annual out-of-pocket maximum (which includes the annual Deductible and Coinsurance that you pay), the Plan pays 100% of covered expenses for the rest of the calendar year, subject to any Plan limits.

Certain expenses do not apply toward your annual out-of-pocket maximum, including:

- Premiums
- Balance-billing charges
- Health care the Plan does not cover

In addition, the annual out-of-pocket maximum limit does not include charges in excess of what is the Allowed Amount for a similar medical expense, charges limited by the Plan's provisions, or charges in excess of the Plan's applicable maximum for a particular benefit.

The Contracted Preferred Provider Organization (PPO)

The Board of Trustees has contracted with a Claims Administrator to allow you access to a Preferred Provider Organization (PPO) Network. Providers who participate in the PPO network have agreed to negotiated, reduced fees. When you go to a PPO provider, you save money for yourself and the Plan because the provider has agreed to accept a reduced amount for its services.

For help locating a PPO network provider, call the phone number shown on the *Important Contact Information* insert.

It's your decision whether to go to a PPO or a non-PPO provider. You always have the final say about the providers you and your family use. However, remember that when you use a non-PPO network provider, you pay a higher percentage of covered charges and you may have to submit a claim for reimbursement.

Pre-Authorization of Non-PPO Network Benefits

Unless you receive written pre-authorization from the Claims Administrator according to the process described below, benefits will be provided as shown in the *Summary of Benefits* insert for non-network providers.

To request pre-authorization of treatment by a non-PPO network provider, your Physician must provide the Claims Administrator with certain documentation. *See the Plan Document*.

A determination will be made as to whether the covered services can be provided by a PPO network provider and that determination will be final and conclusive.

COVERED MAJOR MEDICAL BENEFIT EXPENSES

The following is a summary of some of the major benefits covered under the Plan and are paid up to any limits specified in the *Summary of Benefits* insert. This is intended as a summary only. To review a complete list of covered services and restrictions, please refer to the *Plan Document*.

- Routine physical examination for Active members only, with a maximum of one (1) physical examination per Benefit Period covered at 100%
- Hospital daily room and board, general nursing care, and intensive care
- Medically Necessary services and supplies furnished by the Hospital during a covered Inpatient confinement, but not for private duty nursing care
- Medically Necessary services and supplies furnished in a licensed Ambulatory Surgical Center
- Outpatient Hospital charges for Medical Care and supplies used on the premises of a Hospital
- Medically Necessary services and supplies furnished in a lawfully operating birthing center
- Disposable supplies that serve a specific therapeutic purpose, including syringes, needles, oxygen, and other similar items
- Skilled Nursing Facility expenses for daily room and board
- Professional service charges by a Doctor for medical care or Surgery that is Medically Necessary, including oral surgery to remove bony impacted teeth
- Professional service charges by a Doctor who assists the operating surgeon, if the complexity of the Illness or Injury requires the services
- Professional service charges by a Doctor or nurse anesthetist for the administration of anesthesia if the surgical procedure is a covered service
- Professional service charges made by a Doctor, a laboratory or diagnostic laboratory, or a radiologist for x-ray exams

- Ambulance services
- Private Duty Nursing charges for services performed by an R.N. or L.P.N. outside of a Hospital or Hospice Facility when deemed Medically Necessary by a Physician or ordered by the Physician
- Physiotherapy services provided by a physiotherapist
- Allergy testing and treatment
- Charges incurred for sterilization procedures
- Charges for services of a qualified speech therapist to correct speech loss or damage which:
  - follows Surgery to correct a birth defect;
  - follows Surgery due to Illness; or
  - is due to Illness, except a functional nervous disorder, delayed speech or other learning development condition
- Medical equipment, foot orthotics, and orthopedic and prosthetic devices
- Contraceptives prescribed by a Doctor
- Chiropractic treatment
- Durable Medical Equipment
- Certain Home Healthcare services
- Hospice Facility services when your Doctor recommends (in writing), on or before hospice care is started, a plan of hospice care for palliative care of a terminal Illness (where life expectancy is less than six months) and you or your covered Eligible Dependent elect (in writing) to follow the Doctor's proposed treatment plan
- Outpatient physical and occupational therapy
- Inpatient alcoholism and drug abuse treatment
- Inpatient mental Illness, nervous disorders, psychiatric, psychoanalytic treatment
- Non-Experimental Human Organ Transplant

The Plan will cover rental of Durable Medical Equipment ("DME") up to the purchase price of such equipment. Any DME purchased by the Plan will be the property of the Plan. The Trustees, in their discretion, may require you to enter into a written agreement to return any DME purchased by the Plan when the DME is no longer needed and to abide by any other terms and conditions prescribed by the Plan.

Women's Preventive Services

Under the Patient Protection and Affordable Care Act (PPACA), the Plan covers certain women's preventive services at 100% (no Deductibles or Coinsurance). This includes routine OB/GYN examinations and testing, as well as contraceptive methods mandated by the PPACA.

Genetic Counseling and Testing for Breast Cancer

The Plan covers genetic counseling and genetic testing for BRCA1 and BRCA2 genetic mutations at 100% if recommended as appropriate by a Physician.

Preventive Services

This Plan provides coverage for certain Preventive Services at 100% as required by the Patient Protection and Affordable Care Act of 2010 (PPACA).

Well-Child Care Coverage

The Plan will cover expenses related to newborn and well-child care recommended in the Bright Futures Recommendations at 100% without cost sharing. This includes well-child physical exams.

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. *See the Plan Document for further information.*

MAJOR MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS

The Plan will not cover all expenses as Major Medical Benefits. For instance, coverage is not provided for the following services and supplies:

- Those not prescribed by or performed by or under the direction of a Physician or Other Professional Provider;
- Those performed outside the scope of the Provider's license or by a person who is not legally qualified to perform the service provided;
- Those received from a party other than a Provider;
- Equipment, drugs, devices, services, supplies, tests, medical treatments or procedures that are Experimental or Investigational or are not commonly and customarily recognized in the professional medical community (FDA or AMA) as appropriate treatment of the patient's condition;
- To the extent that governmental units or their agencies provide benefits, except governmental health departments, as determined by the Claims Administrator, unless:
  - for emergency treatment when you or your Eligible Dependent must pay for those services;
  - for non-service-connected disabilities in a Veterans' Administration Hospital; or
  - incurred by a United States military retiree (covered by this Plan) and his Eligible Dependents, if any, while confined in a military medical facility;
- Conditions that occur as a result of any act of war, declared or undeclared, or a release of nuclear energy (except when used solely as medical treatment);
- Those for which no charge is made or for which you have no legal obligation to pay in the absence of this or comparable coverage;
- Those 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;
- Those received from a member of your immediate Family or from someone having the same legal residence as you;
- Those incurred before your coverage as a Covered Person begins or after your coverage as a Covered Person ends, unless covered under COBRA;
- Physical examinations or services required by an insurance company to obtain insurance;
- Physical examinations or services required by a governmental agency such as the Federal Aviation Agency or the United States Department of Transportation;
- Physical examinations or services required by an Employer in order to begin or to continue working;

- Screening examinations, except as specified;
- X-ray examinations with no preserved film image or digital record;
- Conditions occurring in the course of employment, an Injury or Illness arising out of employment, or occupational injuries sustained by sole proprietors, if whole or partial benefits or compensation could be available under the laws of any governmental unit, whether or not you claim such compensation or recover losses from a third party;
- Those for which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This exclusion applies when you are eligible for Medicare, even if you did not apply for or claim Medicare benefits. This exclusion does not apply, however, if, in accordance with federal law, this Plan's coverage is primary and Medicare is the secondary payer of your health care expenses;
- Those received in a military facility for a military service-related condition;
- Cosmetic or Reconstructive 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 for:
  - Injuries received by a Participant or Eligible Dependent in an accident; or
  - repair of birth defects of Eligible Dependent children; or
  - repair of Medically Necessary defects which result from Surgery for which benefits were paid under this Plan;
- Surgery to correct a deformity or birth defect for psychological reasons where there is no functional impairment;
- The removal of tattoos;
- Dietary and/or nutritional guidance or training, except as specified;
- Outpatient educational, vocational or training purposes, except as specified;
- Testing, education, or training relating to learning disabilities, and for treatment of conditions related to a childhood autism spectrum disorder, developmental delay, learning disabilities, attention deficit disorder, hyperkinetic syndromes, behavioral problems or intellectual disability, except as specified;
- Topical anesthetics;
- Routine minor nonoperative endoscopic procedures, except as specified;
- 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 flatfeet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails;
- Weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal, unless such Surgery is determined by the Claims Administrator to be Medically Necessary;
- Weight loss drugs;
- Water aerobics;
- Residential care rendered by a Residential Treatment Facility, except as required by the Mental Health Parity Act;
- Marital counseling or training services;
- Medical treatment of sexual problems not caused by a biological condition and for counseling relating to such problems;
- Gender reassignment Surgery or any treatment leading to or in connection with gender reassignment;
- Reversal of an elective sterilization procedure;

- Surrogate pregnancy or as a result of any Covered Person's acting as, or contracting to be, a surrogate parent;
- Treatment of infertility, including, but not limited to, artificial inseminations, in vitro fertilization, gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT);
- 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;
- Treatments associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) Surgery, except as specified;
- Treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension;
- Treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis;
- Personal hygiene and convenience items and for comfort items such as television, telephone, lotion, or powder;
- Eyeglasses, contact lenses or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of Surgery;
- Any surgical procedure for the correction of a visual refractive problem, including, but not limited to, radial keratotomy, keratectomy, keraplasty, corrective laser Surgery, and LASIK (laser in situ keratomileusis);
- All services related to hearing loss, including hearing aids or examinations for prescribing or fitting them, except as specified;
- Immunizations, except for those covered under PPACA;
- Massotherapy or massage therapy;
- Hypnosis;
- After Hours Care;
- Missed appointments, completion of claim forms or copies of medical records;
- Fraudulent or misrepresented claims;
- Blood or plasma which is available without charge or for which a refund or credit is given;
- Outpatient blood storage services;
- Prescription drugs, except as covered under the Plan's Prescription Benefit Program;
- Over-the-counter drugs, vitamins, herbal remedies, or nutritional or homeopathic supplements;
- Specialized camps;
- Routine services, except as specified;
- A particular health service in the event that a non-PPO network Provider waived copayments, non-PPO network Coinsurance (and/or the non-PPO network Deductible per calendar year);
- Inpatient Private Duty Nursing services;
- Charges not included as covered charges;
- Services related to pre-marital examinations and diagnostic services performed in connection with pre-marital examinations that are not Medically Necessary;
- Services, treatment, or supplies not supported by a medical diagnosis;
- The portion of a charge that exceeds the Plan's limits;
- Injury or Illness resulting from participation in the commission of an assault or felony of which you or an Eligible Dependent is convicted;
- Exercise for the eyes (orthoptics), unless Medically Necessary;

- Nerve stimulators, unless Medically Necessary;
- Custodial Care, including care to assist the patient in the activities of daily living, and maintenance care not expected to improve the patient's medical condition;
- Charges Incurred by other than the diagnosed patient;
- Travel, even though prescribed by a Doctor;
- The purchase or rental of luxury equipment when standard equipment is appropriate for the patient's condition (e.g., motorized wheelchairs or other vehicles, bionic or computerized artificial limbs);
- Thermograms and temperature gradient studies;
- Exercise equipment;
- Unnecessary care or treatment, as defined by an outside review board;
- Expenses that are in any way reimbursable through no fault automobile insurance;
- Air conditioners, purifiers, humidifiers, dehumidifiers, arch supports, corrective shoes, whirlpools, heating pads or hot water bottles, hypo-allergenic pillows, mattress or waterbeds, etc.;
- Items that are ordinarily stocked in the home for general use, including, but not limited to, elastic bandages, thermometers, and corn and bunion pads;
- Services rendered or billed for by a school or halfway house or a member of its staff;
- Milieu therapy, any confinement in an institution primarily to change or control one's environment;
- Expenses for services and/or supplies in connection with procedures for which you are compensated, monetarily or otherwise;
- Expenses in excess of the Allowed Amount;
- Non-covered services or services specifically excluded herein;
- Home Health Care services not previously listed as covered, i.e., homemaker services, food or home delivered meals, and Custodial Care, rest care or care that is only for someone's convenience; and/or
- Hospice care for:
  - services provided by persons who do not regularly charge for their services;
  - counseling that is not provided as part of the hospice care plan;
  - services provided by homemakers, caretakers and the like;
  - funeral expenses; or
  - treatment intended to cure the terminal Illness.

PRESCRIPTION DRUG BENEFITS

The Fund has contracted with a Pharmacy Benefits Manager to provide you with access to a network of retail pharmacies and the convenience of a mail order program.

When you have your prescriptions filled at a participating pharmacy or through the mail order program, you save money for yourself and the Plan.

When you need a medication for a short time, it is best to choose the retail pharmacy program. If you are taking a medication on a long-term basis, it is usually best to have it filled through the mail order program.

Refer to the *Important Contact Information* insert for information on how to locate a participating network pharmacy near you.

HOW THE PLAN WORKS

- When you need to have a prescription filled, go to any participating network retail pharmacy and show your ID card or send your prescription to the mail order program.
- When you receive the medication from the pharmacist, you will have to pay the appropriate Coinsurance amount.
- Before your benefits are payable under the Plan, you must satisfy an annual Deductible. This annual Deductible amount includes expenses paid for prescription drugs dispensed through the retail pharmacy program and/or through the mail order program.
- Once you satisfy the annual Deductible amount, you and the Plan will share expenses, up to an annual maximum amount.

The applicable prescription drug annual Deductible, Coinsurance and annual maximum amounts are specified on the *Summary of Benefits* insert.

These amounts do not count toward the Deductibles or maximum out-of-pocket limits that apply to your medical benefits.

Specialty Pharmacy Program

When you need to have a prescription filled for a specialty medication (including any specialty medications you are currently taking), you will need to contact the Pharmacy Benefits Manager.

Certain utilization programs, such as Step Therapy, Prior Authorization, or Quantity Limits on certain prescription drugs may be required and are described below:

- **Step Therapy:** A program to determine whether you qualify for coverage based upon certain information, such as medical history, drug history, age and gender. The program requires that you try another drug before the target drug will be covered under the Plan, unless special circumstances exist. If your Physician believes that special circumstances exist, he or she may request a coverage review.
- **Prior Authorization:** Prior Authorization is required for most specialty prescription drugs and may also be required for certain other prescription drugs (or the prescribed quantity of a certain prescription drug).
- **Quantity Limits:** Certain prescription drugs are covered only up to a certain limit. Quantity limits help promote appropriate dosing of prescription drugs and enforce medically accepted guidelines for benefit coverage. Obtaining quantities beyond the predetermined limit requires prior authorization.

Specialty drugs are biotech and other drug products that often require special ordering, handling and/or participant services that are distributed by a Specialty Pharmacy.

Retail Pharmacy Program

Participating retail pharmacies are generally able to offer prescriptions at a lower cost than non-participating pharmacies. To take advantage of this cost savings, you should use a participating retail pharmacy whenever you need to fill a prescription. Refer to the *Important Contact Information* insert for the phone number and/or website you can use if you need help locating a participating retail pharmacy.

Mail Order Program

You should use the mail order prescription drug program when you need prescriptions filled for long-term maintenance drugs (medications that you take on an ongoing basis). To use this program, you should:

- Ask your Physician to write a prescription for a short-term supply that you can have filled right away at a participating retail pharmacy and one for a 90-day, refillable supply that you can have filled through the mail order program.
- Mail the original prescription along with the appropriate form to the mail order facility. You can obtain a form from the Third Party Administrator.
- Allow about 14 business days from the time you mail in your order to receive your prescription(s).

Maintenance medications are prescription drugs that are used on an ongoing basis. These prescriptions can be used to treat chronic Illnesses such as:

- **Arthritis;**
- **Diabetes;**
- **Emotional distress;**
- **Heart disorders;**
- **High blood pressure; and**
- **Ulcers.**

Generic Equivalents and Brand Name Medications

Many prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

You should discuss with your Physician if a generic equivalent is available for any prescriptions you need filled. Your Physician or pharmacist can assist you in substituting generic medications when appropriate.

To encourage you to use generic medications whenever possible, your out-of-pocket amount may be less when you use generic medications. In addition, if a generic drug is available and you request a brand name drug, you will be responsible for the difference in the cost of the generic and brand name medication in addition to your brand name prescription drug copayment. This does not apply if your Physician specifies Dispense as Written (DAW) on your prescription for a brand name drug.

A generic equivalent is a copy of a brand-name medication that is no longer protected by a patent. A generic medication usually serves the same purpose as the original (brand name) medication.

Whenever available, a generic medication should be substituted for a brand name medication.

COVERED PRESCRIPTION DRUG EXPENSES

The Plan covers medications that require a written prescription from a Physician, subject to any Plan limits, including but not limited to:

- All medications that require a prescription by a licensed Physician and are a Federal Legend Drug
- Compounded medications containing at least one prescription ingredient
- Insulin and disposable insulin needles/syringes, both products for one (1) co-pay when ordered with a prescription
- Diabetic test strips and lancets
- Prescribed prenatal vitamins
- Retin-A for individuals through the age of 19 years
- Contraceptives, oral or other, whether medication or device, for use by a Participant or eligible Spouse covered under the Patient Protection and Affordable Care Act (PPACA)
- Immunization agents, blood or blood plasma

To save the most money for yourself and the Fund, use participating retail pharmacies when filling a prescription.

PRESCRIPTION DRUG BENEFIT EXCLUSIONS AND LIMITATIONS

The Plan does not cover all medications. The following provides a limited list of items that are not covered by the Plan:

- Over-the-counter prenatal vitamins
- Retin-A for individuals 20 years of age or older
- Weight loss drugs (anorectics)
- Experimental or Investigative drugs
- Cosmetic medication, including, but not limited to:
  - hair growth stimulants (e.g., Propecia)
  - anti-wrinkle agents (e.g., Renova)
  - fluoride supplements
  - levonorgestrel (e.g., Norplant)
  - mineral and nutrient supplements
- Hernatinics, except that Folic Acid is covered
- Charges for the administration or injection of any drug
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, Nursing Home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Over-the-counter non-sedating antihistamines
- Over-the-counter proton pump inhibitors
- Fertility medications
- Therapeutic devices or appliances, including needles, syringes, support garments and other medical supplies
- Oral cystic fibrosis therapies, which include ion-channel modulators and transmembrane conductance regulators
- Any non-prescription items not described in this section

DENTAL BENEFITS

The Fund provides dental care coverage for you and your family, through a contract with Delta Dental Plan of Ohio (Delta Dental). Delta Dental maintains and administers its dental networks, processes your dental claims and performs certain other duties on your behalf.

HOW THE PLAN WORKS

Refer to the *Important Contact Information* insert for information on how to locate a participating network Dentist near you.

You have access to two networks of participating dentists—the Delta Dental PPO network and the Delta Dental Premier network. You can see any dental care provider that you choose. However, your out-of-pocket costs are likely to be less if you receive dental services from a Delta Dental PPO Dentist or Premier Dentist because they have agreed to accept payment according to the dental network provider's fee schedule. This means that in most cases, the fees that they agree to accept in payment for dental services are lower than the fees charged by non-network Dentists.

Deductible

The Plan generally pays a percentage of covered dental charges after you meet the annual dental Deductible. The annual dental Deductible is the dollar amount you pay each year before the Plan pays dental benefits.

The annual dental Deductible applies to each Covered Person each calendar year. The annual Deductible per person is $25.00. However, once the total amount of Deductible expenses paid by all family members meets the overall family dental Deductible, no further dental Deductibles are required for that year. The overall annual family Deductible is $75.00.

The annual dental Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, bitewing x-rays, sealants, and orthodontic services.

Refer to the *Summary of Benefits* insert.

Annual and Lifetime Maximums

The Plan pays up to $2,500 annually, per person, toward the dental expenses you incur. The maximum is waived, however, for children up to age 19 (except for orthodontic treatment). The Plan also pays up to $2,500 per lifetime for orthodontic services but this treatment must begin prior to age 19 for dependents.

COVERED DENTAL EXPENSES

Covered diagnostic and preventive services are covered in full (100%) and include:

- Routine oral exams (2x per year)
- Cleanings (2x per year)
- Space maintainers (unlimited for dependents up to age 19)
- Bitewing X-rays (2x per year and full mouth X-rays once per 2 years)
- Fluoride treatments (2x per year)
- Sealants

DENTAL BENEFIT EXCLUSIONS AND LIMITATIONS

If you or your Eligible Dependent incurs charges for covered dental services, the Plan will pay benefits as specified in the *Summary of Benefits* insert. The benefits payable may not exceed the maximum amount and are subject to the general limitations listed in the *Summary of Benefits,* and the following exclusions and limitations:

- Sealants are payable once per tooth per lifetime for the occlusal surface of permanent teeth up to age 19. The surface must be free from decay and restorations
- Composite resin (white) restorations are covered for posterior teeth
- Porcelain and resin facings on crowns are optional treatment on posterior teeth
- Surgical extractions are payable first by the medical carrier, and are then treated as a covered service under the Plan's dental care benefits program, secondary to medical
- Implants and related services are not covered
- Anesthesia is not covered when performed with oral Surgery services that are not covered
- The initial placement of replacement of full and partial dentures is payable at 80% once in any five-year period. Replacement of full and partial dentures will also be payable at 50% once within five years of payment of a denture at 80%

In addition, no benefits are payable for:

- Services or supplies that are payable under the Plan's medical benefits
- Dental services for visits at home or in a Hospital, except in connection with oral Surgery or emergency dental care
- Charges in excess of the Allowed Amount
- Services and supplies which are considered by the American Dental Association as purely cosmetic
- Drugs dispensed by the Dentist, prescription or otherwise
- Fees for oral instructions or sterilization fees

COVERAGE OUTSIDE UNITED STATES

Through the network provider's Passport Dental program, Covered Persons may receive dental care when they are outside the United States.

VISION BENEFITS

The Fund has partnered with a vision benefit Claims Administrator in order to allow you access to professional vision care network providers and discounted vision services through the EyeMed Insight Network.

HOW THE PLAN WORKS

The Plan covers 100% of one vision exam each calendar year when it is performed by an in-network provider. In addition, the Plan covers expenses for eligible materials received in-network—lenses, frames, and contacts—at the amount listed on the *Summary of Benefits* insert.

It is to your benefit to receive your materials from EyeMed Insight Network providers because the Plan does not cover vision services and/or materials received from non-network providers.

Call Medical Mutual of Ohio or visit its website to locate a vision network provider near you. Contact information is provided in the *Important Contact Information* insert.

COVERED VISION EXPENSES

Covered vision benefits include:

- A complete eye examination
- Eyeglass lenses and frames, including single vision, bifocal, trifocal, lenticular, and progressive lenses
- Contact lenses (coverage includes one pair of either contact lenses or frames and lenses once per calendar year)

Please refer to the *Summary of Benefits* insert to find out whether you are responsible to pay a copayment for certain vision care services or materials.

The vision program also offers discounts off of the retail price of premium contacts and LASIK or PRK vision correction. Contact Medical Mutual of Ohio to determine your out-of-pocket costs for these services.

VISION BENEFIT EXCLUSIONS AND LIMITATIONS

Not all vision care is covered by the Plan. For instance, vision benefits are not paid for the following:

- Vision care received from eyecare services providers who do not participate in the EyeMed Insight Network
- Services or materials provided as a result of any workers' compensation law or similar legislation or obtained through or required by any government agency or program, whether federal, state or any local subdivision
- Professional services or materials for:
  - visual field charting and subnormal vision aids
  - aniseikonic lenses or two pairs of glasses in lieu of bifocals
  - non-prescription lenses, blended bifocals or continuous adds (will be paid as bifocal)
  - medical or surgical treatments
  - Orthoptic or vision training if the Claims Administrator determines that such training is not Medically Necessary

THE HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The Fund offers a Health Reimbursement Arrangement (HRA). An HRA may only be used to pay for eligible health care expenses as defined by the Plan.

HRA HIGHLIGHTS

The HRA is designed to provide reimbursement of certain health care expenses on a tax-free basis. Here's how the HRA works:

- You work for an Employer who contributes to the Fund on your behalf.
- For each hour of contributions made on your behalf, a portion of the hourly contribution rate is credited to an HRA account that is established for you.
- You determine how you want to use the money in your HRA account to reimburse eligible expenses.

The Fund will establish and maintain an HRA account for each eligible Participant but will not create a separate fund or otherwise segregate assets for this purpose. HRAs are recordkeeping accounts only, and are used to keep track of contributions and available reimbursement amounts.

ELIGIBILITY

You are eligible for the HRA if you are eligible for coverage under the Plan.

While contributions are only made on your behalf while you are working for a contributing Employer, you don't have to be an Active Participant to use your HRA account. Your HRA account balance is available when you're not working enough hours and after retirement, which means as long as you, your Spouse, or Eligible Dependents are self-paying to continue coverage under the Plan, you may continue to use your HRA account.

You may use your HRA account for reimbursement of eligible expenses incurred by your Spouse and Eligible Dependents. See page 37 for a list of eligible health care expenses.

Continued Eligibility

Your HRA account balance is available to you as long as you are eligible for coverage, whether your eligibility is based on hours of contributions made on your behalf, self-payment contributions you make to continue coverage, or self-payments you make for COBRA continuation coverage.

Military Leave

If you enter the armed forces for less than 31 days, your HRA account will be maintained if your Employer contributes on your behalf as required by USERRA. If your military service lasts 31 days or longer, you have two options:

- Continue your coverage by making self-payments or electing COBRA continuation coverage, at which time your HRA account balance will be available for use; or
- Notify the Third Party Administrator of your entry into the military, in writing. Your HRA account balance will be frozen for the lesser of your length of service or five years. Your HRA account balance will be available upon your reinstatement of eligibility for coverage.

The more you work, the more contributions are made to your HRA account—and the more your HRA account grows, tax-free.

Plus, money in your HRA account and amounts reimbursed for eligible expenses are not included in your taxable income, which means you aren't taxed on this money.

When You Retire

No new Employer contributions will be credited to your HRA account after you retire. Self-payment contributions are required for retiree coverage. When you retire, you may use the balance in your HRA account to make self-payment contributions for retiree coverage. In addition, as long as you are eligible for retiree coverage, you may also use your HRA account to pay for eligible expenses.

If you have no surviving Spouse and/or other eligible Dependents at the time of your death, any balance in your HRA account will be forfeited and become a part of the Plan's general assets.

In the Event of Your Death

Your HRA account balance will be available to your surviving Spouse and/or Eligible Dependents after your death. They can use the funds to pay for eligible expenses (including expenses you incurred before your death). They can also use the remaining funds to make self-payments to continue coverage under the Plan.

While your surviving Spouse and/or Eligible Dependents may continue to use your HRA account as long as they are eligible to make self-payments for coverage, no further Employer contributions will be made to the HRA account. In addition, under no circumstances will the balance in your HRA account be paid to your beneficiaries in cash.

FREEZING YOUR HRA ACCOUNT BALANCE

You may freeze your HRA account balance if you opt out of the Plan's coverage because you:

- Have coverage available through a non-group health care plan; or
- You receive a subsidy under the Patient Protection and Affordable Care Act to help you pay for your health insurance premiums.

While the funds in your account are frozen, you will not be able to submit a claim for reimbursement through your HRA account. However, when the above conditions no longer apply, you may elect to unfreeze your HRA account, upon which time you will again be able to use the funds in your HRA account for reimbursement purposes.

WHEN ELIGIBILITY ENDS

The Trustees reserve the right to discontinue crediting contributions to your HRA account at any time.

You will stop being eligible to participate in the HRA upon the occurrence of the earliest of the following:

- The termination of the HRA;
- The termination of the Plan;
- The exhaustion of the funds in your HRA account, following your termination of employment with an Employer; or
- The forfeiture of your HRA account.

When you are no longer eligible for coverage, and before your HRA account is forfeited, you may submit a claim for reimbursement of eligible expenses that were incurred **before** your eligibility ended.

HRA ACCOUNT FORFEITURE

Any unused amount in your account at the end of a calendar year carries forward, even into retirement. After termination of eligibility, your HRA account may be carried forward up to 36 consecutive months (12 calendar quarters) without forfeiture. If you engage in disqualifying employment, your balance will be forfeited on the first day of the following month in which you engaged in such employment.

TAX STATUS

Contributions credited to your HRA account are pre-tax (not taxable income when made) and generally are not taxable when paid out as benefits.

If you submit an expense for reimbursement under the Plan's HRA, you cannot deduct that expense on your tax return.

Tax Consequences

If you receive reimbursement under the HRA on a tax-free basis, and the payment does not qualify for tax-free treatment under the Internal Revenue Code, you will be required to indemnify and reimburse the Fund for any liability incurred for failure to withhold federal income taxes, Social Security taxes, or other taxes.

ELIGIBLE HEALTH CARE EXPENSES

As you incur eligible health care expenses, you can use the money in your HRA to pay for eligible expenses incurred by you, your Spouse, and/or your Eligible Dependents.

Examples of eligible expenses include, but are not limited to:

- Copayments for medical/dental/vision visits
- Bandages
- Drugs (Prescription and over-the-counter)
- Medical Equipment (crutches, wheelchair, etc.)
- Eyeglasses and Contact Lenses
- Hearing Aids
- Oxygen
- Pregnancy Tests
- Smoking Cessation Programs

You will receive a debit card to use to pay for eligible expenses. The card acts like a bank debit card that is linked to your HRA. However, if at the time of purchase you pay for an eligible item out-of-pocket not using the debit card, you can request reimbursement, which will be paid directly to you.

HRA ACCOUNT EXCLUSIONS AND LIMITATIONS

Expenses that are not eligible for reimbursement from the HRA account include items that do not constitute "medical care," as defined in Internal Revenue Code § 213(d). For examples of ineligible expenses, please refer to the *Plan Document*.

While requests for reimbursement can be made at any time, the Fund requires that any requests for reimbursement be for a minimum of $50 to limit administrative expenses.

HRA CLAIMS AND REIMBURSEMENTS

You must submit a claim for reimbursement of any eligible expense and back-up documentation in accordance with the procedures described in the "Claims and Appeals Information" section beginning on page 40 and also in the "Claims and Appeals Information" insert with this SPD.

DEATH AND AD&D BENEFITS

All Active and Retired Participants who have satisfied the eligibility requirements are covered by the Death Benefit and Accidental Death and Dismemberment Benefit programs.

DEATH BENEFIT

In the event of your death while you are covered under the Plan as an Active or Retired Employee, the Plan pays your designated beneficiary a Death Benefit. For Active Participants, the benefit is $10,000. For Retired Participants, it is $5,000.

Death Benefits are only available to Active and Retired Employees and are only payable after the Third Party Administrator receives a copy of your death certificate.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

If you are Injured or die due to an accident, you (or your beneficiary) will be paid up to the maximum amount of the Accidental Death and Dismemberment (AD&D) benefit listed on the *Summary of Benefits* insert. This benefit is paid in addition to the Death Benefit.

AD&D Benefit Exclusions and Limitations

AD&D benefits are not paid for any loss caused or contributed to by:

- Physical or mental Illness or infirmity, or the diagnosis or treatment of such Illness or infirmity
- Infection, other than infection occurring in an external Accidental wound
- Suicide or attempted suicide
- Intentionally self-inflicted Injury
- Service in the armed forces of any country or international authority, except the United States National Guard
- Any incident related to:
  - travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight
  - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation
  - travel in an aircraft or device used:
    - for testing or Experimental purposes
    - by or for any military authority
    - for travel or designed for travel beyond the earth’s atmosphere
- Committing or attempting to commit a felony
- The voluntary intake or use by any means of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician
    - an over the counter drug, medication, or sedative taken as directed
  - alcohol in combination with any drug, medication, or sedative
  - poison, gas, or fumes
- War, whether declared or undeclared, or act of war, insurrection, rebellion, or riot

- Intoxication of the Injured party (or if the intoxicated party is the operator of a vehicle or other device involved in the incident)

DESIGNATING A BENEFICIARY

The Death Benefit and AD&D Benefit are paid to the beneficiary you designate and who is on record with the Third Party Administrator.

If any designated beneficiary dies before you, that beneficiary's right to the Death Benefit or the AD&D Benefit terminates. If there is no beneficiary designation on file, your Death Benefit is paid to your surviving:

- Spouse; or if none
- Children in equal shares; or if none
- Parents in equal shares; or if none
- Brothers and sisters in equal shares, or if none
- Estate.

If your marital status or the number of your Dependents changes, you may want to review your beneficiary designation. It is your responsibility to keep your beneficiary designation current.

WEEKLY DISABILITY BENEFIT (ACTIVE EMPLOYEES ONLY)

The Plan includes disability coverage that protects you and your family by providing income in the event that you become disabled and cannot work due to a non-occupational disability.

Weekly Disability Benefits are for Active Participants only.

ELIGIBILITY

Weekly Disability Benefits are not payable for an occupational disability (an Injury or Illness that arises out of or in the course of any employment for wage or profit).

If you are eligible, benefits will begin on the:

- First day of an accident, outpatient Surgery or Hospital confinement
- Eighth day of an Illness without hospitalization.

This benefit's maximum duration is 26 weeks for the same disabilities within a 24 consecutive month period.

WEEKLY DISABILITY BENEFIT EXCLUSIONS AND LIMITATIONS

The Weekly Disability Benefit is subject to limitations. No benefit will be paid for, or on account of, any period of disability:

- For which you are not under the regular care of a Doctor
- For which you have or had a right to payment under any workers' compensation law or occupational disease law
- Which is due to work-related Illness or Injury
- For which you have or had a right to payment under the temporary disability benefit laws of any state or unemployment
- Which is due to or caused by your illegal or willful misconduct.

Benefits under the Plan's Weekly Disability provisions are available for a non-occupational disability only. Abuse of disability benefits is considered fraud and may result in criminal prosecution.

CLAIMS AND APPEALS INFORMATION

A copy of the Claims and Appeals Information and procedures is included as an insert with this SPD. The claims and appeals information and procedures are furnished automatically, without charge, as a separate document. To obtain an additional copy of the Plan's medical, dental, vision and prescription drug claims and appeals processes, contact the Third Party Administrator and the procedures will be sent to you at no cost.

If you are not satisfied with a benefit determination, medical necessity determination, determination of your eligibility to participate in coverage or a decision to rescind your coverage, the Plan offers an appeals process. To submit an appeal electronically, go to the Claims Administrator's website, **www.medmutual.com**, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card. You may also write a letter and mail it to: Medical Mutual, Attn: Member Appeals Unit, MZ: 01-4B-4809, P.O. Box 94580, Cleveland, Ohio 44101-4580.

COORDINATION OF BENEFITS

Your and your Eligible Dependents' benefits are coordinated with other group plans or prepaid group health care plans, but only to the extent coordination is permissible under federal law, including Treasury or IRS regulations.

In no event will this Plan's payment be more than what would have been paid if there were no other plan involved. Benefits payable under another plan include any benefits that would have been payable, even though you may not actually have filed a claim.

Order of Payment

The Plan's Coordination of Benefits provisions determine which plan is primary (pays benefits first) and which plan is secondary.

The Fund pays regular benefits when this Plan is the primary plan. When this Plan is the secondary plan, the Fund will pay no more than the total percentage of costs that the Fund would have paid had this Plan been the primary plan. Remember that the Fund will not pay an amount that is greater than, when added to other amounts paid or payable, the actual expenses incurred.

Non-Dependent of Dependent

The plan that covers the Eligible Person other than as a dependent is the primary plan and the plan that covers the person as a dependent is the secondary plan.

Dependent Child Covered Under More Than One Parent Plan

(a) Unless there is a court decree stating otherwise, plans covering a dependent child will determine the order of benefits as follows:

- For a dependent child whose Parents are not divorced or separated, whether or not they have ever been married:
  - the plan of the Parent whose birthday falls earlier in the Calendar Year is the primary plan; or
  - if both Parents have the same birthday, the plan that has covered the Parent longest is the primary plan.

(b) For a dependent child whose Parents are divorced or separated or are not living together, whether or not they have ever been married:

- If a court decree states that one of the Parents is responsible for the dependent child's health care expenses/ coverage, then that plan is primary. If the Parent with responsibility has no health care coverage for the dependent child's health care expenses, but that Parent's Spouse does, that Parent's Spouse's plan is the primary plan (i.e., the step-parent's plan). This item will not apply with respect to any Plan Year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
- If a court decree states that both Parents are responsible for the dependent child's health care expenses or health care coverage, the provisions set forth in paragraph A will determine the order of benefit.
- If a court decree states that the Parents have joint custody without specifying that one Parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions in paragraph A will determine the order of benefits.
- If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:
  - the plan covering the Custodial Parent; then
  - the plan covering the Custodial Parent's Spouse; then

- the plan covering the Non-Custodial Parent; and then
- the plan covering the Non-Custodial Parent's Spouse.

- The order of benefits determined by court decree in paragraphs A and B will apply even after the dependent child reaches the age of eighteen or the court decree expires.

(c) For a dependent child covered under more than one plan of individuals who are not the Parents of the child, the order of benefits will be determined, as applicable, under paragraph A or B as if those individuals were the Parents of the child

(d) For a dependent child who has coverage under either or both Parents' plans and also has his or her own coverage as a dependent under a Spouse's plan:

- The rule in "Longer or Shorter Length of Coverage," below applies.
- In the event the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both Parents' plans, the order of benefits will be determined by applying the rule in paragraph A to the dependent child's Parent(s) and the dependent's Spouse.

Active Participant or Retired or Laid-Off Participant

(a) The plan that covers an Eligible Person as an Active Participant—a Participant who is neither laid off nor retired—or as a dependent of an Active Participant is the primary plan. The plan covering that same Eligible Person as a retired or laid-off Participant or as a dependent of a retired or laid-off Participant is the secondary plan

(b) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored

(c) This rule does not apply if the rule in "Non-Dependent of Dependent" can determine the order of benefits.

COBRA or State Continuation Coverage

(a) If an Eligible Person whose coverage is provided pursuant to COBRA continuation coverage or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the Eligible Person as a Participant, subscriber, or retiree or covering the person as a dependent of a Participant, subscriber, or retiree is the primary plan and the plan covering that same Eligible Person pursuant to COBRA continuation coverage or under a right of continuation pursuant to state or other federal law is the secondary plan

(b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored

(c) This rule does not apply if the rule in "Non-Dependent of Dependent" can determine the order of benefits.

Longer or Shorter Length of Coverage

(a) If the preceding rules do not determine the order of benefits, the plan that covered the Eligible Person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan

(b) To determine the length of time an Eligible Person has been covered under a plan, two successive plans will be treated as one if the Eligible Person was eligible under the second plan within 24 hours after coverage under the first plan ended

(c) The start of a new plan does not include:

- A change in the amount or scope of a plan's benefits;
- A change in the entity that pays, provides or administers the plan's benefits; and
- A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan

(d) The Eligible Person's length of time covered under a plan is measured from the Eligible Person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the Eligible Person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

No Other Rule Applies

If none of the preceding rules determines the order of benefits, the allowable expenses will be shared equally between the plans.

Plan Rights

The Plan has the right to:

- Obtain and share information with any other plan which may be subject to this provision without your consent
- Require that you provide information about other coverage which may be subject to this provision as a requirement for filing adequate proof of loss
- Pay any amount due under this Plan to any entity entitled to payment under this Plan
- Reject payment of any amount due under the Plan if you fail to provide information or timely respond to a request for information about other coverage which may be subject to this provision as a requirement for filing adequate proof of loss
- Reimburse any other Plan which paid benefits which should have been paid by this Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

Coordination of Benefits With Medicare

When Medicare is involved and entitlement to Medicare coverage is based on age, the order of payment is as follows:

- Medicare
- The Plan
- Retiree's Spouse's health care plan if the Spouse is also retired and has family coverage

However, if the Retiree's Spouse is actively employed and has family coverage under the Spouse's Employer's health care plan, the order of payment is as follows:

- Retiree's Spouse's health care plan
- Medicare
- The Plan

PRIVACY POLICY

The Board of Trustees of the I.B.E.W. Local No. 683 Health and Welfare Plan sponsors the Plan and is the Plan's designated Plan Sponsor. The Plan's administrative staff may have access to the 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 the Clinical Health Act of 2009 ("HITECH Act") and the Genetic Information Nondiscrimination Act of 2008 ("GINA") (collectively referred to as the "HIPAA Omnibus Rules"). These modifications were effective on or after March 26, 2013. The Plan will act in accordance with the uses and disclosures of PHI as modified by HITECH and GINA.

A complete copy of the Plan's Privacy Notice is included as an insert with this SPD. To obtain an additional copy of the Plan's Privacy Notice, contact the Plan's Third Party Administrator. It will be provided to you free of charge. To view a copy of the Plan's Privacy Notice, visit the Plan's website at **www.ibew683benefits.org**.

SUBROGATION

Whenever the Plan provides benefits as a result of claims arising from an Injury or Sickness for which a third party, including an insurer, may be liable, the Fund may make a claim or take legal action against the third party.

Whenever you or an Eligible Dependent have a claim or demand against any third party arising from or in connection with a loss suffered by you or your Eligible Dependent, benefits provided under this Plan will be paid according to the Plan provisions. Before such payments are made, however, you or your Eligible Dependent must agree, in writing, that the Fund will assume legal rights to recover against any such third party that may be held responsible, to the extent of any payments made by the Fund, and that the Fund is entitled to first rights of reimbursement from any recovery by you or your Eligible Dependent.

The right of Subrogation and reimbursement means that the Fund is entitled to recover from any recovery by you or your Eligible Dependent, to the extent of the full amount paid by the Plan on claims arising from or in connection with an injury caused by a third party, before payment is made to anyone else. The Fund has a lien on the benefits you or your Eligible Dependents recover to the extent of all benefits paid on your or your Eligible Dependent's behalf. This subrogation provision does not have an effect on a claim for a Death Benefit.

You will be required to provide the Fund with information regarding the identity of all potential defendants, their addresses, insurers, adjusters and claim numbers, as well as accident reports and any other information the Fund requests. If you fail to notify the Fund, as required, then upon any recovery made, whether by suit, judgment, settlement, compromise or otherwise, by you or your Eligible Dependent, the Fund will be entitled to reimbursement to the extent of benefit paid, immediately upon demand. You or your attorney will be deemed to hold any recovery made against any third party in trust for the Fund.

The Fund has the right to offset any pending or future claims against any recovery by you or your Eligible Dependent to the extent the recovery exceeds the reimbursed benefits paid by the Fund, even if no benefits have been paid by the Fund. The Fund will also have a lien to the extent of the benefits paid which may be filed with any person claimed to be liable to you or your Eligible Dependent on account of the loss incurred.

IMPORTANT PLAN INFORMATION

PLAN NAME

The formal name of the Plan is the I.B.E.W. Local No. 683 Health and Welfare Plan.

PLAN NUMBERS

The Internal Revenue Service assigns an Employer Identification Number (EIN) to organizations sponsoring benefit plans. The EIN number assigned to the Board of Trustees is 31-6084152.

The Trustees assign a Plan Number for use in reporting and disclosure filings required under the Employee Retirement Income Security Act of 1974 (ERISA). The Plan Number assigned is 501.

The Health Plan Identification ("HPID") Number assigned to the Health and Welfare Plan by the United States Department of Health and Human Services is 7427051751.

PLAN YEAR

All records for the Fund are kept on a Plan Year basis. The Plan Year starts on June 1 and ends on May 31.

NAME AND ADDRESS OF ADMINISTRATOR

The Plan Sponsor and/or Administrator of the Plan is the Board of Trustees of the I.B.E.W. Local No. 683 Health and Welfare Plan. The name and address of the Administrator is as follows:

Board of Trustees
I.B.E.W. Local No. 683 Health and Welfare Plan
6525 Centurion Drive
Lansing, Michigan 48917-9275

PLAN SPONSOR AND PLAN ADMINISTRATOR

The Plan is sponsored and administered by the Trustees. The Trustees have the authority to select and retain a professional Third Party Administrator. The Board of Trustees has engaged TIC International Corporation ("TIC") to administer and maintain the Health and Welfare Plan. The Third Party Administrator's name and address are as follows:

TIC International Corporation
6525 Centurion Drive
Lansing, Michigan 48917-9275
Toll Free (844) 683-0683

Questions pertaining to the Health and Welfare Plan should be directed to the Third Party Administrator. The Third Party Administrator handles the day-to-day operations of the Health and Welfare Plan.

TYPE OF PLAN

The Health and Welfare Plan is maintained for the purpose of providing death, dismemberment, disability, hospitalization, surgical, medical, prescription drug, dental, vision and other related benefits, as described in this SPD.

BOARD OF TRUSTEES

The Board of Trustees consists of Union and Employer representatives appointed by the Union and the Association. Refer to the *Important Contact Information* insert. Correspondence can be sent to the Board of Trustees at:

I.B.E.W. Local No. 683 Health and Welfare Plan
6525 Centurion Drive
Lansing, Michigan 48917-9275

The Trustees have delegated some administrative responsibilities to other individuals or organizations. See the *Important Contact Information* insert for a list of those organizations and their responsibilities.

ATTORNEYS FOR FUND AND AGENT FOR SERVICE OF PROCESS

Allotta | Farley Co., L.P.A.
2222 Centennial Road
Toledo, Ohio 43617
Phone (419) 535-0075
Fax (419) 535-1935
www.allottafarley.com

In addition, service of process may be made upon Medical Mutual of Ohio.

NAMES AND ADDRESSES OF EMPLOYERS

The Plan is a multiemployer plan as that term is defined in the Employee Retirement Income Security Act of 1974, and numerous Employers contribute to it. It would not be practical to list them all here; however, upon written request to the Health and Welfare Plan's Third Party Administrator, you will receive information as to whether a particular Employer or Union is contributing to the Health and Welfare Plan, and if so, its address.

SOURCES OF CONTRIBUTIONS TO PLAN

Contributions to this Plan are made by Employers together with self-contributions by Participants, in accordance with the terms and conditions of the Plan, as determined by the Board of Trustees. Contributions to this Plan made by Employers shall be made to the Trust Fund only under the obligations of a collective bargaining agreement and/or other written agreement between the contributing Employer and the Union. The Union shall be the authority for the specific provisions of the collective bargaining agreement establishing the obligation of the Employer to make contributions.

SELF-FUNDED BENEFITS

Most of the benefits provided through the Fund are self-funded (refer to the *Important Contact Information* insert in the back pocket of this booklet for information regarding the vendors that contract with the Fund). This means your Employer's contributions and any self-payment contributions are made directly to the Fund, and benefit payments to you or your beneficiaries are made directly from the Fund. There is no insurance company in between to collect premiums and pay benefits.

This procedure helps keep costs down and enables the Fund to provide more money for benefits. In addition, it means that all of us are part of a self-sufficient group. This places responsibility upon all of us, both Trustees and Participants, to spend the Fund's money for benefits with the same care and cost consciousness we would use in spending our own money.

INSURED BENEFITS

No benefits are offered through an insurance policy. All benefits are self-funded from accumulated assets and are provided directly from the Fund.

FUNDING MEDIUM FOR ACCUMULATION OF PLAN ASSETS

Assets are accumulated and benefits provided directly by the Trust Fund. The principal and income of this Plan are to be used for the exclusive benefit of Participating Employees, their Beneficiaries and for defraying proper expenses of administering the Plan.

PLAN AMENDMENT AND TERMINATION

The Trustees reserve the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended or terminated, you and other Active and Retired Employees may not receive benefits as described in other sections of this SPD. You may be entitled to receive different benefits or benefits under different conditions. However, it is possible that you will lose all benefit coverage. This may happen at any time, even after you retire, if the Trustees decide to terminate the Plan or your coverage under the Plan. In no event will you become entitled to any vested rights under this Plan. Further, the provisions of this paragraph cannot be modified in any manner except by resolution of the Board of Trustees.

THE PLAN IS NOT A CONTRACT

The Plan shall not be deemed to be a contract between the Administrator and any Participant, or to be an inducement to or condition of employment. Nothing in the Plan shall be deemed to give an Employee the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge any Employee at any time.

BOARD OF TRUSTEES' DISCRETION AND AUTHORITY

The Trustees or, where Trustee responsibility has been delegated to others, the other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of the Plan. Decisions of the Trustees or their delegates are final and binding. The Trustees or their delegates have broad discretion to determine eligibility for benefits and to interpret Plan language and their decisions will be accorded judicial deference in any subsequent action at a court or administrative proceeding to the extent that they do not constitute an abuse of discretion.

Benefits under this Plan will be paid only when the Trustees decide, or persons delegated by the Trustees decide, in their discretion, that you or a beneficiary is entitled to benefits in accordance with the terms of the Plan. Your coverage by this Plan does not constitute a guarantee of employment and you are not vested in the benefits described in this booklet.

In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that the decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over the matter.

You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. You may have, at your own expense, legal representation at any stage of the review process.

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

DISCLOSURE OF NON-GRANDFATHERED STATUS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

This Plan is a non-grandfathered health plan. As such, the Plan will be required to comply with various in-network cost-sharing limits that are mandated by the Affordable Care Act. The limits are subject to indexing each year based on a "premium adjustment percentage" as determined by the United States Department of Health and Human Services.

Further, the Plan must include certain consumer protections as required by the Affordable Care Act, including—

- Offering an essential benefit package
- Eliminating cost-sharing for certain preventive services
- Reporting on quality improvement activities
- Guaranteeing access to emergency, pediatric, and ob-gyn services

Questions regarding the Plan's status as a non-grandfathered health plan can be directed to the Third Party Administrator at:

I.B.E.W. Local No. 683 Health and Welfare Plan
6525 Centurion Drive
Lansing, Michigan 48917-9275
Toll Free (844) 683-0683

YOUR ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD (the Plan Administrator may make a reasonable charge for the copies).
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to furnish to each Participant.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to continue health care coverage for yourself, your Spouse, or your Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your Spouse, or your Eligible Dependents may have to pay for such coverage. Review this SPD and any documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in the United States District Court for the Eastern District of Wisconsin. 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 the United States District Court for the Eastern District of Wisconsin. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in the United States District Court

for the Eastern District of Wisconsin. 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.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or at:

Division of Technical Assistance and Inquiries

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by:

- Calling (866) 444-3272;
- Sending electronic inquiries to **www.askebsa.dol.gov**; or
- Visiting the website of the EBSA at **www.dol.gov/ebsa**.

GLOSSARY

Many words used in this Summary Plan Description ("SPD") have special meanings. These words will appear capitalized and are defined for you in this section. By reviewing these definitions, you will have a clearer understanding of your SPD.

After Hours Care means services received in a Physician's office at times other than regularly scheduled office hours, including days when the office is normally closed (e.g., holidays or Sundays).

Agreement means the administrative services agreement between the Claims Administrator and the Plan's Board of Trustees. The Agreement includes the individual Enrollment Forms of Participants and Eligible Dependents, the Benefit Book that describes the Plan's benefits, terms, conditions, limitations, and exclusions, Schedules of Benefits, and any Riders or addenda.

Alcoholism means a condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as alcohol dependence, abuse or alcoholic psychosis.

Allowed Amount means, for PPO Network and Contracting Providers, including Pharmacies, the Allowed Amount is the lesser of the applicable Negotiated Amount or Covered Charge. For Non-Contracting Providers, including non-Network Pharmacies, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the Billed Charges.

Ambulatory Surgical Center means a facility that's primary purpose is to perform surgical procedures strictly on an outpatient basis.

Association means the Columbus Division of the Central Ohio Chapter of the National Electrical Contractors Association, other individual Employers whom they negotiate on behalf of and/or Employers who make contributions into the Trust Fund pursuant to a Collective Bargaining Agreement or written participation agreement with the Board of Trustees and its successors.

Benefit Book means the booklet (and any amendments to such booklet) issued by the Claims Administrator that describes the Plan's benefits, terms, conditions, limitations, and exclusions, Schedules of Benefits, and any Riders or addenda.

Benefit Period means 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 twelve (12) months, depending on the Effective Date and the date your Coverage terminates.

Coinsurance means a percentage of the Allowed Amount or Non-Contracting Amount for which you are responsible after you have met your Deductible or paid your Copayment, if applicable.

Copayment means a dollar amount, if specified in the Schedule of Benefits, that a Covered Person may be required to pay at the time covered services are rendered.

Cosmetic or Reconstructive Surgery means any surgical procedure performed primarily to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction. The determination of whether a surgical procedure is Cosmetic or Reconstructive Surgery shall be made by the Trustees in their sole discretion, and any such determination shall be final, binding and conclusive. In no event shall this Plan provide payment for any loss, expense or charge which results from Cosmetic or Reconstructive Surgery, except:

1. For injuries received in an accident; or
2. For repair of birth defects of Eligible Dependent children; or

3. For repair of Medically Necessary defects which result from Surgery for which benefits were paid under this Plan; or
4. Medical and surgical benefits with respect to a mastectomy will be covered for eligible Participants and Eligible Dependents who elect breast reconstruction in connection with such mastectomy as listed below:
   i. reconstruction of the breast on which the mastectomy has been performed; or
   ii. surgery and reconstruction of the other breast to produce asymmetrical appearance; or
   iii. coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Any such mastectomy will be covered in a manner determined in consultation with the attending Physician. Such coverage will be subject to the Deductibles and Coinsurance rate provisions that are consistent with those established for other benefits under the Plan.

Covered Charges means the Billed Charges for covered services, except that the Claims Administrator reserves the right to limit the amount of Covered Charges for covered services provided by a Non-Contracting Institutional Provider to the Non-Contracting Amount determined as payable by the Claims Administrator.

Covered Employment means employment under the jurisdiction of the Union for which an Employer is obligated by its Collective Bargaining Agreement with the Union or by any other separate written agreement approved by the Board of Trustees to contribute to the Fund, either individually or as a member of the Association.

Covered Person means a Participant and, if family coverage is in force, an Eligible Dependent who has enrolled for coverage under the Plan's terms and conditions and persons continuing coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and any other legally mandated continuation of coverage.

Creditable Coverage means coverage of an individual under any of the following:

1. A group health plan, including church and governmental plans;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. The health plan for active military personnel, including TRICARE;
5. The Indian Health Service or other tribal organization program;
6. A state health benefits risk pool;
7. The Federal Employees Health Benefits Program;
8. A public health plan as defined in federal regulations;
9. A health benefit plan under Section 5(c) of the Peace Corps Act; or
10. Any other plan that provides comprehensive Hospital, medical and surgical services.

Custodial Care means care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting his or her activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

1. Administration of medication which can be self-administered or administered by a lay person; or
2. 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.

Custodian means a person who, by court order, has permanent custody of a child.

Deductible means the specified dollar amount of Covered Charges which a Participant or family must incur each Benefit Period before a Covered Charge will be partially or fully paid. Separate individual and family Deductibles are set forth in the Schedule of Benefits.

Dentist means a Doctor of Dental Surgery (D.D.S.) or Doctor of dental medicine (D.M.D.) practicing within the scope of his or her license.

Doctor means a Doctor of medicine (M.D.), Doctor of osteopathy (D.O.), Doctor of chiropractic (D.C.), ophthalmologist, optometrist (for vision therapy only), podiatrist, Dentist, psychiatrist, or Psychologist practicing within the scope of his or her license. Doctor does not include the Participant nor the Spouse, parent, child, brother or sister or any other family member of the Participant.

Eligible Dependent means persons designated as such in Article V, Section A, provided they are not eligible to be covered under the Plan as Employees and, if previously covered as Employees, are not eligible to receive any benefits under the Plan as a result of a disability existing when coverage as an Employee was discontinued. The coverage of any person who is eligible to be covered under the Plan both as an Employee and as an Eligible Dependent shall be governed by the Plan's Coordination of Benefits rules.

Eligible Employee or **Covered Member** means any person who meets the Eligibility Rules as adopted by the Trustees.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to the individual's bodily functions; or
3. Serious dysfunction of a bodily organ or part of the individual.

Emergency Services means a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee means any member of a collective bargaining unit represented by the Union who first qualifies as an inside journeyman wireman electrician working in Covered Employment on or after October 1, 2019.

Employer means:

1. Any individual, firm, association, partnership or corporation that is a member of the Association and/or is represented in collective bargaining by the Association and/or who is bound by a Collective Bargaining Agreement with said Union and in accordance therewith agrees to participate in and contribute to the Trust Fund.
2. Any individual, firm, association, partnership or corporation that is not a member of nor represented in collective bargaining by the Association, but who has duly executed and/or is bound by the Collective Bargaining Agreement with the Union or signs a participation agreement with the Board of Trustees and in accordance therewith agrees to participate in and contribute to the Trust Fund.
3. The Union, the Trustees, or the Joint Apprenticeship Training Committee to the extent, and solely to the extent, that it acts in the capacity of an Employer of its Employees on whose behalf it makes Contributions to the Trust Fund pursuant to the Amended Agreement and Declaration of Trust and the rules and procedures prescribed by the Trustees.

The Employers, as defined herein, shall, by the making of payments to the Trust Fund pursuant to the Collective Bargaining Agreement, be conclusively deemed to have accepted and be bound by the Amended Agreement and Declaration of Trust and the Plan.

Essential Health Benefits means benefits defined under the Patient Protection and Affordable Care Act (PPACA) as including benefits in at least the following categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Expenses Incurred means those Charges made for services and supplies which a prudent person would consider to be reasonably priced and reasonably necessary in the light of the Injury or sickness being treated. Expenses Incurred are deemed to be incurred on the day the purchase is made or the service is rendered unless specifically stated in this booklet and/or the Schedule of Benefits. Expenses Incurred do not include any charge for a service or supply which is not covered by this Plan; or which is in excess of the Allowed Amount for a service or supply; or not approved by the Board of Trustees. Expenses Incurred as a result of an intentionally self-inflicted Injury or Illness are excluded under this Plan.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure means a drug, device, medical treatment or procedure that is deemed to be Experimental or Investigational. A drug or device is deemed to be Experimental or Investigational:

1. 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 provided
2. If reliable evidence shows that the drug, device, medical treatment or procedure is not considered to be the standard of care, is the subject of ongoing 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
3. If reliable evidence shows that the consensus of opinion among experts is that the drug, device, medical treatment or procedure is not the standard of care and 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. For this purpose, reliable evidence may consist of any one or more of the following:
    i. published reports and articles in the authoritative medical and scientific literature
    ii. opinions expressed by expert consultants retained by the Claims Administrator to evaluate requests for coverage
    iii. 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
    iv. the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure

v. corporate medical policies developed by the Claims Administrator

vi. any other findings, studies, research and other relevant information published by government agencies and nationally recognized organizations

Even if a drug, device, or portion of a medical treatment or procedure is determined to be Experimental or Investigational, the Plan will cover those Medically Necessary services associated with the Experimental or Investigational drug, device, or portion of a medical treatment or procedure that the Plan would otherwise cover had those Medically Necessary services been provided on a non-Experimental or non-Investigational basis.

The determination of whether a drug, device, medical treatment or procedure is Experimental or Investigational shall be made by the Group and the Claims Administrator in their sole discretion, and that determination shall be final and conclusive, subject to any available appeal process.

Home Health Care Agency means a public or private agency which:

1. Is certified as a Home Health Care Agency under Medicare or is licensed as a Home Health Care Agency by the state
2. Is primarily engaged in providing skilled nursing and other therapeutic services
3. Has its policies set by a professional group which governs the services provided
4. Maintains records for each patient
5. Is not connected to a Nursing Home, convalescent home, rest home, or Hospice Facility

Hospice Facility means a facility which is licensed, where required, which provides palliative care for terminally ill patients.

Hospital means an accredited Institution that meets the specifications set forth in the appropriate Chapter of the Ohio Revised Code and any other regional, state or federal licensing requirements, except for the requirement that such Institution be operated within the State of Ohio.

Illness means a sickness or disease (including mental disorders) which requires treatment by a Doctor and is recognized by the terms of this Plan and the Trustees. Unless otherwise excluded under this Plan, "Illness" includes pregnancy, childbirth or miscarriage, and complications associated therewith for members or Spouses of members only. Charges as a result of intentionally self-inflicted Illness are excluded under this Plan. Determination of whether Illnesses are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

The term "Illness" shall also include congenital defects or birth abnormalities, including premature birth for which more than routine nursery care is required, and transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the condition, when such ambulance transportation is certified by the attending Physician as necessary to protect the health and safety of the newborn child. The coverage of such transportation shall not exceed the Allowed Amount.

An occupational disease which entitles the person to benefits under a Workers' Compensation law or similar legislation is excluded under this Plan. This Plan excludes any treatment, service, or expense which may be connected with an occupational disease in which the person has received a lump sum settlement for his or her claim for benefits under Workers' Compensation law or similar legislation. This Plan also does not provide benefits for services, supplies or charges which are received in a military facility for a military service related Injury, ailment, condition, disease, disorder or Illness.

Injury means any accidental bodily Injury which requires treatment by a Physician and is recognized by the terms of this Plan and the Trustees. The Injury must result in loss independently of Illness and other causes. All injuries sustained by a person in connection with one accident will be considered one Injury.

An Injury or occupational disease which entitles the person to benefits under a Workers' Compensation law or similar legislation is excluded under this Plan. Further, this Plan excludes any treatment, service, or expense which may be connected with an Injury in which the person has received a lump sum settlement for his or her claim for benefits under Workers' Compensation law or similar legislation. This Plan also does not provide benefits for services, supplies or charges which are received in a military facility for a military service related Injury, ailment, condition, disease, disorder or Illness. The determination of whether Injuries are included or excluded under this Plan shall be made by the Trustees in their sole discretion, and such determination shall be final, binding and conclusive.

Legal Guardian means an individual who is either the natural guardian of a child or who was appointed a guardian of a child in a legal proceeding by a court having the appropriate jurisdiction.

Medically Necessary means a covered service, supply and/or Prescription Drug that is required to diagnose or treat a condition and which the Claims Administrator determines is:

1. Appropriate with regard to the standards of good medical practice and not Experimental or Investigational
2. Not primarily for your convenience or the convenience of a Provider
3. The most appropriate supply or level of service which can be safely provided to you

When applied to the care of an Inpatient, Medically Necessary means that your medical symptoms or condition require that the services cannot be safely or adequately provided to you as an Outpatient. When applied to Prescription Drugs, Medically Necessary means the Prescription Drug is cost-effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

Mental Illness means a condition classified as a mental disorder in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, excluding Drug Abuse and Alcoholism.

Nursing Home means a place which is operating legally to provide room and board for sick or injured persons under the supervision of a registered nurse or a Doctor, and along with the services of Nurses at all hours, meets all of the following tests:

1. It has available at all times the services of a Doctor who is on the staff of a Hospital
2. It keeps a daily medical record for each patient
3. It is not primarily a place for rest or Custodial Care, a place for the aged, or a hotel

Out-of-Pocket Maximum means the maximum dollar amount that a Covered Person will be required to pay during a given Benefit Period for the Deductibles and Coinsurance charged for covered services received, subject to the following:

1. If only the Employee is covered, the Out-of-Pocket maximum amount listed as "Individual" will apply
2. If the Employee covers himself/herself and one Eligible Dependent, both will be required to meet the "Individual" Out-of-Pocket maximum amount
3. If the Employee covers two (2) or more Eligible Dependents, both the "Individual" and "Family" Out-of-Pocket maximum amounts will apply. Each person in the Family plan is required to contribute up to the "Individual" amount toward the "Family" Out-of-Pocket maximum. Once the "Family" Out-of-Pocket maximum amount is met, the "Individual" Out-of-Pocket maximum amount is satisfied for all Covered Persons

Participant means any Employee or former Employee of an Employer or any member or former member of the Union who is or may become eligible to receive a benefit of any type from the Plan, or whose Eligible Dependents may be eligible to receive any such benefit.

Physician means a person who is licensed and legally authorized to practice medicine.

PPO Network Provider means any Provider, a Contracting Hospital or Contracting Other Facility Provider that is included in a limited panel of Providers as designated by the Claims Administrator and for which the greatest benefit will be payable when one of these Providers is used.

Provider means a Hospital, Other Facility Provider, Physician or Other Professional Provider.

Psychologist means an Other Professional Provider who is a licensed Psychologist having either a doctorate in psychology or a minimum of five (5) years of clinical experience. In states in which there is no licensure law, the psychologist must be certified by the appropriate professional body.

Residential Treatment Facility means an accredited facility that provides live-in care for the evaluation and treatment of mental health or substance abuse disorders.

Skilled Nursing Facility means 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 either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

Spouse means that person, if any, who:

1. Is recognized as legally married to the Participant by a domestic or foreign jurisdiction whose laws authorized the marriage at the time the Participant and such person entered into the marital relationship
2. Has not been declared legally separated from the Participant by any judicial order

The term "Spouse" shall include a person of the opposite or same gender as the Participant.

Surgery means:

1. The performance of generally accepted operative and other invasive procedures
2. The correction of fractures and dislocations
3. Usual and related preoperative and postoperative care
4. Other procedures as reasonably approved by the Claims Administrator

Total Disability or **Totally Disabled** means a condition resulting from an Injury or Illness that renders an individual unable to:

1. Work for pay, profit, or gain at any job for which one is suited by reason of education, training or experience
2. Engage in one's regular and usual activities and not working at any job for pay, profit or gain

The provisions of 1. above apply to each person who is covered as an Active Employee. The provisions of 2. above apply to all other Covered Persons. The determination of whether an Eligible Employee or an Eligible Dependent is Totally Disabled or has a Total Disability will be made by the Trustees in their sole discretion, and such determination shall be final, binding and conclusive.

Transplant Center means a facility approved by the Claims Administrator that is an integral part of a Hospital and that:

1. Has consistent, fair and practical criteria for selecting patients for transplants
2. Complies with all federal and state laws and regulations that apply to transplants covered under this Plan

Trust Fund, Trust or **Fund** means the I.B.E.W. Local No. 683 Health and Welfare Fund and the Fund's entire assets, including all funds received by the Trustees in the form of Employer contributions, together with all contracts (including dividends, interest, refunds and other sums payable to the Trust Fund on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits from such investments, and any other property or funds received and held by the Trustees under the Amended Agreement and Declaration of Trust.

Union means the International Brotherhood of Electrical Workers, Local Union No. 683 and its successors, and any other local union that by contract with an Employer approved by the Board of Trustees agrees to become a part of this Health and Welfare Plan and to be bound by the Trust Agreement, Plan document and the rules and procedures prescribed by the Trustees.

Urgent Care means any condition that is not an Emergency Medical condition but requires immediate attention.

Year of Service means the greatest number of Years of Service that, pursuant to any of the following administrative records, have been credited to an Employee who has satisfied the Plan's eligibility requirements:

1. The administrative records of any Union-sponsored employee benefit plan in which the Employee has participated
2. Such other administrative records of the Union as the Board of Trustees, in their discretion, may accept as reliable in accurately determining the Employee's service in Covered Employment

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International Brotherhood of Electrical Workers
Local No. 683 Health and Welfare Plan
6525 Centurion Drive
Lansing, MI 48917-9275