THE LAKE COUNTY INDIANA,
NECA – I.B.E.W.
HEALTH AND BENEFIT PLAN

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT
(Incorporating Plan changes through July 31, 2020)

HOW TO USE THIS MANUAL

This manual serves both as the Summary Plan Description Book as well as the Plan Document. It is designed to help you understand how your Plan works. To that end, and with the exception of the sections titled “A Brief Overview of Your Health and Benefit Plan” and “General Plan Information” directly following this page, the rules, provisions and benefit descriptions have all been arranged in alphabetical order by topic. For instance, if you wanted to enroll your newborn child into the Plan you would reference the “Enrollment” section. If you wanted to learn more about your pharmacy benefit, you would reference the “Pharmacy benefit” section, and so forth.

Should you have any other questions about the Plan and how its coverage works, contact:

The Lake County Indiana, NECA/I.B.E.W. Health and Benefit Plan
7200 Mississippi Street
Suite 300
Merrillville, IN 46410
219-940-6181.

A BRIEF OVERVIEW OF YOUR HEALTH AND BENEFIT PLAN.

Three important features differentiate this Plan from other insurance programs under which you may have been covered in the past.

First, the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Plan began and remains an indemnity Health and Benefit plan designed to reduce the out-of-pocket expenses incurred whenever its participants need catastrophic or day-to-day medical care. Simply put, the Health and Benefit Plan is here to help protect you against losing too much money when medical maladies arise in your life. As with other insurance plans, the Fund was never designed to fully pay for every procedure or expense associated with you or your dependent's dental, medical, pharmaceutical or vision care.

Secondly, the Health and Benefit Plan is a self-insured plan. As such, all of the contributing employer contributions, participant self-payments and investment income are pooled together to pay the dental, medical, pharmaceutical and vision claims of the less fortunate non-healthy participants.

Thirdly, regardless of any medical network affiliation, the Health and Benefit Plan directly provides you and any eligible dependent the benefits contained within this document. It is the Health and Benefit Plan that assumes the responsibility for paying claims in accordance to the terms, conditions and provisions set forth within this document.

Further, benefits are offered thought the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Plan instead of cash. There are several good reasons for having benefits sponsored by the Plan:

A. The money the Plan spends on benefits is a form of tax-free income to you. If your employers paid to you directly the same amount of money they contribute on your behalf for these benefits, that money would be taxed, leaving less to spend on benefits themselves.

B. Because the Fund provides coverage for thousands of people, it can obtain better benefits at lower costs than you could purchase individually.

C. A Fund-sponsored benefit program can generally offer protection to everyone. This means even those people who might be considered uninsurable can get coverage.

The Deductible: You are required to pay an annual deductible. Once your medical bills exceed the deductible limit, the Health and Benefit Fund will begin to make payments according to the provisions and benefits set forth within this document.

Freedom to Choose Medical Providers: As a participant of the Plan, you are free to seek medical care from the provider of your choice. Meaning: you have the option to utilize a participating provider or a non-participating provider at any time you need care. However, participants are advised that, as with any freedom, comes responsibility. It is your responsibility to know the network affiliation of all medical practitioners being utilized by you and your family as well as the provisions and benefits of the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Plan.

Participating Physicians / In-Network Physicians: The Trustees have contracted with a medical provider network in-order to help reduce most out-of-pocket costs that you may incur when seeking medical attention. If you choose to utilize the services of one of these participating physicians, the Fund will pay ninety percent (90%) of the negotiated fee for covered services that exceed your annual deductible.

Designated Hospitals and Facilities. This section is referring to facility charges that are incurred when a person utilizes a signatory hospital and facility. Participants are cautioned that. persons, professionals or physicians who render services within these signatory facilities may be independent of said facility. Meaning; These professionals may be out of network.

The Plan maintains a narrow network of participating hospitals and facilities. Meaning, the number of participating hospitals and facilities that have agreed to accept the Plans reasonable and allowable payment schedule is very limited.

There are **two levels** of participating hospitals and facilities.

Level A hospitals are those facilities or institutions that have agreed to accept the Plans determination of its' Reasonable Allowable Amount as payment in full for any covered expense. When utilizing a level A hospital or facility:

1. The facility will not balance bill participants for amounts in-excess of the Plans payment for any covered facility related service.

2. Level A facility charges will not be subject to the Plan's annual deductible requirement.

Level B hospitals are those facilities or institutions that have agreed to a Reasonable and Allowable Amount as the maximum payment for any covered facility service. However, when utilizing a Level B facility;

1. The Plan will pay ninety percent (90%) of the agreed upon Reasonable and Allowed Amount for any covered facility service.

2. The patient will be responsible for the ten percent (10%) difference between what the Plan paid and the agreed upon Reasonable and Allowed Amount (termed "co-insurance"), PLUS and any applicable deductible.

Out-of-Network Physicians, Hospitals and Facilities. Out-of-network providers are those entities that:

A. Have chosen not to belong to the contracted physician's network or,

B. Are a hospital or facility that does not maintain an agreement with the Lake County Indiana, NECA – I.B.E.W., Health and Benefit Plan, or a referenced based priced agreement with the third-party entity the Plan has contracted with, to provide repricing and/or contracting services.

After the participants deductible is satisfied, the Plan will pay seventy percent (70%) of one-hundred and thirty percent (130%) of the Plan's determination of the Reasonable and Allowed Amount for any covered service provided by an out-of-network physician, hospital and/or facility. Any balance that exceeds the Plan's payment will remain the responsibility of the participant.

GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan is sponsored by a joint labor-management Board of Trustees. The Board of Trustees are both the Plan Sponsor and Plan Administrator. The Board is divided equally between Trustees appointed by the Union and by Trustees appointed by the National Electronic Contractors Association (NECA). The names and addresses of the individual Trustees are shown within the section of this document titled "Plan Administration Information".

The Plan Sponsor has established the Plan in accordance with the terms and conditions described herein for:

1. The benefit of eligible collectively bargained individuals and their eligible dependents.

2. Certain non-bargained participants and their eligible dependents.

Participants in the Plan may be required to contribute toward their benefits in the form of self-payments. Contributions received from participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible participants and their dependents against certain health expenses and to help defray the financial effects arising from injury or sickness. To accomplish this purpose, the Trustees are mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provision, all the while, effectively assigning the resources available in accordance to the terms of the Plan Document to help participants in the Plan to the maximum feasible extent.

The Plan Sponsor is required under ERISA to provide to participants a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan's Trust Document is maintained by the Fund Manager and may be reviewed at any time during normal working hours by any Participant.

The Trustees are assisted in the administration of the Plan by a salaried Fund Manager, who is an employee of the Fund. The name and address of the Fund Manager, which is also the address of the Fund Office, is:

Patrick J. Keenan
Fund Manager
Lake County, Indiana N.E.C.A./I.B.E.W. Health and Benefit Plan
7200 Mississippi Street, Suite 300
Merrillville, IN 46410

Further assistance is provided by a third-party administrator (TPA), an attorney and consultant. These entities are identified within the section of this document titled "Plan Administration Information".

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Office.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions, and a listing of EBSA field offices, at the EBSA website at www.dol.gov/ebsa.

Conformity with Applicable Laws

It is intended that the Plan will conform to the requirements of Employee Retirement Income Security Act (ERISA) as it applies to Employee Welfare Plans as well as any other applicable law. Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, exclusions, or statutes of limitations.

Continue Group Health Plan Coverage

In certain cases, you can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Consequently, participants that find themselves in this situation need to review the rules governing your eligibility or COBRA rights under the sections of this document titled “Eligibility” and /or “COBRA”.

Discretionary Authority of the Board of Trustees

The Board of Trustees shall have sole, full and final discretionary authority to interpret all Plan provisions, rules, and procedures including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regard to issues relating to eligibility for benefits; to decide disputes that may arise relative to rights; and to determine all questions of fact and law arising under the Plan. The Boards interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees, or a party to whom the Trustees have delegated decision-making authority, is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by the Board to make such decisions, decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

The Trustees have the authority to amend the Plan, which includes the authority to change eligibility rules and other provisions of the Plan, and to increase, decrease or eliminate benefits. However, no amendment may be adopted which alters:

1. The basic principles of the trust agreement founding the Fund, or,
2. That conflicts with collective bargaining agreement provisions that are applicable to the contributions to the Fund, or,
3. Is contrary to laws governing multiemployer ERISA trust funds, or,
4. Is contrary to agreements entered into by the Trustees.

In addition, and as more fully explained in the "Plan Discontinuation or Termination" section, the Trustees may terminate the Trust and this Plan of Benefits at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. The Trustees may adopt such rules as they feel are necessary, desirable or appropriate, and they may change these rules and procedures at any time.

The Trustees specifically have the right and the authority to change the provisions relating to coverage for retirees and their dependents at any time and in their sole discretion, since the Plan's retiree benefits are not "accrued" or "vested" benefits. Any such change made by the Trustees will be effective even though an employee has already become a covered retiree.

The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participants and beneficiaries.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 a state or federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

Get Plan Material

As described under the section titled "Your Rights Under ERISA" within the segment of this document, you can read Plan documents and material by making an appointment at the Fund Office during normal business hours. Also, copies of requested material will be mailed to you if you send a written request to the Fund Office. There may be a small charge for copying some of the material, so call the Fund Office to find out the cost before requesting material. If a charge is made, your check must be attached to your written request for the material. The Fund Office address and phone number are shown on the inside front cover of this booklet, listed within the section of this book titled Administration Information as well as on the Plan's website.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Mental Health Parity

Pursuant to both the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Fund Manager.

No Waiver or Estoppel

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein and shall be interpreted in the narrowest fashion possible.

Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible employee's and his or her dependent's/dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible employee's and his or her dependent's/dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

If you believe that the Plan has failed to comply with any applicable Federal civil rights laws and/or you believe you have been discriminated based upon race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Fund Office by mail, fax or in person at Lake County, Indiana NECA/IBEW Health and Benefit Plan, 7200 Mississippi Street, Suite 300, Merrillville, IN 46410, telephone 1-219-845-4433. If you need help filing a grievance, Fund Office personnel are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ ocr/office/file/index.html.

Notice Regarding the Plan's Grandfathered Status

The Trustees of the Lake County, Indiana NECA-IBEW Health and Benefit Plan have determined that the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement to cover preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office, in care of the Fund Office at 7200 Mississippi St., Suite 300, Merrillville, IN 46410, telephone 1-219-845-4433. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Other Plans Provided by this Fund

The Fund provides a class of benefits, called Class 4, for surviving dependents of eligible participants who died prior to January 1, 2001. Class 4 has been closed to new participants since that date. The eligibility requirements and benefits for Class 4 are described in the January 1, 2002 edition of the Summary Plan Description. A summary of those rules and benefits is available upon request to the Fund Office.

Plan Discontinuation or Termination

The Plan of Benefits may be terminated under certain conditions: if there is no longer a collective bargaining agreement or participation agreement requiring contributions to the Fund; or, if it is determined that the Fund is inadequate to carry out the purposes for which the Fund was founded. The Plan may be terminated at any time by a vote of the Trustees or by a written mutual agreement of the Union and the Association to terminate the trust, if the action is taken in conformity with applicable law. In such a case, benefits for covered expenses incurred before the termination date will be paid on behalf of covered persons as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets; and benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

Plan Participation

The classes of individuals permitted to be covered under this Plan can be found within the section of this book titled "Definitions" under the term "Dependents" and "Participant".

The Plan shall take effect for each participating employer on the date that they became signatory to the Union's collective bargained agreement, or participation agreement. The Plan shall take effect for each participating employer on the effective date, unless otherwise noted and mutually agreed upon between the Plan and the Employer.

Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any participant, the Plan Administrator in its sole discretion may terminate the interest of such participant or former participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such participant or former participant, his or her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a dependent of such participant or former participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

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.

Right of Recovery

Whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: Any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the participant or his or her dependents. See the Payment Recovery provision of this document for full details.

Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator or its duly authorized representative, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise in regard to all such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Statements

All statements made by the employer or by a participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the participant.

Any participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Unclaimed Plan Funds

In the event a benefits check issued by the Plan or it's third-party administrator is not cashed within one year of the date of issue, the check will be voided, and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. Should a participant subsequently request payment with respect to the voided check, the third-party administrator for the Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA and any other applicable State law(s).

Word Usage

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Written Notice

Any written notice required under this Plan which, as of the effective date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Your Rights Under ERISA

As a participant in the Lake County, Indiana NECA - IBEW Health and Benefit 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 shall be entitled to receive information about your Plan and Benefits and/or:

- Examine without charge, at the Plan Administrator or the office of the Board of Trustees and at other specified locations, all documents under which this Plan is maintained, including insurance contracts, your collective bargaining agreement and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Upon written request to the Plan Administrator, obtain copies of all documents under which this Plan is maintained, including information as to whether a particular employer is a contributing employer and, if so, the employer's address. A reasonable charge may be made for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

PLAN ADMINISTRATION INFORMATON

Name of Plan: The Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan

Plan Administrator: (Named Fiduciary) The Board of Trustees of the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan

Plan Sponsor ID No. (EIN): 35-0911491.

Source of Funding: The Fund receives contributions from employers under the terms of collective bargaining agreements and participation agreements from the Union or Trust. The Fund also receives self-payments from employees, retirees and dependents for continuing coverage under the Plan. It may also receive rebates from its prescription benefit manager.

All employer contributions, rebates and self-payments by employees, retirees and dependents are received and held in trust by the Trustees pending the payment of benefits, insurance premiums and administrative expenses.

The Trustees shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the participating employer and the amounts to be contributed (if any) by each participant. Such determination shall be made on a lawful and sound basis and as such, be made in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other applicable laws and regulations. The level, manner and means by which the Plan is funded shall be solely determined by the Trustees to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Trustees obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to collect contributions and make said contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Plan's obligation with respect to such payments.

In the event that the Trustees terminate the Plan, then as of the effective date of termination, the employer and eligible participants shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Plan Status: Grandfathered

Applicable Law: ERISA

Plan Year: January 1st through December 31st

Plan Number: 501

Plan Types: The Lake County, Indiana NECA/I.B.E.W. Health and Benefit Plan is classified as a health and welfare benefit plan. The Plan provides medical, surgical, hospital, disability, dental and vision benefits on a self-insured basis. When benefits are self-insured, the benefits are paid directly from the Fund to the claimant or beneficiary. The self-insured benefits payable by the Plan are limited to the Plan assets available for such purposes and all benefits paid remain self-insured regardless if made by this Plan or through any contracted third-party entity.

This Plan is not an insurance policy and no benefits other than the life insurance and AD&D insurance are provided by or through an insurance company. The Plan provides life insurance and AD&D insurance benefits through the Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166-0188.

Agent for Service of Process: The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Fund Manager. The Fund Manager assists the Trustees in the administration of the Plan and is a salaried employee of the Fund. The name and address of the Fund Manager, which is also the address of the Fund Office, is:

Patrick J. Keenan
Fund Manager
The Lake County Indiana, NECA/IBEW Health and Benefit Plan
7200 Mississippi Street, Suite 300
Merrillville, IN 46410
Telephone 219-940-6181

Fund Attorney: Harold G. Hagberg,
Hagberg and Associates,
11045 Broadway Avenue,
Suite D,
Crown Point, IN 46307
Telephone 1-219-864-9055.

Fund Consultant: Foster & Foster, Inc.,
One Oakbrook Terrace,
Suite 720, Oakbrook Terrace, IL 60181-4419.

Participating Employer(s): A complete list of employers and the Union sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Board of Trustees, and is available for examination by participants and beneficiaries, as required by DOL regulations 29 CFR §§ 2520.104b-1 and

2520.104b-30. This right includes a "superseded" collective bargaining agreement if such agreement controls any duties, rights or benefits under the Plan.

Plan Trustees:	**Union Trustees**	**Employer Trustees**
	Alec Davis	Rick Anderson
	Phil Hernandez	Thomas Corsiglia
	Ryan Reithel	Edward Shikany
	Daniel Waldrop	William Walton

Prescription Benefit Manager:

SavRX
224 North Park Avenue
Fremont, NE 68025
phone: 1-866-233-4239
Fax: 1-888-310-1394
Web address: www.savrx.com

Third Party Administrator:

MagnaCare
P.O. Box 1001
Garden City, NY 11530

SUMMARY
SCHEDULE OF BENEFITS

Covered Expense	In-Network	Non-Network	Benefit Limits
Alcohol Dependency Level A Inpatient Facility Level B Inpatient Facility Level A Intensive Out-Patient Facility Level B Intensive Out-Patient Facility Partial Day Program Outpatient Physician	Precertification Required 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Services obtained prior to precertification will not be covered.
Ambulance Ground Transportation Air Ambulance	For Emergencies Only 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. 90% of the RAA. Subject to the Deductible and Annual Out-of-Pocket Maximum.	For Emergencies Only 70% of the billed charge or 200% of the Medicare Reimbursable Allowance, whichever is less. Subject to the Deductible and Annual Out-of-Pocket Maximum. 70% of the billed charge or 200% of the Medicare Reimbursable Allowance, whichever is less.	Services that do not meet the Plans definition of an "Emergency" – are not covered. The Plan's reimbursement for air ambulance charges that fail to meet all of the four benefit criteria as outlined within the air ambulance benefit description will be paid in accordance to this Plan's ground transportation

Covered Expense	In-Network	Non-Network	Benefit Limits
		Subject to the Deductible and Annual Out-of-Pocket Maximum	ambulance provision.
Ambulatory Surgical Center	Precertification Required	Pre-certification Required	Services obtained prior to precertification will not be covered.
Physician/Surgeon Fees	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximums	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Level A Facility Fee	100% of the Reasonable and Allowed Amount.		
Level B Facility Fee	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximums		
Anesthesia	Subject to the Deductible and Out-of-Pocket Maximum	Subject to the Deductible and Out-of-Pocket Maximum	Base Unit Maximum Allowable Amount (MAA) = $100.00 per unit.
Emergency	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	Base Unit Maximum Allowed Amount + Time Unit Maximum Allowed Amount x 90%	Time Unit Maximum Allowed Amount = $100.00.
Scheduled Non-Emergency	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	If performed by a non-participating provider in a non-participating facility. Base Unit Maximum Allowed Amount + Time Unit Maximum Allowed Amount x 70%	
CNRA & Anesthesiologist both submitting bills.	90% of the Reasonable and Allowed Amount. Payment is split 50% / 50%. Subject to the Deductible and Annual Out-of-Pocket Maximum	If performed by a non-participating provider in a non-participating facility. Base Unit Maximum Allowed Amount + Time Unit Maximum	

Covered Expense	In-Network	Non-Network	Benefit Limits
CRNA Only	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Allowed Amount x 70% Payment is split - 50% - 50% Between CNRA & Anesthesiologist. If performed by a non-participating provider in a non-participating facility. 70% of the Reasonable and Allowed Amount.	
Annual Out of Pocket Maximum Individual Family	 $2,500.00 $5,000.00	 $5,000.00 $10,000.00	The following items will not accumulate toward an individual's annual our-of-pocket maximums. C.O.B.R.A. premiums Deductibles Dental expenses Expenses that exceed the Plans allowance, set limits or maximums Expenses that are for treatments or benefits not covered under the Plan. Hearing aid benefits that exceed the Plan's benefit. Self-payment amounts of monthly or quarterly premiums Vision expenses that exceed the Plan's limits.

Covered Expense	In-Network	Non-Network	Benefit Limits
Assistant Surgeons	Precertification Required 90% of the Reasonable and Allowed Amount for the surgeon. Subject to the Deductible and Out-of-Pocket Maximum.	Precertification Required ¼ of 70% of 130% of the Reasonable and Allowed Amount for the surgeon. Subject to the Deductible and Out-of-Pocket Maximum.	
B-12 Shots	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out of Pocket Maximum.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out of Pocket Maximum	
Bariatric/Gastric Bypass	Pre-certification required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Services received prior to receiving precertification are not covered.
Birthing Center	Precertification required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Services received prior to receiving precertification are not covered.
Blood & Plasma	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	
Bone Density Testing	100% of the Reasonable and Allowed Amount. Subject to the Out-of-Pocket Maximum. No-Deductible.	70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible & Annual	

Covered Expense	In-Network	Non-Network	Benefit Limits
		Out-of-Pocket applies	
Breast Pump	Up to 90% of the charge, not to exceed $150.00. Subject to the deductible and Out-of-Pocket Maximum	Up to 70% of the charge, not to exceed $150.00. Subject to the deductible and Out-of-Pocket Maximum	$150.00 Maximum Allowance.
Cardiac Rehabilitation	Precertification Required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Services received prior to receiving precertification are not covered.
Cardiac Risk Assessments	100% of the Reasonable and Allowed Amount. Subject to Out-of-Pocket Maximum. No-Deductible.	70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible and Out-of-Pocket Maximum	
Cataract Surgery	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required 70% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Surgery performed prior to receiving precertification will not be covered.
Cat Scans	See Diagnostic Imaging	See Diagnostic Imaging	
Cervical Exams	100% of the Reasonable and Allowed Amount. Subject to the Out-of-Pocket Maximum. No-Deductible	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	
Chemical Dependency Inpatient Level A Facility	Precertification Required 100% of the Reasonable and Allowed Amount.	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the	Precertification Required Services obtained prior to precertification will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Inpatient Level B Facility	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Deductible and Annual Out-of-Pocket Maximum.	
Intensive Outpatient Level A Facility	100% of the Reasonable and Allowed Amount		
Intensive Outpatient Level B Facility	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Partial Day Program	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Outpatient Physician	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Chemotherapy	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Services obtained prior to precertification will not be covered
Chiropractor	90% of the covered expense up to a maximum of $40.00. Subject to the Deductible, Out-of-Pocket Maximum & Annual Allowance	70% of the Reasonable and Allowed Amount up to the maximum of $40.00. Subject to the Deductible, Out-of-Pocket Maximum & Annual Allowance	Maximum Annual Allowance of $1,500.00
C.O.B.R.A	N/A	N/A	Please reference this Plan's C.O.B.R.A. provision for exact details.
Co-Insurance Level A Facilities Level B Facilities	0.%	Participants utilizing non-participating providers, will be responsible for the difference between	

Covered Expense	In-Network	Non-Network	Benefit Limits
In-Network Physicians	10% of the Reasonable and Allowed Amount + Deductible 10% of the Reasonable and Allowed Amount.	what the Plan paid and the amount the non-participating facility or provider charged for the services they received.	
Colorectal Cancer Screening	100% of the Reasonable and Allowed Amount. Subject to the Annual Out-of-Pocket Maximum. No Deductible	70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible and Out-of-Pocket Maximum	Cologuard limited to once every three years.
Corrective and/or Cosmetic Surgery	Precertification required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Precertification required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Services received prior to receiving precertification are not covered. See Plan benefit description for exclusions and limitations.
Co-Surgeons	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket & Annual Maximum.	
Deductible			Annual Limit $200.00 per person. $400 per family. The deductible does not apply to prescription drug coverage.
Dental Care	The Plan will pay 75% of incurred charges up to the Annual Family Maximum of $2,000	The Plan will pay 75% of the incurred charge up to the Annual Family Maximum of $2,0000	Annual Maximum for family is $2,000 per calendar year. There is no separate orthodontia benefit.

Covered Expense	In-Network	Non-Network	Benefit Limits
			Orthodontia treatments are applied to the $2,000 calendar year dental maximum.
Dental Care Performed in a Hospital Setting Level A Facility Level B Facility Physician	Precertification is Required 100% of the Reasonable and Allowed Amount Paid at 90% of the RAA for medically necessary procedures. Subject to the Deductible and Out-of-Pocket Maximum Paid at 90% of the RAA for medically necessary procedures. Subject to the Deductible and Out-of-Pocket Maximum	Precertification is Required. Paid at 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Only available to individuals with systemic diseases, multiple disorders or severe physical and/or mental disabilities or those participants as a necessity to protect their life or health. Services received prior to receiving precertification are not covered. Services performed in a hospital setting as a convenience for any reason, including but not limited to age, fear, or a dislike of any dental anesthetic will not be covered.
Diabetes Assessments	100% of the Reasonable and Allowed Amount. Subject to the Out-of-Pocket Maximum. No Deductible	70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible and Out-of-Pocket Maximum	
Diabetic Management	Precertification required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Services received prior to receiving precertification are not covered. Diabetic Education is not covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Diagnostic Imaging/Testing Facility Charge Level A Facility Level B Facility	Precertification Required. 100% of the Reasonable and Allowed Amount 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Services received prior to receiving precertification are not covered. Please refer to the section of this document titled "Precertification" for a list of procedures that require precertification.
Diagnostic Imaging /Testing Physician Charge	Precertification Required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Services received prior to receiving precertification are not covered.
Dialysis Level A Facilities Level B Facilities Physician	Precertification Required. 100% of the Reasonable and Allowed Amount 90% of the RAA. Subject to the Deductible and Annual Out-of-Pocket. Maximum 90% of the RAA. Subject to the Deductible and Annual Out-of-Pocket. Maximum	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket.	Services obtained prior to receiving precertification are not covered.
Dietician/Nutritionist (Including self-management, e.g., nutrition education.)	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. Limited to 6 visits per year and a total of 18 visits per lifetime.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximums.	Benefits are only provided to diabetics Benefits are limited to 6 visits per year and 18 visits per lifetime. Services received prior to precertification will not be covered.
Drugs	Subject to Annual Out of Pocket Maximum.	Subject to Annual Out of Pocket Maximum.	Generic substitution and step therapy apply.

Covered Expense	In-Network	Non-Network	Benefit Limits
		Prescriptions filled by a Non-Participating pharmacy is limited to the in-network negotiated rate.	The balance between what the Plan pays, and the charge incurred at non-participating pharmacies will remain the responsibility of the participant.
Generic	20% Co-Pay with a $10 Minimum.	20% Co-Pay with a $10 Minimum.	
Formulary Brand	20% Co-Pay with a $20 Minimum.	20% Co-Pay with a $20 Minimum.	
Non-Formulary Brand	20% Co-Pay with a $35 Minimum.	20% Co-Pay with a $10 Minimum	
Specialty Drugs	20% Co-Pay with a $35 Minimum	20% Minimum Specialty Drugs not secured through the Plan's PBM and/or the Plan's Specialty Drug PBM will be limited to the parameters and amounts that the Plan would have paid if procured through those programs.	Specialty Drugs must be pre-certified and secured through the Plan's PBM and/or the Plan's Specialty Drug PBM. Specialty Drugs not pre-certified will not be covered by the Plan. If a Specialty Drug is ultimately unavailable through the Plan's PBM and/or its Specialty Drug PBM, the Plan Administrator may utilize its discretionary authority, based upon medical criteria and in a non-discriminatory fashion, to approve an otherwise-eligible Specialty Drug from another source.
Durable Medical Equipment	Precertification required for supplies or durable medical equipment of $1,000 or greater.	Precertification required for supplies or durable medical	Equipment of $1000 or greater ordered or received prior to

Covered Expense	In-Network	Non-Network	Benefit Limits
	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximums.	equipment of $1,000 or greater. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket.	obtaining precertification will not be covered.
EKG Level A Facility Level B Facility Physician	100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	90% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	
Emergency Room Facility Charges Level A Facility Level B Facility	For Emergencies Only 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	For Emergencies Only 90% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	Services that do not meet the Plans definition of an "Emergency" will not be covered.
Emergency Room Physician Charges	For Emergency Medical Conditions Only 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	For Emergency Medical Conditions Only 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Services that do not meet the Plans definition of an "Emergency Medical Condition" – will not be covered.
Epidural Injections	Precertification required	Precertification required	If pre-certification is not obtained,

Covered Expense	In-Network	Non-Network	Benefit Limits
	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	services will not be covered.
Fitness Club Stipend Policy Holder Only Policy Holder and Spouse	N/A	N/A	The Plan's payment will not exceed the levels identified directly below: 8 – 11 visits per month, per person = $12.00 reimbursement. 12 or more visits per month, per person = $25.00 reimbursement. 8 – 11 visits a per month, per person = $24.00 reimbursement. 12 or more visits per month, per person = $50.00 reimbursement. The maximum payment allowed for a husband and wife who went 12 or more times each calendar month during a calendar year will be 599.00.
Gastric Bypass	Precertification required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Precertification required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification required If pre-certification is not obtained, services will not be covered.
Genetic Counseling	Not Covered	Not Covered	

Covered Expense	In-Network	Non-Network	Benefit Limits
Genetic Testing	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Genetic testing that is not for the diagnosis or treatment of an existing medical condition is not covered. Prenatal genetic testing is not covered.
Grand Rounds	100% of the telephone consultation	N/A	N/A
Hearing Aid	Once Every Three Years. The Plan will pay 90% of its maximum allowance up to $1,500.00. Subject to the Deductible, but not subject to the Out-of-Pocket Maximums	Once Every Three Years. The Plan will pay 70% of its maximum allowance up to $1,500.00. Subject to the Deductibles, but not subject to the Annual Out-of-Pocket Maximums	
Health Reimbursement Account - HRA	100% of those expenses that are listed under the Health Reimbursement Account (HRA) benefit description.	100% of those expenses that are listed under the Health Reimbursement Account (HRA) benefit description.	
Home Health Care	Precertification required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Precertification required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out of Pocket Maximum	Services received prior to precertification will not be covered.
Hospice	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out of Pocket Maximum.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Patients who are in hospice for a period of greater than six months will be re-evaluated to determine if there is a need for recertification of hospice care.

Covered Expense	In-Network	Non-Network	Benefit Limits
Hospital Facility – Inpatient Level A Facility Level B Facility	Precertification Required 100% of the Reasonable and Allowed Amount 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Services received prior to precertification will not be covered.
Hospital Facility – Outpatient Level A Facility Level B Facility	Precertification Required 100% of the Reasonable and Allowed Amount 90% of the RAA. Subject to the Deductible and Annual Out-of-Pocket Maximum	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Services received prior to precertification will not be covered.
Hour Bank	N/A	N/A	On October 1, 2018, balances within an employee's hour bank were combined with whatever balance existed within their MRP account to create the HRA. Please reference the section of this book titled "Health Reimbursement Arrangement (HRA) for information concerning how you can utilize HRA monies to pay for any shortage of hours you may have incurred.
Immunizations	90% of the Reasonable and Allowed Amount. Subject to the Annual Out-of-Pocket Maximum. No Deductible	70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible & Annual Out-of-Pocket limit applies.	

Covered Expense	In-Network	Non-Network	Benefit Limits
Immunizations for reasons of travel	Not Covered	Not Covered	
Infant formula	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required 70% of 130% of Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	The Plan covers only specialized infant formula for children with an inborn error of metabolism. Services received prior to precertification will not be covered.
Injectables administered in Office	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Services received prior to precertification will not be covered.
Infertility Treatment	Not Covered.	Not Covered.	Not covered.
Infusion Therapy	Precertification required if the infusion cannot be obtained through this Plans pharmaceutical/drug program. If administered by a participating provider, 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification Required if the infusion cannot be obtained through this Plans pharmaceutical/drug program. If administered by a non-participating provider, 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	Infusions not secured though this Plans pharmaceutical/drug program without prior approval will not be covered.
Inpatient Rehabilitation Level A Facility Level B Facility	Precertification Required 100% of the Reasonable and Allowed Amount.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the	Services received prior to precertification will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Physician	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	Deductible and Annual Out-of-Pocket Maximum	
Laboratory	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	
Lasik Surgery	Not Covered	Not Covered	Not Covered
Life Insurance	N/A	N/A	For Active participants and early retirees $15,000.00 and an additional $15,000.00 if death was caused as a result of an accident. Retirees over the age of 65 please reference the section of this book titled Life Insurance.
Mammograms	100% of the Reasonable and Allowed Amount. Subject to the Annual Out-of-Pocket Maximum No-Deductible	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Mastectomy Level A Facility Level B Facility Physician	Precertification Required 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Benefit is limited to cancer patients. Services obtained prior to precertification will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Maternity Services Level A Facility Level B Facility Physician	 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Licensed Midwifes will be paid in accordance to the non-network payment methodology of this provision The Plan does not cover maternity benefits for dependent children. The Plan does not cover delivery services performed in a non-hospital setting or for services performed by a Doula.
Mental Health benefits Inpatient Intensive Out-Patient Level A Facilities Partial Day Program Level A Facilities Intensive Out-Patient Level B Facilities Partial Day Program Level B Facilities	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. 100% of the Reasonable and Allowed Amount. 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Services obtained prior to precertification will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Outpatient Physician	Deductible and Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
MRI Level A Facility Level B Facility	Precertification Required. 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Services received prior to receiving precertification are not covered.
MRP	N/A	N/A	On October 1, 2018, balances within an employee's MRP account were combined with their hour bank to create the HRA. Please reference the section of this book titled "Health Reimbursement Arrangement (HRA) for information concerning how you can utilize HRA monies to pay for most out of pocket dental, medical, pharmaceutical, shortage of hours and vision expenses you may have incurred.
Nasal Surgery	Precertification is required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Annual Maximum.	Precertification is required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and	Services received prior to receiving precertification are not covered. Services rendered for cosmetic reasons are not covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
		Annual Out-of-Pocket Maximum	
Newborn Care	90% of the RAA. Subject to the Deductible and Annual Out-of-Pocket Maximum.	70% of 130% of the RAA. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Neuropsychological Testing	Precertification Required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. -	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	The Plan allows up to a maximum allowance of 12 units per test, per calendar year based upon medical necessity. Services obtained prior to precertification being received are not covered.
Occupational therapy	Treatment above 17 visits require precertification. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Annual Maximum.	Treatments above 17 visits require precertification. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Services obtained prior to precertification being received are not covered.
Office Visits	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Annual Maximum	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Oral Contraceptives Generic Formulary Brand	Subject to Annual Out of Pocket Maximum. 20% Co-Pay with a $10 Minimum. 20% Co-Pay with a $20 Minimum.	Subject to Annual Out of Pocket Maximum. 20% Co-Pay with a $10 Minimum. 20% Co-Pay with a $20 Minimum.	Generic substitution applies. Prescriptions filled by a Non-Participating pharmacy is limited to the in-network negotiated rate. As such, the balance

Covered Expense	In-Network	Non-Network	Benefit Limits
Non-Formulary Brand	20% Co-Pay with a $35 Minimum.	20% Co-Pay with a $35 Minimum	between what the Plan pays, and the charge incurred at non-participating pharmacies will remain the responsibility of the participant.
Orthotics	Precertification is required for purchases of $1000 or greater. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification is required for purchases over $1000 or greater 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Orthotics of value of $1000 or greater ordered or received prior to receiving precertification will not be covered. Custom made orthotic devices are not medically necessary unless there is clinical documentation indicating that a non-custom-made orthotic device is not appropriate for the condition or diagnosis
Orthotripsy	Precertification Required 90% of the Reasonable and Allowed Amount. Prior Approval required. Subject to the Deductible and Annual Out-of-Pocket Maximum	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Services received prior to receiving precertification will not be covered.
Outpatient Advanced Imaging (CPT/MRI)	Precertification is Required. 90% of the Reasonable and Allowed Amount. Subject to the Annual Deductible and Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Services received prior to receiving precertification will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Pap Tests	100% of the Reasonable and Allowed Amount. Subject to the Annual Out-of-Pocket Maximum No Deductible	70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible & Annual Out-of-Pocket limit applies.	
Pediatric Care Level A Facility Level B Facility Physician	 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amounts. Subject to the Deductible and Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	
Pharmacogenetics	Precertification Required. 90% of the Reasonable and Allowed Amount. Subject to the deductible and Annual Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible & annual Out-of-Pocket Maximum.	Services received prior to receiving precertification will not be covered.
Physicals	Routine physicals are paid at 100% of the Reasonable and allowed Amount. Subject to the Annual Out-of-Pocket Maximum. No Deductible	Routine physicals are paid at 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	
Physical Therapy Inpatient Facility Charges Level A Facility Level B Facility	Precertification Required 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amounts. Subject to	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and	Inpatient treatments are limited to one consecutive stay immediately after discharge from a hospital. Services received prior to receiving

Covered Expense	In-Network	Non-Network	Benefit Limits
	the Deductible and Annual Out-of-Pocket Maximum.	Annual Out-of-Pocket Maximum.	precertification will not be covered.
Physical Therapy Inpatient Physician Charges	90% of the Reasonable and Allowed Amounts. Subject to the Deductible and Annual Out-of-Pocket Maximum.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Physical Therapy Outpatient	Precertification required for out-patient treatments greater than 17. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification required for treatments greater than 17. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Treatments beyond seventeen (17) visits that do not receive precertification are not covered.
Physician Services	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Podiatric Services	Precertification needed for surgeries 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification needed for surgeries 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Treatments received prior to receiving precertification are not covered.
Preventive Care for Adults	100% of the Reasonable Allowed Amount. Annual Out-of-Pocket Maximum applies. No deductible Covered Preventative Services	70% of the RAA. Subject to the deductible & Annual Out-of-Pocket Maximum applies.	Preventative Services are limited to: Bone density tests Cardiac risk assessments Cervical exams Colorectal cancer screening

Covered Expense	In-Network	Non-Network	Benefit Limits
			Diabetes assessments Mammograms Pap tests PSA test and Prostate exams Routine Physicals & Well baby visits
Private Duty Nursing	Not Covered	Not Covered	Not Covered
Prosthetics	Precertification Required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible and Annual Out-of-Pocket Maximum.	Treatments received prior to receiving precertification are not covered. Limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the participant.
PSA Tests	100% of the Reasonable and Allowed Amount. Subject to the Annual Out-of-Pocket Maximum. No Deductible	70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible & Annual Out-of-Pocket limit applies	
Prostate Exams (Annually)	100% of the Reasonable and Allowed Amount. Subject to the Annual Out-of-Pocket Maximum No Deductible	70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible & Annual Out-of-Pocket limit applies	
Pulmonary Rehabilitation	Precertification Required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification Required. Services received prior to precertification is obtained will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Radiation Therapy	Precertification Required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible and Annual Out-of-Pocket Maximum.	Must be performed by a physician. Services received prior to precertification is obtained will not be covered.
Reconstructive and Corrective Surgery	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible and Annual Out-of-Pocket Maximum.	Services received prior to precertification is obtained will not be covered.
Rehabilitative Therapy	Rehabilitative therapy performed by either an in-network physical therapist or in-network physiotherapist will be paid at 90% of the Reasonable and Allowed Amount up to a maximum of $40.00. Subject to the Deductible and Annual Out-of- Pocket Maximum.	Rehabilitative therapy performed by either a non-participating physical therapist or non-participating physiotherapist will be paid at 70% of 130% of the Reasonable and Allowed Amount up to a maximum of $40.00. Subject to the Deductible and Annual Out-of-Pocket Maximum.	All therapy rendered on the same day will be considered one visit. Pre-certification is required for all out-patient rehabilitative therapy in excess of 17 visits.
Respiration Therapy	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the deductible and Annual Out-of-Pocket Maximum.	Services received prior to precertification is obtained will not be covered.
Routine Well-Baby Care during initial confinement	90% of the Reasonable and Allowed Amount. Subject to the	70% of 130% of the Reasonable and Allowed Amount.	

Covered Expense	In-Network	Non-Network	Benefit Limits
	Deductible and Annual Out-of-Pocket Maximum.	Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Sclerotherapy	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification Required 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Services received prior to precertification is obtained will not be covered.
Second Surgical Opinions	Unless required by the Fund, 90% of the Reasonable and Allowed Amounts. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Unless required by the Fund, 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	If the Plan directs you to a specific provider for a second opinion, there will be no cost to you for the second opinion
Short Term Disability	N/A	N/A	Up to fifty percent (50%) of your weekly salary (excluding any overtime) up to a maximum of $550.00 per week
Skilled Nursing Facility	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Sleep Study	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	
Speech Therapy	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount.	Services received prior to precertification is obtained will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
	Deductible and Out-of-Pocket Maximum	Subject to the Deductible and Out-of-Pocket Maximum	
Substance Abuse Benefits Inpatient Level A Facility Inpatient Level B Facility Intensive Outpatient Level A Facility Intensive Outpatient Level B Facility Partial Day Program Outpatient Intermediate Outpatient	Precertification Required 100% of the Reasonable and Allowed Amount 90% of the Reasonable and Allowed Amount Subject to the Deductible and Annual Out-of-Pocket Maximum. 100% of the Reasonable and Allowed Amount 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification required. 70% of 130% of the Reasonable and Allowed Amount.	Services received without being pre-certified will not be covered.
Synagis Injections	Precertification Required 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Services received prior to precertification is obtained will not be covered.
Teledoc	100% of the expense of the consultation. Not subject to the deductible.	Not Applicable	Not Applicable
Transplants	Precertification Required.	Not Covered	Precertification Required.

Covered Expense	In-Network	Non-Network	Benefit Limits
A Local 697 participant who receives an organ. A Local 697 participant who donates to another covered Local 697 participant. A Local 697 participant who donates to a non-covered participant.	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum. A maximum of $10,000.00 per transplant, payable only if no other insurance exists and payable at 90% of the Reasonable and Allowed Amount. Subject to the Deductible.		
Trigger Point Injections	Precertification Required. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Precertification Required. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Treatments are approved in sets of three. However, updated notes must be provided by the treating physician for further administration.
Urgent Care	Level A Hospital Affiliated Urgent Care Facility – 100% of the Reasonable and Allowed Amounts. Level B Hospital Affiliated Urgent Care Facility - 90% of the RAA. Subject to the Deductible & Annual Out-of-Pocket Maximum applies.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Limits.	
Vision Benefits Annual Exam Biennial (Once every two years) Frames Annual lenses Single vision Lined bifocal	 $5 co-pay then provided in full $10 materials co-pay, then provided in full up to a maximum allowance of $140.00. $10 co-pay then provided in full $10 co-pay then provided in full $10 co-pay then provided in full	 $35.00 $45.00 $25 $40 $55	

Covered Expense	In-Network	Non-Network	Benefit Limits
Lined trifocal Lenticular	$10 co-pay then provided in full	$80	
Contacts			
Annually & in-lieu of glasses	$10 materials co-pay, then provided in full up to a maximum allowance of $120.00.	$105	
Annually & visually necessary	$10 co-pay then provided in full	$210	
Safety Glasses (Employee Only)	Provided in full every calendar year when received in combination with an eye exam and eyeglasses or contacts.	N/A	
Weight Loss Programs	90% of the Reasonable and Allowed Amount. Not subject to the deductible. Annual Out-of-Pocket Cap applies	70% of the Reasonable and Allowed Amount. Subject to the deductible & Annual Out-of-Pocket Maximum	Physician Supervised weight loss programs only Two (2) attempts per lifetime.
Well Baby Visits	100% of the Reasonable and Allowed Amount. Not subject to the deductible. Annual Out-of-Pocket Cap applies	70% of the RAA. Subject to the deductible & Annual Out-of-Pocket Maximum	
Wheelchair Benefit	90% up to the maximum Fund allowance of $500. Subject to the Deductible and Annual Out-of-Pocket Maximum.	70% up to the maximum Fund allowance of $500. Subject to the Deductible and Annual Out-of-Pocket Maximum	Maximum benefit payable for rental and/or purchase of a wheelchair or scooter is $500.00
Wigs	90% up to the Maximum Fund lifetime allowance. Subject to the Deductible and Annual Out-of-Pocket Maximum.	70% of 130% of the Reasonable and Allowed Amount up to the lifetime maximum. Subject to the Deductible and Annual Out-of-Pocket Maximum	$2,000.00 Lifetime Maximum Allowance.
X-Ray	90% of the Reasonable and Allowed Amount. Subject to the	70% of 130% of the Reasonable and	

Covered Expense	In-Network	Non-Network	Benefit Limits
	Deductible and Annual Out-of-Pocket Maximum	Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan accidental death and dismemberment (AD&D) benefit is provided under a group term insurance policy issued by a life insurance company selected by the Trustees. Benefit payments are governed by the terms of the insurance policy. If there is an inconsistency or question of interpretation between the policy and this booklet, the terms of the policy will prevail.

The principle sum of the Plan's AD&D Benefit is $15,000 and the total amount payable for all losses resulting from any one accident, including those that lead to loss of life cannot exceed this amount.

Accidental Death Benefit.

Should your demise be the result of a fatal accident, the amount paid for the loss of life would be $15,000.00 less any benefit amounts paid towards any dismemberment. The Plan's accidental death benefit is in addition to this Plans life insurance benefit.

Accidental Dismemberment Benefit.

The dismemberment benefit is available to those participants who were eligible for the AD&D benefit at the time the accident occurred and remain covered by the Plan within the 365 days from the initial loss. The dismemberment coverage of the policy works on a "per-member" basis and will only paid if you suffer any of the losses within the Table of Losses listed below. For example, if you lose one member (a hand, foot, limb, sight in one eye, speech or hearing), the insurance company will usually pay you or your beneficiary a percentage of the full benefit. If you lose two members, you will receive the whole benefit

Table of Losses

Loss	*Amount Payable*
Life	100% of full amount
One hand or one foot	50% of full amount
Two hands, two feet, or sight of two eyes	100% of full amount
One arm or one leg	75% of full amount
Any combination of hand, foot, sight of one eye	100% of full amount
Thumb and index finger of same hand	25% of full amount

Table of Losses	
Speech and hearing	100% of full amount
Speech or hearing	50% of full amount
Paralysis of both arms and both legs	100% of full amount
Paralysis of both legs	50% of full amount
Paralysis of the arm and leg on either side of the body	50% of full amount
Paralysis of one arm or leg	25% of full amount
Brain damage	100% of full amount
Coma	1% monthly beginning on the 7th day, for a maximum duration of 60 months

Accidental Death and Dismemberment Exclusions

The Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan's AD&D Insurance policy will not pay for any loss that occurs more than 365 days after the date of the accident causing the loss; or that is caused directly or indirectly or contributed to by any of the following:

1. Active duty at a full-time status for more than 30 days in the armed forces of any country or international authority, except the National Guard or organized reserve corps duty.
2. Car racing.
3. Commission or attempt to commit of a felony.
4. Death during surgery.
5. Death resulting from a mental or physical illness.
6. Drug overdose or use of intoxicants unless taken under the advice of a physician.
7. Drunk driving.
8. Internal conflicts, insurrection or rebellion of any country.
9. Sickness, disease or bacterial infection, unless the latter was due to an accidental cut, wound, or due to botulism or ptomaine poisoning.
10. Suicide, attempted suicide or intentionally self-inflicted injury.
11. Travel, including but not limited to, getting in or out of a vehicle used for aerial navigation if the person is:
    a. Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    b. Performing, learning to perform or instructing others to perform as a pilot or crew member of any kind.
12. War or an act of war, whether or not declared,

ALCOHOL DEPENDENCY

Precertification is required.

The Plan provides benefits for the treatment of mental Illness and nervous disorders.

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 and will pay for only those services deemed medically necessary and which are delivered within the lawful scope of the licensed provider.

Covered providers include:

1. Alcohol abuse treatment facilities
2. Hospitals
3. Licensed clinical social workers
4. Licensed professional counselors
5. Psychologists
6. Psychiatric residential and nonresidential treatment of facilities
7. Physicians

Types of services covered:

1. Detoxification
2. Group therapy
3. Inpatient
4. Intensive out-patient
5. Office
6. Out-patient
7. Partial in-patient
8. Residential

The Plan will only pay for the services rendered by participating providers or within participating facilities. Residential treatment must meet the following criteria:

1. The facility must meet the definition of an approved "residential treatment facility" as defined by this Plan. And,

2. The confinement must begin within thirty (30) days of a covered hospital confinement lasting at least three (3) days, and it must be due to the condition that required previous hospital confinement.

3. The confinement must be pre-certified by the Plan or its review organization.

Participating provider charges will be subject to the deductible, and payable at 90% of the Plan's Reasonable Allowable Amount.

Non-participating provider charges will be subject to the deductible and payable at 70% of 130% of the Plan's Reasonable and Allowable Amount.

AMBULANCE AND AMBULETTE SERVICE

Ambulance services provided by skilled emergency transportation from the location of a life-threatening medical emergency to the closest hospital qualified to treat the patient's medical emergency are covered and will be paid as follows:

- Ambulance services provided by participating providers will be subject to the deductible and annual out-of-pocket maximum and paid at 90% of the Plan's Reasonable Allowed Amount.

- Ambulance services provided by non-participating and non-network providers will be subject to the deductible and annual out-of-pocket maximum and paid at 70% of 200% of the Plan's Reasonable Allowed Amount or 70% of the billed amount whichever is less.

Services that are not deemed medically necessary will not be covered.

Intra-facility ambulance. If the needed care is not available locally, the Fund will pay for intra-facility ambulance and/or ambulette transportation outside your local area to the closest facility that can provide the care. Payment for transportation to another facility located further away will be based on how much it would have cost for transportation to the closer facility.

Air ambulance services are covered if:

1. The patient requires immediate medical attention; and

2. The patient's condition is so severe that no other mode of transportation could be used without endangering the patient's life or seriously endangering the patient's health; and

3. The service is provided by a licensed air ambulance service: and

4. The services are provided from the location of a sudden illness or injury to the nearest hospital where emergency treatment can be provided, or when, in connection with an inpatient confinement, transfer to the nearest facility having the capability to treat the condition is medically necessary.

The Plan's reimbursement for those air ambulance charges that fail to meet all four of the criteria outlined directly above, will be paid as follows:

- Air ambulance services provided by participating providers will be limited to the fee schedule that the Plan would pay for transportation by ground ambulance. It will be subject to the deductible and annual out-of-pocket maximum and paid at 90% of the Plan's Reasonable and Allowed Amount.

- Ambulance services provided by non-participating and non-network providers will be limited to this Plan's out of network ground ambulance reimbursement methodology which is that charges will be subject to the deductible and annual out-of-pocket maximum and paid at 70% of 200% of the Plan's Reasonable Allowed Amount or 70% of the billed amount whichever is less.

Warning: Chartered air flights are not covered as such any out-of-pocket expenses incurred will not accumulate toward a participant's or family's annual out-of-pocket expense.

An individual's desire to receive services or to convalesce closer to home does not constitute medical necessity and as such, will not be a factor in the determination of the need for air-ambulance services.

Payment for air ambulance services will be paid as follows:

- Services provided by participating or in-network providers will be paid at 90% of the Plan's Reasonable Allowed Amount.
- Services provided by participating or in-network providers will be paid at 70% of 200% of the Plan's Reasonable and Allowed Amount or 70% of the billed amount whichever is less.

ANESTHESIA

Anesthesia benefits are payable in connection with a surgery when anesthesia is administered by a physician (M.D. or D.O.) or a nurse anesthetist (CRNA).

Participating M.D. or D.O. provider charges will be subject to the deductible, and payable at the negotiated rate.

Participating CRNA charges will be subject to the deductible and payable at 90% of the Reasonable and Allowed Amount.

Non-participating M.D. or D.O. provider charges for **treatments rendered within a participating hospital or facility as a result of an emergency** will be subject to the deductible and payment will be made at 90% of the Funds Reasonable and Allowed Amount (RAA) for both the base and time units. The following formula will be used when calculating the Funds payment.

Base Unit RAA + Time Unit RAA x 90% = Non-participating reimbursement

Non-participating M.D. or D.O. provider charges for treatments rendered within a non-participating hospital or facility will be subject to the deductible and payment will be made at 70% of the Funds Reasonable and Allowed Amount (RAA) for both the base and time units. The following formula will be used when calculating the Funds payment.

Base Unit RAA + Time Unit RAA x 70% = Non-participating reimbursement

Non-participating CRNA charges will be subject to the deductible and payment will be made at 50% of the following formula:

Base Unit RAA + Time Unit RAA x 70% x 50% = Non-participating reimbursement

The Reasonable and Allowed Amount for a base unit and time unit is subject to many factors, such as, but not limited to, the geographical location of the administered service. Consequently, the reasonable allowance that the Plan will pay can vary. If you are scheduled to have an elective surgery, please do not forget to inquire about the network affiliation of the anesthesiologist prior to your surgery. Should you discover prior to your elective surgery that the anesthesiologist does not participate, you can always request that the Plan try and negotiate with the anesthesiologist or try to find an in-network anesthesiologist. Should you be in that position, please do not hesitate to call the Fund Office at 219-940-6181 for assistance.

ANNUAL OUT-OF-POCKET MAXIUM

The annual out-of-pocket maximum limits the amount of money a participant will have to pay toward his or her co-insurance obligation during a calendar year. This is a form of financial protection and is designed to reduce your out-of-pocket costs should you or a family member experience a major health issue or injury.

The Plan maintains two levels of out-of-pocket limits for individuals. Once the first limit is met, the Plan will pay one hundred percent (100%) of covered services rendered by a participating provider for the remainder of the calendar year.

After the second annual maximum limit is met, the Plan will pay one hundred percent (100%) of the Fund's allowable expense for a covered service rendered by a non-participating provider.

Additionally, families can meet the annual family out-of-pocket maximum limit without each family member meeting their individual out-of-pocket maximum. Once the family maximum is met, the Plan will pay in accordance to the percentages set forth in the subsequent chart.

How It Works

Once a participant has satisfied their annual deductible, the Plan will start making payment for the covered services received by a participant. Depending on the network affiliation of the provider, the Plan will either pay ninety percent (90%) or seventy percent (70%) of a predetermined referenced based fee for a covered service. The percentage of the non-reimbursable amount of the referenced based fee (either 10% or 30% for medical claims or in the case of your pharmaceutical benefit, 20%) is termed co-insurance.

The amount of a participant's co-insurance is tracked annually by the Fund. During a calendar year, should a participant's co-insurance total $2,500.00, the claims for covered services rendered by a participating provider for the remainder of that calendar year will be paid at one hundred percent (100%) of the Fund's allowance.

Upon attaining $5,000.00 of co-insurance payments, the Fund will pay one hundred percent (100%) of the Fund's allowance on future claims for covered services rendered by a non-participating provider during the remainder of the calendar year.

To summarize:

If	Then
A participant's co-insurance totals $2,500.00	In-network claims are paid at 100% of the Fund allowance for covered services for the remainder of the calendar year
A participant's co-insurance totals $5,000.00	Out-of-network claims will be paid at 100% of the Fund allowance for covered services for the remainder of the calendar year
Two or more family members co-insurance totals $5,000.00	In-network claims for all eligible family members are paid at 100% of Fund allowance for covered services for the remainder of the calendar year
Two or more family members co-insurance totals $10,000.00	Out-of-network claims for all eligible family members paid at 100% of Fund allowance for covered services for the remainder of the calendar year

Important

A. The annual out-of-pocket applies to each participant.
B. Some expenses are not counted toward your annual out-of-pocket maximum limit. Such expenses would include, but are not limited to, the following:

1. Balance billing for health care expenses that exceed the Plans allowance.
2. COBRA self-payments.
3. Deductibles. A participant's annual deductible does not accumulate toward their annual out-of-pocket expense.
4. Dental expenses.
5. Expenses that are incurred in excess of a limit or maximum.
6. Expenses incurred for treatment or services that are not covered by the Plan- including, but not limited to those non-participating providers' charges that exceed the Fund's maximum allowable payment amount.
7. Self-payments of monthly or quarterly self-payments.

ANNUAL PHYISICALS

The Fund recommends that each eligible participant have a physical once every calendar year.

Participating provider charges will be subject to the deductible, and payable at 100% of the Plan's Reasonable and Allowed Amount.

Non-participating provider charges will be subject to the deductible and payable at 70% of the Plan's Reasonable and Allowed Amount.

APPEALS

If your claim has been denied in whole or in part, you may request a full and fair review (called an "appeal") by the Board of Trustees by filing a written notice of appeal with the Plan.

Timing of Your Appeal

A notice of appeal must be received at the Fund Office (the office of Fund Manager) not more than 180 days after you receive the written notice of denial of the claim. Your appeal is considered to have been filed on the date the written notice of appeal is received by the Fund Office. To appeal, write to:

Board of Trustee
of the

Lake County, Indiana NECA - IBEW Health and Benefit Plan
7200 Mississippi Street, Suite 300
Merrillville, IN 46410

The review will not be performed by a person, or a subordinate of the person, who made the original claim denial.

Who May Appeal?

1. A claimant.

2. A representative of a claimant. Provided you submit to the Plan a notarized appointment of authorized representation, another individual or a health care professional with knowledge of the participant's medical condition may represent you in connection with an appeal. To obtain a copy of the Plan's appointment of authorized representation, please contact the Health and Benefit Plan. Any representation by another person will be at your own expense.

Claim Appeal Process

1. You must submit all documents that the Trustees, in their sole discretion, deem necessary in order to consider your appeal. This includes, if necessary, a signed authorization allowing release of any records, including medical records, to the Trustees.

2. You or your authorized representative may review pertinent documents and may submit comments and relevant information in writing. The Fund Office will not charge you for copies of documents you request in connection with an appeal.

3. Upon written request, the Fund Office will provide reasonable access to, and copies of, all documents, records or other information relevant to your claim.

4. If the Fund Office obtained an opinion from a medical or vocational expert in connection with your claim, the Fund Office will, on written request, provide you with the name of that expert.

5. In deciding your appeal, the Board of Trustees will consider all comments and documents that you submit, regardless of whether that information was available at the time of the original claim denial. The review will not defer to the initial denial, and will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was previously submitted or relied upon in the initial determination.

6. If an appeal involves a medical judgment, such as whether treatment is medically necessary, the Board of Trustees may consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the Trustees will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.

Time Periods for Processing Appeals

Post-Service Claims - The Board of Trustees generally meets on a quarterly basis. If your request for review is received within 30 days preceding the date of such meeting, a determination may be made by no later than the date of the quarterly meeting following the appeal request.

If special circumstances (such as the need to hold a hearing) require a further extension of time, a determination will be made not later than the third meeting of the Board of Trustees. Before the start of the extension, you will be notified in writing of the extension, and that notice will include a description of the special circumstances and the date as of which the determination will be made.

Whenever there are "special circumstances" that require that the decision be delayed until the next following meeting, you will be advised in writing of why the extension of time was needed and when the appeal will be decided.

When the Board of Trustees, in its discretion, determines that it can decide an appeal sooner than the time limits stated above, the Trustees will do so.

Once the Board of Trustees has made a determination on your appeal, the Plan will send you a written notice of that decision. The notice will be mailed within five days of the Board's decision.

Pre-Service Claims - For a pre-service claim that is not an urgent care claim, the Plan will notify you of the decision on appeal within 30 days of the Plan's receipt of the appeal.

For an urgent care claim, the Plan will notify you of the decision on appeal within 72 hours of the Plan's receipt of the appeal. Also, for appeals of urgent care claims, the notice of appeal can be oral instead of in writing, and the Plan may notify you of its decision by telephone or facsimile ("fax").

If a claimant whose pre-service claim was denied obtains the service or treatment that had been denied, the claim is no longer a pre-service claim and any appeal of the denial of the pre-service claim will be handled under the rules that apply to post-service claims.

Notification Following Review

You will be informed of the Board's decision as soon as practical, normally within five business days of the review. The decision will be in writing. When you receive the written decision, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement of your right to bring an action under section 502(a) of ERISA. If applicable, you will also be informed of your right to receive free of charge upon request the specific internal rule, guideline, protocol or similar criterion relied on to make the decision. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request. Denial notices will be provided in a culturally and linguistically appropriate manner to the extent required under applicable law.

In addition to the above, a denial of a disability claim will also include:

- A statement regarding you and your authorized representative's rights; and
- A discussion of the decision, including an explanation of the basis for disagreeing with the views presented by you or the health care professionals treating you and/or the vocational professionals who evaluated you; and/or the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the benefit determination; and if provided by you, the disability determination made by the Social Security Administration.

If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, you may go to court to enforce your rights. A claimant may not file suit against the Plan until the claimant has exhausted all these procedures.

Limitations Period

The Plan provides for a "limitations period," which is the period of time within which any lawsuit must be filed. The limitations period is three years from the date of the Plan's notice advising you of the determination of your claim. If you file a timely internal appeal, the limitations period is three years from the date of the Plan's notice advising you of the determination of your internal appeal. Also, if your claim is denied and you fail to file a timely internal appeal, a lawsuit, even if filed within the limitations period, will be subject to dismissal because, as explained above, the Plan requires you to use the appeal process before filing a lawsuit. Finally, if the Plan fails to send a notice advising you of the determination of your claim, the limitations period is three years from the date a determination was due under these claim and appeal procedures.

Appointment of Authorized Representative

A claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed, notarized, and dated by the claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Third-Party Administrator.

The Plan will permit at its sole discretion and only in a medically urgent situation, such as a claim involving Urgent Care, a claimant's treating health care practitioner to act as the claimant's authorized representative without completion of the authorized representative form.

Should a claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the claimant, until such time the participant provides the Plan with their written and notarized instructions stating otherwise. A claimant can revoke the authorized representative at any time. A claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion a similar form. An Assignment of Benefits by a claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described in the section of this document titled "Assignment of Benefits".

APPRENTICE ELIGIBILITY

Apprentice eligibility under the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan is comprised of three different components;

1. A Health and Benefit Plan enrollment component.
2. An hourly component and,
3. A Local 697 JATC registration requirement component.

Apprentices wishing to be covered under the Plan must satisfy each of the three components. Failure to meet any of these requirements will result in you and any eligible dependents being unable to receive benefits under this Plan.

The requirements of the aforementioned components are as follows:

JATC Registration Requirement Component

All Apprentices must be and remain registered within the Local 697 JATC program to be covered under the Apprenticeship eligibility provision of this Plan.

Health and Benefit Plan Enrollment Requirement Component

All Apprentices must be properly enrolled within the Health and Benefit Plan. This means that you have signed the required enrollment forms and supplied the appropriate supporting documentation to the Health and Benefit Plan for yourself and any dependents.

Hourly Requirement

Apprentices are advised that coverage under the Plan is divided into four benefit periods which are known as work quarters. Each work quarter consists of three consecutive calendar months: January through March, April through June, July through September and October through December.

Calendar quarters in which the Fund received hourly contributions on an Apprentice's behalf are termed "Work Quarters".

A "Quarter of Coverage" is credited when the required number of hours or the premium expense equivalent is received by the Fund for the corresponding calendar "Work Quarter".

Work Quarter		***Quarter of Coverage***
January, February, March		July, August, September
April, May June		October, November, December
July, August, September		January, February, March
October, November, December		April, May June

Please note that the middle column is deliberately left blank to emphasize the fact that there exists an administrative "lag quarter" that separates a work quarter from its corresponding quarter of coverage. Meaning: Contributions received for covered worked performed in any work quarter do not provide coverage in the subsequent calendar quarter of coverage. Rather, it skips a quarter.

Initial Eligibility

Apprentices seeking coverage under the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Plan for the first time can obtain their initial eligibility under this Plan in one of two ways; fast-tracked eligibility or standard eligibility.

- **Fast Tracked Eligibility**. Initial eligibility for all Apprentices may be expedited if:
    - Upon enrollment, the participant provides the Plan with a letter of creditable coverage indicating that they had health insurance coverage within the prior sixty-two (62) calendar days of being eligible under this Plan. And,

- During the prior six-month period in which the participant was not covered under this Plan, 160 hours of employer contributions were accumulated.

If those two conditions are met, initial coverage will begin on the first day of the first month following the month in which the 160 hours were received by the Plan. The initial period of coverage will be the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

- **Standard Initial Eligibility**:

  - For apprentices who cannot provide a letter of creditable coverage indicating health insurance coverage within the prior sixty-two (62) calendar days of being eligible under this Plan, a requirement of at least 420 hours of employer contributions must be accumulated. Said accumulation will encompass the employer contributions made to the Health and Benefit Plan on your behalf in the immediate six-month period in which you were not covered under this Plan, prior to regaining eligibility.

    Upon meeting the aforementioned requirement, the participant's initial eligibility will begin on the first day of the first month following the month in which the 420 of accumulated hours of employer contributions were received by the Plan. The initial period of coverage will be the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

Termination of Eligibility

Withdrawal or Expulsion from the Local 697 JATC program will terminate your eligibility under the Plan at the end of the month in which either of those events occurred.

Upon the cessation of your eligibility you will be offered to continue your coverage under the provisions set forth within the Consolidated Omnibus Reduction Act (C.O.B.R.A.) of 1984. Be advised that C.O.B.R.A. premiums are un-subsidized and if elected, you will be required to pay at the current journeypersons C.O.B.R.A. rate.

Should you fail to earn enough hours, your eligibility under the Plan will cease at the beginning of the coverage quarter that corresponds to the work quarter that:

- The minimum number of required hours of employer contributions for your classification were not received and/or,

- The participant failed to timely make the required self-payment.

The latter of which is always due no later than the close of the first business day of the quarter of coverage in which they would not be covered under this Plan.

Insufficient Work Hours Received in Quarters		***Will Result in a Lapse in Eligibility for Benefits in Quarter of Coverage***
January, February, March		July, August, September

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

ASSIGNMENT OF BENEFITS

The term “Assignment of Benefits” shall mean an arrangement whereby the Plan participant assigns his or her right to seek and receive payment from the Plan for covered expenses to a provider, in strict accordance with the conditions and limitations of such rights provided under the terms of this Plan Document.

An assignment is not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan.

The following conditions and limitations apply to an assignment of benefits:

1. The validity of an assignment of benefits by a Plan participant to a provider is limited by the terms of this Plan Document. An assignment of benefits is considered valid on the condition that the provider accepts the payment received from the Plan as consideration, in full, for covered expenses for services, supplies and/or treatment rendered. This amount does not include any cost sharing amounts (i.e. copayments, deductibles, or co-insurance), or charges for non-covered services; the provider may bill the Plan participant directly for these amounts.

2. An assignment of benefits cannot be inferred, implied or transferred. An assignment of benefits must be made by the Plan participant to the provider directly through a valid written instrument that is signed and dated by the Plan participant.

3. Unless specifically prohibited by a participant, a provider with a valid assignment of benefits AND a notarized appointment of authorized representative may exhaust, on behalf of the Plan participant, any administrative remedies available under the terms of the Plan Document, including initiating an internal or external appeal of an adverse benefit determination in accordance with the terms of the Plan Document. Notwithstanding the foregoing, the Plan participant does not, under any circumstances, including but not limited to the periods of time he or she is a participant in the Plan, or following his or her termination as a participant, in any manner have the right to assign to any provider (or his or her representative) through an assignment of benefits any right to initiate any cause of action against the Plan that the Plan participant them self may be afforded under applicable law. This includes, but is not limited to, any right to bring suit as such is afforded to Plan participants under ERISA section 502(a). The assignment of any right to initiate suit against the Plan to a provider is strictly prohibited.

   A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

4. An assignment of benefits does not grant the provider any rights other than those specifically set forth herein.

5. The Plan Administrator may disregard an assignment of benefits at its discretion and continue to treat the Plan participant as the sole recipient of the benefits available under the terms of the Plan.

6. An assignment of benefits by a participant to a provider will not constitute the appointment of an authorized representative.

By submitting a claim to the Plan and accepting payment by the Plan, the provider is expressly agreeing to the foregoing conditions and limitations of an assignment of benefits in addition to the terms of the Plan Document. The provider further agrees that:

A. The payments received constitute an **'**accord and satisfaction**'** and consideration, in full, for the covered expenses for services, supplies and/or treatment rendered.

B. The conditions and limitations of an assignment of benefits as set forth herein shall supersede any previous terms and/or agreements.

C. The specific condition that the patient not be balance billed for any amount beyond applicable cost sharing amounts (i.e. copayments, deductibles, or co-insurance), or charges for non-covered services; the provider may bill the Plan participant directly for these amounts.

D. If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the claimant for any outstanding amount(s).

If a provider refuses to accept an assignment of benefits under the conditions and limitations as set forth herein, any covered expenses payable under the terms of the Plan Document will be payable directly to the Plan participant, and the Plan will be deemed to have fulfilled its obligations with respect to such covered expense.

ASSISTANT SURGEONS

The decision to request an assistant surgeon for your elective surgery remains the responsibility of the primary surgeon and is generally based upon the complexity of the surgical procedure. As such, the primary surgeon should disclose the need for an assistant surgeon to you prior to your elective surgery so that you can determine the network affiliation and subsequent out-of-pocket expense.

Should you discover prior to your elective surgery that the assistant surgeon does not participate in the Plan's network, you can always request the Plan to try and negotiate with the assistant surgeon or try to find an in-network assistant surgeon prior to the surgery taking place.

Participants are advised that there are procedures that almost never require the services of an assistant surgeon. Therefore, the Plan reserves the right to not to pay and/or withhold payment for such services until the need is quantified in accordance to plan provisions and the standards

or concepts supported by the American College of Surgeons and certain other surgical specialty organizations.

Assistant surgeon benefits are available for one assistant surgeon per inpatient operative session when:

- The hospital does not employ a house staff of surgeons or surgical residents,
- When the hospital surgeons or surgical residents are unavailable to assist the surgeon, or
- When necessitated by law.

Participating provider charges will be subject to the deductible and will be payable at the negotiated rate.

Non-participating provider charges will be subject to the deductible, and will be calculated using the following formula:

¼ of the Plan's Reasonable and Allowed amount (RAA) of the surgeon x 70%

NOTE: The Plan understands that:

- "Almost never" does not imply that the services of an assistant surgeon are never needed.
- That patient characteristics can have an impact on the need for an assistant surgeon.
- The qualifications of the person in this role may vary with the nature of the operation, the surgical specialty and the type of hospital or ambulatory surgical facility.

Consequently, if your assistant surgeon bill is rejected, your surgeon will need to provide the Plan with a written explanation as to the reason the assistant surgeon was needed as well as any supporting documentation as required by the Plan.

BARIATRIC (OBESITY) SURGERY

Precertification is required before the Plan can make payment for bariatric services.

Participating provider charges will be subject to the deductible, and payable at 90% of the negotiated rate.

Non-participating provider charges will be subject to the deductible and payment will be made at 70% of the Funds Reasonable and Allowable Amount (RAA)

The Plan will not make any payment for this benefit unless a true life–threatening medical condition exists. Participants must meet the following criteria to be eligible for this benefit:

- At least one hundred (100) pounds over normal weight for more than five years; and,

- Six (6) continuous months of non-surgical methods of weight reduction supervised, monitored and documented by a medical physician or health professional during the past two (2) years.

Warning:

- The Plan excludes more than one bariatric (obesity) procedure benefit in a person's lifetime.

- A letter of medical necessity is required that explains:

    - The patient's complete medical report, with medical diagnosis and any supporting documentation.
    - A pre-operative evaluation by a licensed psychologist and/or licensed board-certified psychiatrist qualified in the assessment and diagnosis of mental health illness, who also has familiarity with bariatric surgery procedures, follow-up, and required behavioral changes.
    - Documentation of a motivated attempt of weight loss through a structured diet program, prior to the bariatric surgery, which includes physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program for a minimum of six months.
    - Any supporting documentation requested to obtain precertification and to determine that surgery is not being performed for any cosmetic reason.

- Band adjustments are covered only up to the first year following the surgery and require precertification.

- Participants are advised that if they are receiving laparoscopic sleeve gastrectomy (LSG) as a first step procedure with the second stage procedure being gastric by-pass, the Plan will only pay for first bariatric procedures and not the second.

- The reversal of the gastric bypass surgery will require the patient to submit a detailed assessment to rule out that the poor response to the primary bariatric surgery is due to anatomic causes that led to inadequate weight loss or weight regain, rather than the patient's post-operative behavior, such as not following the prescribed diet and lifestyle changes (e.g., consuming large portions, high-calorie foods, and/or snacks between meals; not exercising).

- Panniculectomy or the "re-contouring" to remove loose skin is not a covered benefit of the Plan.

Failed eating and/or exercise regimens and motivations that are of a cosmetic nature are not covered.

BENEFICIARY

The Plan will pay the proceeds of the Life Insurance policy to the beneficiary(ies) you designated and who is on record with the Fund Office at the time of death.

Participants are advised that:

- Only you can name your beneficiary. As such, it is your responsibility to see that the person or persons you wish to receive your life insurance proceeds have been properly named and that those beneficiaries are on file at the Health and Benefit Plan office.
- You may name more than one beneficiary.
- If you name more than one beneficiary, you will need to identify the percentage of the amounts each beneficiary is to receive.
- If you do not identify the percentage amounts of each beneficiary, then the Plan will pay each beneficiary equally.
- If any designated beneficiary dies before you, that beneficiary's right to this Plan's benefit terminates.
- You can change your beneficiaries at any time.
- You will want to review your beneficiary designations on file with this and each Benefit program offered by the International Brotherhood of Electrical Workers, Local 697, if your;
    - Marital status changes,
    - Number of dependents changes,
    - An existing beneficiary predeceases you.

All changes must be in writing and will become effective on the date the document(s) are received at the Fund Office. Changes received by the Fund Office after your death will not be honored, even if those changes were postmarked prior to the date of death. To change your beneficiary(s), contact the Fund Office at 219-940-6181 or go online to www.ibew697benefits.com.

Selecting a Beneficiary

A beneficiary can be an individual, an institution, an organization, a trust, or your estate. Beneficiaries can also be the children of the beneficiaries that you designate on the beneficiary form. You can choose primary and contingent beneficiaries. Your primary beneficiary(ies) receives benefits at the time of your death. If a form includes more than one person, the benefits are paid proportionately among the living beneficiaries unless you specify otherwise. If there are no living primary beneficiaries at the time of your death the benefits will become payable to your contingent beneficiary(ies). If none of the beneficiaries are living at the time of your death, or you did not provide the Plan a completed beneficiary form, benefits will be paid as follows:

1) As decreed within a Court order.
2) In the absence of a Court order, benefits will be paid in the following order:
    a. Your spouse,
    b. Your children,
    c. Your parents,
    d. Your brothers and sisters,
    e. Your estate.

Did you know that incomplete information can make it difficult for us to find your beneficiaries?

To help ensure that your beneficiaries receive their survivor benefits, it's important that we have complete information on file to locate them at all times. This includes each beneficiary's name, address, telephone number, date of birth, Social Security Number or Taxpayer Identification Number and relationship to you and the portion of the benefits to which they are entitled.

To update or change your beneficiary designation, please visit us online at www.ibew697benefits.org and download the Designation of Beneficiary form. Remember, you will need to have the document notarized prior to mailing it back to the Benefit Fund Office. Forms that are not notarized will be returned to the sender.

If you don't have computer access, please do not hesitate to call the Fund Office at 219-940-6181.

BIRTH

Parents of newborn children will be provided a ninety-day (90) grace period from the date of the child's birth to enroll their child into the Plan and submit the proper and required documentation as identified within this section.

In order to enroll your child into the Plan, you will need to submit the following:

- A completed enrollment form.
- A copy of the child's birth certificate.
- A copy of the child's Social Security card.
- Information on any other health care coverage the child has, including the policyholders name and Social Security number, policy name, policy number and mailing address.

If both you and your spouse are covered as participants, you both may cover your eligible dependents under the plan. However, you and your dependents' health care coverage will be coordinated so the Plan will not pay more than 100% of the covered expenses for services and supplies.

Warning: Failure to submit properly completed forms and all supporting documentation in their entirety within the ninety (90) day period will result in the Plan:

1. Ceasing future payments of benefits for the child; and

2. Demanding reimbursement for any claims that the Plan has paid prior on the child from the participant.

3. The submission of documentation and/or a properly completed enrollment form after the ninety (90) day grace period will neither result in the Plan making payments toward claims incurred during that grace period, nor will it cause the Plan to reverse its demand for reimbursement. As such, claims incurred during that time will remain the responsibility of the participant.

BREAST PUMPS

In conjunction with each new pregnancy, and only up until one year postpartum, the Plan will provide a maximum allowance of $150.00 toward the purchase or rental of a breast pump.

Breast pumps purchased from a participating provider will be subject to the deductible and paid at 90% of the Plan's Reasonable and Allowed Amount.

Breast pumps purchased from a non-participating or out of network provider will be subject to the deductible and paid at 70% of the Plans Reasonable and Allowed Amount.

Warning: The Plan will not pay for:

- Breast pump expenses above the Funds allowable limit.
- Breast pump replacement parts.
- Breast pumps purchased prior to the birth of the child.

CARDIAC REHABILIATION

Inpatient Cardiac Rehabilitation: Precertification is required for intensive cardiac rehabilitation (ICR) and cardiac rehabilitation services provided in an inpatient setting when the inpatient admission has been previously authorized by the Plan.

Phase II outpatient cardiac rehabilitation require precertification provided:

Warning: Phase III and phase IV cardiac rehabilitation programs are considered maintenance programs and therefore are NOT considered medically necessary by the Plan regardless of the completion of any outpatient, medically necessary and supervised, phase II cardiac rehabilitation.

Participating provider charges will be subject to the deductible, and payable at 90% of the Reasonable and Allowed Amount.

Non-participating provider charges will be subject to the deductible and payment will be made at 70% of the Fund's Reasonable and Allowed Amount (RAA)

CARE MANAGEMENT AND/OR CASE MANAGEMENT

The Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan wants to provide you and your eligible dependents with a health care benefit plan that financially protects you from significant health care expenses as well as provides you with quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are administered and used.

Regarding the latter, the Plan has contracted with a care management company to identify and assist individuals with conditions requiring extensive or on-going medical services and/or prescription medications. The program is not intended to diagnose or treat medical conditions, guarantee benefits, make payments, or validate eligibility for Plan coverage. The program focuses on:

1. Making recommendations regarding the appropriateness and medical necessity of specified health services, which may be grounds for denying benefits under the Plan, and,

2. Ensuring timely, coordinated access to medically appropriate levels of health, support services and continuity of care through the initial and ongoing assessment of the participant's, and other family members', needs and personal support systems.

You and any eligible dependents are required to cooperate with the Plans affiliated case management program, when deemed applicable, or benefits may not be payable under the Plan.

How it Works

A case manager consults with the patient and the attending physician in order to develop a plan of care for the patient. This plan of care may include some or all of the following:

Personal support to the patient
Contacting the family to offer assistance and support
Monitoring hospital or skilled nursing facility confinement
Determining alternative care options; and
Assisting in obtaining any necessary equipment and services

Once an agreement has been reached, the Fund Manager will direct the Plan to cover medically necessary expenses as stated in the treatment plan. Unless specifically provided to the contrary in the Fund's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note:

A. Participants are informed that the case manager may require your assistance in obtaining your medical records and documents from your physician or medical provider. These documents are needed to determine the reason why a particular procedure, service, or treatment was chosen or recommended, whether or not it is medically necessary, or even appropriate for the circumstances, and whether the procedure is covered.

B. The Plan may elect, in its sole discretion, to provide alternative benefits that are otherwise excluded under the Plan. This would generally occur when the alternative benefit would be beneficial to the patient and the Plan.

C. An individual's participation within this program shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other covered person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan. As such, participants are informed that each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

D. The Plan's case management program is driven by quality-based outcomes such as, but not limited to:

1. The participant's improved and/or maintained functional status.
2. The participant's improved and/or maintained clinical status.
3. The participant's enhanced quality of life and/or quality of life satisfaction.
4. The participant's adherence to the care plan.
5. The participant's autonomy.
6. The participant's improved safety.
7. Improvement in the reduction of out-of-pocket expenses when possible.

Warning:

The Plan reserves the right to enroll each participant within this program as it deems appropriate. Failure to comply with the program will result in the payment of your in-network providers made at 70% and your out of network providers at 50%.

CERTIFIED REGISTERED NURSE ANESTHETISTS - CRNA

A certified registered nurse anesthetists (CRNAs) can work independently or in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other professionals to ensure the safe administration of anesthesia. Some of their responsibilities include providing pain management, assisting with stabilization services, and overseeing patient recovery. These services may be used through all phases of surgery and for diagnostic, obstetrical, and therapeutic procedures as well.

Participating CRNA charges will be subject to the deductible and annual out-of-pocket limits and payable at 90% of the negotiated rate.

Non-participating CRNA provider charges for **treatments rendered within a participating hospital or facility** will be subject to the deductible and annual out-of-pocket limits and payment will be made at 90% of the Fund's Reasonable and Allowed Amount (RAA) for both the base and time unit. The following formula will be used when calculating the Funds payment.

Base Unit RAA + Time Unit RAA x 90% = Non-participating reimbursement

CRNA provider charges that are submitted in conjunction with an Anesthesiologist provider charges for treatments rendered within any **participating hospital or facility will be** subject to the deductible and annual out-of-pocket limits and payment will be made at 90% of the Fund's Reasonable and Allowed Amount (RAA) for both the base and time unit and divided 50/50 between the two professionals. The following formula will be used when calculating the Funds payment.

Base Unit RAA + Time Unit RAA x 90% / 2 = Non-participating reimbursement

Non-participating CRNA provider charges that are administered for or with other **true emergency treatments and rendered within a non-participating hospital or facility** will be subject to the deductible and annual out-of-pocket limits and payment will be made at 90% of the Fund's Reasonable and Allowed Amount (RAA) for both the base and time unit. The following formula will be used when calculating the Funds payment.

Base Unit RAA + Time Unit RAA x 90% = Non-participating reimbursement

Non-participating CRNA provider charges for **non-emergent treatments rendered within a non-participating hospital or facility** will be subject to the deductible and annual out-of-pocket limits and payment will be made at 70% of the Fund's Reasonable and Allowed Amount (RAA) for both the base and time unit. The following formula will be used when calculating the Fund's payment.

Base Unit RAA + Time Unit RAA x 70% = Non-participating reimbursement

CRNA provider charges that are submitted in conjunction with an Anesthesiologist provider charges for treatments rendered within any **non-participating hospital or facility will be** subject to the deductible and annual out-of-pocket limits. Payment will be made at the maximum allowable amount for both the base and time unit and multiplied by the higher of the

net-work affiliation rate of the two and split 50/50. If both the CRNA and Anesthesiologist do not participate, then the Reasonable and Allowed Amounts will be multiplied by 70%. The following formula will be used when calculating the Funds payment.

Base Unit RAA + Time Unit RAA x 70% / 2 = Non-participating reimbursement

CHEMOTHERAPY

Precertification is necessary prior to receiving any chemotherapy treatment.

Chemotherapy received in a physician's office or facility other than a hospital will be paid as follows:

- Participating provider charges and facility charges will be subject to the deductible and payable at 90% of the Reasonable and Allowed Amount.

- Non-participating provider charges and facility charges will be subject to the deductible and payable at 70% of the Plan's Reasonable and Allowed Amount.

Chemotherapy treatments received in a level A hospital facility will be paid as follows:

- Facility fees will be paid at 100% of the Reasonable and Allowed Amount and will be not subject to the annual deductible.

- Physician charges will be paid in accordance to the network affiliation of the medical professional rendering treatment. Consequently:

    - If the physician or professional rendering service is an employee of the hospital, then the Plan will not make any payment as that professional's salary is incorporated within the facility fee.

    - If the physician or medical professional rendering service is a participating provider, then the Plan will pay 90% of the Reasonable and Allowed Amount (RAA).

    - If the physician or medical professional rendering service is a non-participating provider, then the Plan's payment will be subject to the deductible and will be paid at 70% of the Plan's RAA.

Chemotherapy treatments received in a level B hospital facility will be paid as follows:

- Facility fees will be paid at 90% of the Reasonable and Allowed Amount will be subject to the annual deductible and annual out of pocket maximums.

- Physician charges will be paid in accordance to the network affiliation of the medical professional rendering treatment. Consequently:

- If the physician or professional rendering the service is an employee of the hospital, then the Plan will not make any payment as that professional's salary is incorporated within the facility fee.

- If the physician or medical professional rendering the service is a participating provider, then the Plan's payment will be subject to the deductible and will be paid at 90% of the Reasonable and Allowed Amount (RAA).

- If the physician or medical professional rendering the service is a non-participating provider, then the Plan's payment will be subject to the deductible and will be paid at 70% of the Plans Reasonable and Allowed Amount (RAA) payment methodology.

Chemotherapy treatments received in all other hospital facilities will be paid as follows:

- Facility fees will be subject the annual deductible and paid at 70% of the Plan's Reasonable and Allowed Amount (RAA) payment methodology.

- Physician charges will be paid in accordance to the network affiliation of the medical professional rendering treatment. Consequently:

  - If the physician or professional rendering the service is an employee of the hospital, then the Plan will not make any payment as that professional's salary is incorporated within the facility fee.

  - If the physician or medical professional rendering the service is a participating provider, then the Plan's payment will be subject to the deductible and will paid at 90% of the Reasonable and Allowed Amount.

  - If the physician or medical professional rendering the service is a non-participating provider, then the Plan's payment will be subject to the deductible and will be paid at 70% of the Plan's Reasonable and Allowed Amount (RAA).

Warning:

1. The Plan will not make any payment toward medical services, treatments, drugs or supplies that are considered educational, investigational or experimental.

2. Although the Plan believes that most physicians and hospitals are administrating the most useful intravenous chemotherapy treatment for the patient, the fact remains that the current U.S. healthcare system creates a financial incentive to not only administer chemotherapy but to also potentially choose a more expensive drug when there is a choice for a cheaper alternative. All things being equal, many physicians and hospitals alike, elect to utilize chemo drugs that either receive a more generous insurance reimbursements or the ones that garner the largest margins. For these reasons, the Plan reserves the right to purchase directly from its prescription benefit administrator (PBA) or the manufacturer the pharmaceutical that the physician is administrating. If a

physician or a hospital refuses to allow the Plan to purchase directly the pharmaceutical, then the Plan will only reimburse the physician or hospital only the amount it would have paid if it purchased the pharmaceutical itself.

CHILDREN

A child's eligibility is contingent upon the employee's eligibility and whether or not the child has been properly enrolled into the Plan.

Parents who wish to enroll their child into the Plan must submit:

- A completed enrollment form.
- A copy of the child's birth certificate. (Or, if applicable, the adoption papers, court order for legal guardianship, the Qualified Medical Child Support Order or National Medical Support Notice.)
- A copy of the child's Social Security card.
- Information on any other health care coverage the child has, including the policyholder's name and Social Security number, policy name, policy number and mailing address.

In order to be covered by the Fund, your "child" must be:

1. Your biological, legally adopted child, or a stepchild who is dependent on you for at least one-half his or her support annually. Such child will be covered to the end of the calendar month in which the child's twenty-six (26th) birthday occurs.
2. A child who is to be considered as an eligible dependent of yours as required by a Qualified Medical Child Support Order (QMCSO). *Coverage will continue until the end of the calendar month he or she turns 26 years of age.*
3. Your Incapacitated child, who meets the following requirements:
    - The child's incapacity commenced prior to age 19, and
    - The child was continuously covered since he/she became eligible for such coverage prior to attaining the limiting age as stated in the numbers above, and
    - He/she is mentally or physically incapable of sustaining his or her own living and
    - He/she resides with you and,
    - The child is dependent upon you for at least one-half his/her support

Written proof of your child's incapacity must be received by the Fund Office within 31 days of his/her nineteenth (19th) birthday.

Such child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated above. "Proof of financial support" means a signed and submitted copy of your federal income tax returns showing that you claimed and continue to claim the child as your dependent.

Your incapacitated child may remain an eligible dependent as long as he/she remains incapacitated and you maintain your eligibility.

When your child is enrolled.

Assuming you have met the hourly requirements, you and/or any eligible dependent will be enrolled in the Plan on the first day after the Health and Benefit Plan receives and deems complete the enrollment form and all supporting documentation proper.

Parents of newborn children will be provided a ninety-day (90) grace period from the date of the child's birth to enroll their child into the Plan and submit the proper and required documentation as identified within this section.

Warning: Failure to submit properly completed forms and all supporting documentation in their entirety within the ninety (90) day period will result in the Plan:

1. Ceasing future payments of benefits for the child; and

2. Demanding reimbursement for any claims that the Plan has paid prior on the child from the participant.

3. The submission of documentation and/or a properly completed enrollment form after the ninety (90) day grace period will neither result in the Plan making payments toward claims incurred during that grace period, nor will it cause the Plan to reverse its demand for reimbursement. As such, claims incurred during that time will remain the responsibility of the participant.

Warning:

- Missing, or incomplete enrollment forms, or the untimely completion and/or untimely submission of the enrollment form, and/or requested documents will result in the individuals being unable to claim benefits from this Plan. Consequently, any bills incurred prior to the Plan's enrollment of you and/or any eligible dependent will remain the sole responsibility of the participant.

- If both you and your spouse are covered as participants, you both may cover your eligible dependents under the plan. However, you and your dependents' health care coverage will be coordinated so the Plan will not pay more than 100% of the covered expenses for services and supplies.

CHIROPRACTOR

The maximum payable for all chiropractor charges incurred during a visit is $40.00, and the maximum chiropractor benefit per calendar year is $1,500. With the exception of medically necessary x-rays, all treatments rendered on the same day will be considered one visit.

Participating chiropractor charges will be subject to the deductible and payable at 90% of the negotiated rate up to the maximum of $40.00 for manipulations, adjustments or other services and treatments received.

Non-participating chiropractor charges will be subject to the deductible and payable at 70% of the Reasonable and Allowed Amount up to $40.00 for either manipulations, adjustments or other services and treatment received.

Medically necessary x-rays:

- performed by a participating chiropractor will be subject to the deductible and payment will be made at 90% of the Fund's Reasonable and Allowed Amount (RAA).

- Medically necessary x-rays associated with a non-participating chiropractor will be subject to the deductible and payment will be made at 70% of the Fund's Reasonable and Allowed Amount (RAA).

Warning: Modalities other than adjustments and manipulations, i.e., physical therapy provided by a chiropractor are not covered by the Plan.

CLAIM AUDITS AND REVIEWS

The Plan reserves the right to audit and/or review any claim incurred by you or any eligible dependent to make certain that that the charges reported by the hospital, physician, laboratory, or any other provider involved are accurate.

The purpose of this audit is to ensure that claims with many charges are made and processed properly. Whenever a claim is reviewed or audited it usually results in a slight delay in processing. Generally, any benefits due will paid as usual. However, should the medical provider or a participant fails to submit requested information, or submit said information on a timely basis, then the processing of the claim could be lengthened. Failure to submit requested information within three-hundred and sixty-five days (365) of its initial request will result in the claim being denied.

CLAIM PROCEDURES

In order for the Plan to pay benefits, a claim must be filed with the Claims Administrator within three-hundred and sixty-five days from the date of service. A claim can be filed by you, your eligible dependent or by someone authorized to act on behalf of you or your eligible dependent.

A paper claim is considered to have been filed on the date it is received at the Claims Administrator's office, even if the claim is incomplete. The Claims Administrator receives claims during regular business hours, Monday through Friday.

The electronic data interchange (EDI) system accepts claims twenty-four (24) hours a day, seven (7) days a week; however, claims received after 6 P.M. eastern time or on a weekend or holiday are considered received the next business day.

A "claim" is a request for Plan benefits, normally because the claimant has incurred a healthcare expense. A request for confirmation of Plan coverage is not a claim if you have not yet incurred the expense unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy, whether or not the pharmacy is a prescription network provider.

You may designate another person as your authorized representative for purposes of filing a claim. Such designations must be in writing.

Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you.

When you designate a person as your authorized representative, it allows that person to deal with the Plan on your behalf, but it does not mean that the Plan will send your benefit payments to that person. Designating an authorized representative is different from assigning benefits to a medical provider. When you assign benefits (usually on a form that the medical provider supplies), the assignment allows the Plan to pay benefits directly to the medical provider, but the provider does not become your authorized representative because that must be done using a form from the Plan.

Claim Processing Time Periods

The amount of time the Plan can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

1. A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested.

2. A "disability claim" is a claim for Disability Benefits.

3. A "pre-service claim" is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining the care.

4. An "urgent care claim" is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function, or that could subject you to severe pain that cannot be adequately managed without the proposed treatment.

5. A "concurrent care claim" is also a type of pre-service claim. A claim is a concurrent care claim if a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved.

6. If all the information needed to process your claim is provided to the Claims Administrator, which in the case of a provider-submitted claim, means that the Claims Administrator has received a "clean claim" (as described in the definitions section of this document under the title "Clean Claim"), your claim will be processed as soon as possible. However, the

processing time needed will not exceed the time frames allowed by law, which are as follows:

- *Post-service* claims - 30 days
- *Disability* claims - 45 days
- *Pre-service* claims - 15 days
- *Urgent care* claims - 72 hours
- *Concurrent care* claims - 24 hours if the concurrent care is urgent and if the request for the extension is made within 24 hours prior to the end of the already authorized treatment. If such a request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, i.e., as soon as possible and not later than 72 hours after receipt.

When Additional Information Is Needed (Claimant Extension)

If additional information is needed from you, your doctor or the provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the normal time limits shown above, except that the additional information needed to decide an urgent care claim will be requested within 24 hours.

It is your responsibility to see that the missing information is provided to the Claims Administrator. The normal processing period will be extended by the time it takes you to provide the information, and the time period will start to run once the Claims Administrator has received a response to its request. If you do not provide the missing information within 180 days (48 hours for an urgent care claim), from the date of issuance of said notice or request, the Claims Administrator will make a decision on your claim without it, and your claim could be denied as a result.

Plan Extension

The time periods above may be extended if the Claims Administrator determines that an extension is necessary due to matters beyond its control (but not including situations where it needs to request additional information from you or the provider). You will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

- *Post-service claims* - 15 days
- *Disability claims* - 30 days (a second 30-day extension may be needed in special circumstances)
- *Pre-service claims* - 15 days

If all the information needed to process your claim is provided to the Claims Administrator, your claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are 30 days for post-service claims and 45 days for disability claims.

Claim Denials

If all or a part of your claim is denied after the Claims Administrator has received all other necessary information from you, you will be sent a written notice giving you the reasons for the

denial. The notice will include reference to the Plan provisions on which the denial was based and an explanation of the claim appeal procedure. If applicable, it will give a description of any additional material or information necessary for you to perfect the claim, and the reason such information is necessary. The notice will provide a description of the appeal procedures and the applicable time limits for following the procedures. It will also include a statement concerning your right to bring a civil action under section 502(a) of ERISA. In cases where the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the notice will state that the specific internal rule, guideline, protocol or criterion will be provided to you free of charge upon request. If the decision was based on medical necessity or if the treatment was deemed experimental, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

In addition to the above, a denial of a Disability Claim will also include:

- A statement regarding your and your authorized representative's rights; and

- A discussion of the decision, including an explanation of the basis for disagreeing with or the views presented by you of health care professionals treating you and vocational professionals who evaluated you; and/or the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the benefit determination; and if provided by you, the disability determination made by the Social Security Administration.

CLERICAL ERROR AND DELAYS

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by participants due to such clerical error will be returned to the participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan participant, the amount of overpayment may be deducted from future benefits payable.

COBRA

Federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), provides participants and their eligible dependents the right to be offered an opportunity to make self-payments for continued health care coverage if coverage is terminated for certain reasons. This continued coverage is called "continuation coverage," "COBRA continuation coverage," or "COBRA coverage." Below is an outline of the rules governing COBRA coverage. If you have any questions about COBRA, call the Fund Office.

After your initial election for coverage under COBRA, self-payments are due no later than the first business day in and for the same month you are eligible for benefits.

Other Coverage Options

There may be other coverage options for you and your family since you are now be able to buy coverage through the health insurance marketplace (exchange). On the exchange you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Qualifying Events and Maximum Time of Continued Coverage

The following is a summary of the maximum period of C.O.B.R.A. coverage permissible by a qualifying event. Each qualifying event is outlined in more detail within section "A" through "E" directly after the summary chart.

Qualifying Event Causing Termination	Employee	Spouse	Dependent Child(ren)
Termination (For reasons other than gross misconduct)	18 Months	18 Months	18 Months
Reduction in hours	18 Months	18 Months	18 Months
Employee Dies	N/A	36 Months	36 Months
Divorce	N/A	36 Months	36 Months
Entitled to Social Security Disability Benefits	29 Months	29 Months	29 Months
Becomes entitled to Medicare	N/A	36 Months	36 Months
Child loses dependent status	N/A	N/A	36 Months

A. **18-Month Maximum Coverage Period** - You and/or your eligible dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for a maximum period of up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"):

1. The failure of a non-bargaining participant's employer, or the failure of an owner or owner-in-fact, to make the contributions required to obtain coverage under this Plan is not in itself a COBRA qualifying event.

2. A reduction in your hours.

3. Termination of your employment (which includes retirement).

B. **29-Month Maximum Coverage Period** - If you or an eligible dependent is disabled (as defined by the Social Security Administration for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or an eligible dependent becomes so disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The COBRA self-payment may be higher for the extra eleven (11) months of coverage for the family. Also, you must notify the Fund Office within 60 days of such a determination by the Social Security Administration and within the initial 18-month period, and within 30 days of the date Social Security determines that the person is no longer disabled.

C. **36-Month Maximum Coverage Period** - Your dependents (spouse or children) are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following qualifying events:

• Your divorce from your spouse.
• A dependent child's loss of dependent status.
• Your death.

D. **Multiple Qualifying Events** - If your dependents are covered under COBRA coverage under an 18-month maximum coverage period due to termination of your employment or a reduction in your hours and then a second qualifying event occurs, their COBRA coverage may be extended as follows:

- If you die, or if you are divorced, or if a child loses dependent status while your dependents are covered under an 18-month COBRA coverage period, your dependent(s) who are affected by the second qualifying event are entitled to COBRA coverage for up to a maximum of 36 months minus the number of months of COBRA coverage already received under the 18-month continuation.

- Only a person (spouse or child) who was your dependent on the day before the occurrence of the first qualifying event (termination of your employment or a reduction in your hours) is entitled to make an election for this extended coverage when a second qualifying event occurs. Exception: If a child is born to you (the employee), or adopted by you, or placed with you for adoption during the first 18-month COBRA period, that child will have the same election rights when a second qualifying event occurs as your other dependents who were eligible dependents on the day before the first qualifying event.

- It is the affected dependent's responsibility to notify the Fund Office within 60 days after a second qualifying event occurs. If the Fund Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

E. **Special Medicare Entitlement Rule** - A special rule for dependents provides that if a covered employee becomes entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of hours, the period of coverage for the employee's spouse and dependent children ends

with the later of the 36-month period that begins on the date the covered employee became entitled to Medicare, or the 18- or 29-month period (whichever applies) that begins on the date of the covered employee's termination of employment or reduction of employment hours.

Benefits Provided Under COBRA Coverage

When you or a dependent elect and make self-payments for COBRA coverage, you will be eligible to elect the same medical, prescription drug, dental and vision coverage you had when your qualifying event occurred. You can also elect medical and prescription drug coverage only. COBRA coverage does not include life and AD&D insurance, or Loss or Time Benefits.
A COBRA self-payment covers all persons in your family who were eligible for Plan benefits when the qualifying event occurred and whose coverage would otherwise be lost due to that event. There is no single-only coverage option.

Notification Responsibilities

A. If you get divorced, or if your child loses dependent status, you, your spouse or child must notify the Fund Office and request a COBRA election notice. The Fund Office must be notified, and if applicable, your divorce decree must be submitted, within 60 days of the date of the qualifying event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later.

B. For purposes of extending an 18-month maximum coverage period to 29 months, the Fund Office must be notified of the person's determination of eligibility for Social Security disability benefits within 60 days of the Social Security notice of such determination and before the end of the initial 18-month period. The Fund Office must also be notified within 30 days of the date Social Security determines that the person is no longer disabled.

C. It is your employer's responsibility to notify the Fund Office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you or a dependent should also notify the Fund Office and request a COBRA election notice any time any type of qualifying event occurs.

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the contact information of family members. This would include, but is not limited to cell phone numbers and e-mail addresses. You should also keep a copy, for your records, of any notices you send to the Fund Office or that the Fund Office sends you.

Electing COBRA Coverage

A. When the Fund Office is notified of a qualifying event, and you request notification about your COBRA rights, an election notice will be sent to you and/or your dependent(s) who would lose coverage due to the event. The election notice tells you about your right to elect COBRA coverage, the due dates, the amount of the self-payments, and other pertinent information.

B. An election form will be sent along with the election notice. This is the form you or a dependent fill in and return to the Fund Office if you want to elect COBRA coverage.

C. The person electing COBRA coverage has 60 days after he is sent the election notice or 60 days after his coverage would terminate, whichever is later, to return the completed election form. An election of COBRA coverage is considered to be made on the date the election form is personally delivered or mailed back to the Fund Office (the postmark date will govern the date of mailing).

D. If the election form is not returned to the Fund Office within the allowable period, you and/or your dependents will be considered to have waived your right to COBRA coverage.

COBRA Self-Payment Rules

A. COBRA coverage self-payments must be made monthly and must be received by the Fund Office in a timely manner. Your self-payment will be considered on time if it is personally delivered or mailed by the due date. (Postmarks affixed by the U.S. Postal Service will be considered proof of date of mailing.)

B. The amounts of the monthly self-payments are determined by the Trustees based on federal regulations. The amounts are subject to change, but not more often than once a year unless substantial changes are made in the benefits.

C. A person electing COBRA coverage has 45 days after the signed election form is returned to the Fund Office to make the initial (first) self-payment for coverage provided between the date coverage would have terminated and the date of the payment. (If a person waits 45 days to make the initial payment, the next monthly payment may also fall due within that period and must also be paid at that time.)

D. The due date for each following monthly self-payment is the first day of the month for which payment is made. A monthly self-payment will be accepted if it is received by the Fund Office within a 30-day grace period after the due date. Your self-payment will be considered on time if it is personally delivered or mailed by the due date.

E. If a self-payment is not made within the time allowed, COBRA coverage for all affected family members will terminate. You may not make up the payment or reinstate coverage by making future payments.

F. If a COBRA payment made on your behalf is rejected due to non-sufficient funds, you must pay the full amount by money order or cashier's check before the original due date or within ten calendar days, whichever is sooner. The ten-day repayment period will be measured from the date you are contacted about the NSF check. If you are contacted by telephone, it will be measured from the date of the call. If you are informed by mail, it will be measured from the date of the notice. If you fail to make an in-full and on-time repayment, your COBRA coverage will terminate at the end of the last month for which you made a proper payment, and it will not be reinstated.

Additional COBRA Coverage Rules

1. COBRA coverage may not be elected by anyone who was not eligible for Plan benefits on the day before the occurrence of a qualifying event.

2. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage.

3. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents.

4. If coverage is going to terminate due to your termination of employment or reduction in hours and you don't elect COBRA coverage for your dependents when they are entitled to the coverage, your dependent spouse has the right to elect COBRA for up to 18 months for herself and any children within the time period that you could have elected COBRA coverage.

5. A person who is already covered by another group health plan or Medicare may elect COBRA coverage. However, if a person becomes covered under another group health plan or Medicare after the date of the COBRA election, his COBRA coverage will terminate. Note to Medicare-Eligible Participants: You MUST have Part B coverage before your COBRA starts. Although this Plan is primary to Medicare while you are covered as an active employee, this Plan becomes secondary to Medicare when you elect COBRA. This Plan will not pay any charges that could have been paid by Medicare – even if you haven't elected it. If you do not elect Part B, you will be responsible for most of your non-hospital medical expenses.

6. You do not have to show proof that you and/or your dependents are insurable in order to be entitled to COBRA coverage.

Termination of COBRA

Normally, COBRA coverage for a person will terminate at the end of the last month of the maximum period to which the person was entitled and for which correct and timely payments were made. However, COBRA coverage for a covered person will terminate before the end of the maximum period when the first of the following events occurs:

1. A correct and timely payment is not made to the Fund.
2. After an election of COBRA coverage, the person becomes entitled to Medicare benefits.
3. After an election of COBRA coverage, the person becomes covered under another group health care plan.
4. This Plan no longer provides group health coverage to any employees.
5. The person was receiving extended coverage for up to 29 months due to his or another family member's disability, and Social Security determines that he or the other family member is no longer disabled.

For More Information on COBRA

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a health insurance marketplace, visit

www.healthcare.gov. For specific information about this Fund or how to elect COBRA, call the Fund Office at 1-219-845-4433.

COMMUNICATIONS OF BENEFIT UPDATES, CHANGES, REMINDERS AND NOTICES OF PAYMENTS DUE AND DELINQUENCIES

The Plan communicates utilizing a variety of methods and channels, such as but not limited to:

Benefit fairs and other events
Blogs
Cards
E-mail or e-cards
Handouts
Interactive e-brochures or presentations
Mail (When required by law)
Meetings
Newsletters
Posters and postcards
SMS text messages
Social media
Summary Plan Description Books
Video
Web portals, apps and widgets

When communicating benefit updates and/or changes, the Plan reserves the right to utilize and change between any one or all these methods or channels of communication from time to time and at any time in its sole discretion.

Reminder notices will be at the discretion of the Fund and are a courtesy and not a right. Reminder notices, if any, can be posted on the Fund's website, mobile app or another website disclosed to you and/or delivered to the electronic address you provide.

Delivery of Electronic Communications: Regardless of which electronic method a participant prefers to be informed of benefit updates and benefit changes the following policies will apply to the Plan's electronic communications.

Website and Mobile Apps: Any communication made by electronically posting it to the Fund's website or to its mobile app, will be considered sent at the time it is publicly available. If the communication is posted to the website and/or mobile app, then it will be deemed to have been received by you no later than five (5) business days after the Fund posts the communication to the website.

E-mails, Text Messaging and Instant Messaging: Any electronic communication sent by e-mail, text messaging and/or instant messaging is considered to be sent at the time that it is directed by the Plan's server to the address or number provided by the participant. These types of Plan communications will be deemed to have been received by you, whether or not you retrieve these messages by opening them.

Note: The Fund will not be responsible for misdirected mail, misdirected electronic communications, returned mail, returned electronic communications, unopened mail, unopen electronic communication, undelivered mail or undelivered electronic communication because of the failure of the participant to update his or her contact information with the Plan. As such, it is the responsibility of the participant to provide the Plan with his or her current e-mail address or other electronic address.

COORDINATION OF BENEFITS (COB)

Quite frequently, members of a family are covered under more than one group health plan. Thus, there are many instances of double coverage - two plans paying benefits for the same dollar of dental, medical, hospital, pharmaceutical and/or vision expenses. For that reason, a Coordination of Benefits provision has been adopted that will coordinate the benefits payable herein (with the exception of life insurance) with similar benefits payable under other plans.

This Plan will fully coordinate benefits with other plans, such that the combined benefits from both Plans can never exceed 100% of this Plan's allowable expenses. Deductible limits will still apply under both plans.

The Coordination of Benefits (COB) provision will apply anytime a covered person has health care coverage under more than one Plan. If you fall into this category, meaning; you are covered by more than one health plan, you should file all your claims with each plan.

Participants are advised that the order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. In other words, the primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.

The Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total allowable expense.

Rules for coordination of benefits.

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

(1) **Non-dependent or dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or policy holder, is the primary plan and the plan that covers the person as a dependent is secondary.

(2) **A Plan with no COB rules.** Except as provided in paragraph (1), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

(3) **Dependent Child.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

   i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

   ii. 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:

   i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, that plan is primary.

   ii. 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.

   iii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph A of this Plan's rules of coordination of benefits shall determine the order of benefits;

   iv. 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 of subparagraph A of this Plan's rules of coordination of benefits shall determine the order of benefits; or

   v. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      a. The plan covering the custodial parent;
      b. The plan covering the custodial parent's spouse;
      c. The plan covering the non-custodial parent; and then
      d. The plan covering the non-custodial parent's spouse.

C. For a dependent child who is employed or married, the order of benefits will be as follows:

   i. The plan covering the child as an employee will pay first,
   ii. The plan covering the child as a spouse will pay second, and
   iii. The plan covering the child as a depend child will pay third.

   If there is more than one plan covering the child as a dependent child, the plan covering the parent with the earliest birthdate (disregarding the year of birth) will pay before the other parent's plan.

D. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph A or B of this Plan's rules of coordination of benefits, as if those individuals were parents of the child.

E. For a dependent child who is also covered under this Plan as a non-dependent, benefits will be payable only as a claim for him or her as an employee. The Plan will not pay or coordinate benefits under your coverage for his or her claims.

(4) COBRA coverage. If a person whose coverage is provided under a right of continuation of coverage provided by Federal law is also covered under another plan, the plan covering the person as an employee or retiree (or as that person's dependent) is primary, and the continuation (COBRA) coverage is secondary. However, this rule will not apply if the person is covered as a dependent under one plan and as a non-dependent under the other plan. In that case, the plan covering him as a non-dependent is primary, even if the non-dependent coverage is COBRA coverage.

(5) **Closed panel plans.** If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(6) **Automobile**. Automobile "no fault" and traditional automobile "fault" type insurance contracts will always be primary.

(7) **Active or inactive employee.** The plan that covers a person as an active employee is prime over a plan that covers the person as a laid-off or retired employee. The same order applies to the person's dependents. However, coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the non-dependent or dependent provision within this section of this document.

(8) More than one secondary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decides the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this provision, has its benefits determined before those of that secondary plan.

(9) Longer or shorter length of coverage. The plan that covered the person as an employee or retiree longer is primary.

vi. This item shall not apply with respect to any plan year during which benefits are paid or provided before this Plan entity has actual knowledge of the court decree provision;

Excess Coverage Limitation

Regardless of any other rule stating otherwise, all benefits payable under this Plan will be limited to being in excess of the benefits which are payable by any other plan or group insurance policy which is or purports to be an "excess policy" or an "excess plan" paying

benefits only in excess of benefits provided by any other plan or policy. If an entity or insurer of such other group excess plan or group excess policy agrees to pay benefits as if it were not an excess plan or policy, the Plan's benefits will be without regard to the provision of the previous paragraph.

Other Important Information About this Plan's Coordination of Benefits Provision.

(1) Benefits are coordinated on all employee and dependent claims for payment or reimbursement. C.O.B. applies to the medical, prescription drug, dental and vision benefits provided by this Plan.

(2) Benefits are coordinated with other group plans. This Plan will also pay secondary to an individual plan (one for which you pay the full premiums) if it provides benefits in the form of payment for actual medical services rendered on a non-excess basis. This Plan will not coordinate with an individual policy that provides a per-diem benefit directly to you based on days of hospitalization or disability. Benefits are also coordinated with Medicare.

(3) Benefits are paid in C.O.B. for "allowable expenses," which are expenses that are eligible to be considered for reimbursement by one or more of the plans covering the expense.

(4) A plan that pays "primary" benefits is the plan that is required to pay its benefits first. The plan that pays "secondary" benefits is the plan that pays its benefits after the other plan has paid its benefits.

(5) You must file a claim for any benefits to which you are entitled from any other source. Whether or not you file a claim with these other sources, your Plan payments will be calculated as though you have received any benefits to which you are entitled.

(6) When this Plan is the secondary plan, and there is a difference between the amount the primary plan allows and the amount allowable by this Plan, this Plan will usually coordinate its benefits using the primary plan's allowable amount, unless the provider's contractual arrangement with the Plan requires otherwise.

(7) If another plan is the primary plan but some or all of the benefits otherwise payable by that plan are denied or reduced because of the claimant's failure to comply with that plan's required procedures governing receipt of medical care, this Plan's secondary benefits will only be those that would have been payable if the claimant had complied with all of the required procedures of the other plan. The required procedures could include, but are not limited to, complying with utilization review or cost containment procedures such as hospital preadmission review or certification, second surgical opinions, certification of mental health treatment, or any other required notification or procedure of the other plan.

(8) If this Plan is secondary on a covered person's claim under its order of benefit determination rules, but the person's primary plan has a rule allowing it to pay less than its normal benefits when there is secondary coverage, this Plan will ignore the primary plan's rules. In such case the maximum payable by this Plan will be the amount payable after application of this Plan's coordination of benefits rules.

The covered person must claim benefits due from the primary plan for its share of covered expenses, including benefits or services available from prepayment coverage programs such as health maintenance organizations (HMOs). When this Plan is secondary it will not pay benefits for any claim or portion of a claim that would have been paid by the primary plan if the person had made a proper claim on that Plan or had used its services. This Plan's liability and its benefit payments will not increase simply because the eligible person elects not to use the primary coverage.

COSMETIC SURGERY

The Plan only pays for cosmetic surgery associated with the:

1. Correction of defects incurred through traumatic injuries sustained as a result of an accident within one year of the surgery;

2. Correction of congenital defects; or

3. Breast reconstruction following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance.

Participating provider charges will be subject to the deductible, and payable at 90% of the negotiated rate.

Non-participating provider charges will be subject to the deductible and payment will be made at 70% of the Fund's Reasonable and Allowed Amount (RAA).

The Plan will not cover cosmetic surgery services and/or supplies for any other medical reasons such as, but not limited to, the correction of an inferior cosmetic surgery.

CREDITABLE COVERAGE

Creditable Coverage Issued by the Plan.

You and any of your eligible dependent will be automatically provided with a Certificate of Creditable Coverage when:

1. Your coverage under this Plan terminates.

2. Any continuation coverage under this Plan ceases; and

3. At any time, you or your eligible dependents make a written request, while you or your dependents are covered by the Plan and for twenty-four (24) months after coverage under the Plan ceases.

Creditable Coverage Required by the Plan

If you have enrolled into the Plan and are seeking eligibility for the first time and have a letter of creditable coverage from your previous medical insurance provider that indicates you had coverage within the prior sixty-two (62) calendar days or less before being covered under this

Plan, then the Plan will allow you to gain initial eligibility on the first of the month following the month in which one hundred and sixty (160) hours are received. For more information on the Plans eligibility and enrollment rules, please see the sections of this book titled “Eligibility” and “Enrollment”.

DEATH

Should you pass away while you are an eligible employee (who is not making COBRA self-payments), and if you would have been eligible on the last day of the month in which your death occurs, Plan coverage for your surviving dependents will be continued until the last day of the third month following your death.

After such time, your surviving spouse and any eligible dependents will be offered the opportunity to continue coverage under the Plan. Coverage will last until such time that continuous, on-time and correct survivor self-payments cease, or, until your surviving spouse remarries, whichever occurs first. Your children’s coverage will terminate when your spouse’s coverage terminates, or, if earlier, on the date they no longer meet the Plan’s definition of a dependent (for example, when they reach the limiting age).

Coverage for a surviving child will terminate in the event of the surviving parent’s death. (If your dependent’s coverage terminates, they will be offered the opportunity to continue coverage under the Plans COBRA provisions.

At any time that your surviving dependents fail to make a self-payment or make it timely, they will be terminated from the Plan. At which point they will be offered the opportunity to continue coverage under the COBRA provisions of the Plan. Should they elect COBRA, the rules governing COBRA coverage will apply. Note: Should they elect COBRA, they will not be entitled to elect survivor coverage at any future date. Similarly, if they choose the survivor coverage option, she will lose the right to elect COBRA coverage (unless her survivor coverage terminates within the first 36 months after your death, in which case she can elect and pay for COBRA for the remainder of that 36-month period).

If you have eligible children at the time of your death, your surviving spouse can make survivor self-payments for their coverage also. They cannot make survivor self-pays in their own right, but they can elect COBRA.

Reminder: Self-payments and COBRA payments are always due on the first day of the coverage month. If survivor coverage terminates, it cannot be reinstated.

DEDUCTIBLE

Services covered under the medical benefits are subject to an annual deductible based on the calendar year. The key word there is “medical benefits”. The deductible does not apply to dental, pharmaceutical and vision benefits.

The Plan maintains two different levels of deductibles, an annual individual deductible and an annual family deductible. The amounts of these deductibles are as follows:

Calendar Year Deductible	Amount

Individual	$200.00
Family (2 or More Family Members)	$400.00

How the deductible works

The deductible applies only once in a calendar year, even though the covered individual(s) may have several different accidents or illnesses. This deductible applies to both in-network providers and out-of-network providers.

Individual Deductible: The Fund requires that each participant satisfy the Plans medical deductible per calendar year. Once a participant satisfies the annual deductible amount identified above, the Plan will reimburse the participant's covered expenses at the percentage identified within this book for the remainder of the calendar year.

Family Deductible: The family deductible is satisfied when two or more family members have combined covered expenses that meet or exceed the amount of the family deductible listed within the chart above. However, the Plan will not apply more than the individual deductible amount to any one family member. Once the annual family deductible has been met, the Plan will reimburse the covered expenses incurred by any eligible family member at the percentage identified within this book for the reminder of that calendar year.

How the Plan Calculates Your Deductible

The Plan applies covered expenses toward your deductible as it processes claims, rather than according to the date of service. Since providers submit their claims in accordance with their own billing schedules, this quite often results in the Plan receiving claims that are chronologically out-of-order with regard to the sequence in which you received care, especially when multiple providers are utilized.

Therefore, it is always prudent for participants to wait until they receive the Plan's explanation of benefits (E.O.B.) prior to making any payment to their provider for their deductible.

Additionally, if a provider waives or routinely waives (does not require the participant to pay) a deductible or an out-of-pocket amount, the Claims Administrator will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived. (Amounts you are not required to pay are not covered by the Plan.)

DEFINITIONS

The following words and phrases shall have the following meanings when used in this Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used.

Becoming familiar with the terms defined in this Definitions section will help to better understand the provisions of this Plan.

"Administrative Lag Quarter"
"Administrative lag quarter" shall mean the length of time between the work quarter and the corresponding quarter of coverage.

"Ambulette"
"Ambulette" services are wheelchair-accessible transportation vehicles that provide non-emergency-related transference or passage.

"Accident"
"Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental bodily injury" or "accidental injury" shall mean an Injury sustained as the result of an accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

"Adverse Benefit Determination"
"Adverse benefit determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

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

"Allowable Amount"
"Allowable amount" shall mean the maximum covered charge for a specific item or service under the Plan. The allowable amount is calculated by the Plan Administrator taking into account and after having analyzed:

1. The Reasonable and Allowed Amount as defined by the Plan;
2. The amount calculated based on the Plan's reference-based price provisions;
3. The charge otherwise specified under the terms of the Plan;
4. The rate negotiated by the Plan and the provider;
5. For non-PPO (Preferred Provider Organization) facilities, 130% of Medicare's allowable amount; or
6. The actual charges if they are less than the amount determined in Nos. 1-5 above.

Certain services are subject to specific limitations, and certain general limitations apply to benefits for all services. The Plan will take these limitations into account in calculating its' allowable amount.

The allowable amount, and the maximum payable by the Plan, will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, treatment for hospital-acquired conditions, provider errors, and charges for services not performed.

Allowable amount shall also mean the Reasonable and Allowed Amount for any medically necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the application to benefit determinations provision in the Coordination of Benefits section, this Plan's reasonable allowed expense shall in no event exceed the other Plan's allowable expenses.

When some "other plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any other plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

"Alternate Recipient"
"Alternate recipient" shall mean any child of a participant who is recognized under a medical child support order as having a right of enrollment under this Plan as the participant's eligible dependent. For purposes of the benefits provided under this Plan, an alternate recipient shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a participant.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulatory Surgical Center"
"Ambulatory surgical center" shall mean any permanent public or private state-licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing surgical procedures to patients not requiring hospitalization with an organized medical staff of physicians, with continuous physician and nursing care by registered nurses (R.N.s). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

"Apprentice"

An “apprentice” is a person who is accepted, registered and actively participating in a JATC course of training in the Local 697’s Electrical Training Center.

“Assignment of Benefits”
“Assignment of Benefits” shall mean an arrangement by which a patient request’s that his or her health benefit payments be made directly to a designated person or facility, such as a dentist, physician or hospital.

An assignment of benefits will be deemed valid if it:

1. was signed and dated on the date of service, and
2. contains the patient’s original signature, and
3. the context of the assignment that was originally signed contains specific language as it relates to being bargained for detriment, and
4. the original assignment or a notarized copy was submitted along with claim for adjudication, and
5. the assignment contains the correct legal name of the providers entity and
6. the Provider accepts the payment received from the Plan as consideration, in full, for covered expenses for services, supplies and/or treatment rendered. Or,

“Association”
“Association” shall mean the Northern Indiana Chapter of the National Electrical Contractors Association, Inc. (NECA)

“Bargaining Unit Employee”
“Bargaining unit employee” is a person other than an apprentice who is employed by a contributing employer and whose employment is subject to a collective bargaining agreement with the Union.

“Birthing Center”
“Birthing center” means any freestanding health facility, place, professional office or institution which is not a hospital or in a hospital, where births occur in a home like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre or post-delivery confinement.

“Brand Name”
“Brand name” means a trade name medication.

“Calendar Year”
“Calendar year” shall mean the 12-month period from January 1 through December 31 of each year.

“Cardiac Rehabilitation”

“Cardiac rehabilitation” shall mean services received in a separate, clearly designated service area which is maintained at either a doctor’s office or within a hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
4. It contains at least two beds for the accommodation of critically ill patients.
5. It provides at least one professional registered nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

“Care Management or Case Management”
“Care management” shall mean a set of participant-centered, goal-oriented, medically relevant and logical steps to assure that a participant receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

“Center(s) of Excellence”
“Center(s) of excellence” shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what in-network of centers of excellence are to be used.

Any participant in need of an organ transplant may contact the Third-Party Administrator to initiate the precertification process resulting in a referral to a center of excellence. The Third-Party Administrator acts as the primary liaison with the center of excellence, patient and attending physician for all transplant admissions taking place at a center of excellence.

If a Participant chooses not to use a center of excellence, the payment for services will be limited to what would have been the cost at the nearest center of excellence.

Additional information about this option, as well as a list of centers of excellence, will be given to covered Employees and updated as requested.

“Child” and/or “Children”
“Child” and/or "children" shall mean the employee’s biological child, any stepchild, legally adopted child, or any other child for whom the employee has been named legal guardian, or an “eligible foster child,” which is defined as an individual placed with the employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction, excluding a child for whom any federal, state or private social agency pays more than one-half of such child’s support and maintenance to reimburse you and/or your spouse. For purposes of this definition, a legally adopted child shall include a child placed in an employee’s physical custody in anticipation of adoption. “Child” shall also mean a covered employee’s child who is an alternate recipient under a Qualified Medical Child Support Order.

“Chiropractic Care”
“Chiropractic care” shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

"Claim Determination Period"
"Claim determination period" shall mean each calendar year.

"Claimant"
"Claimant" shall mean a participant of the plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an adverse benefit determination.

"Clean Claim"
A clean claim is a claim for a Covered Expense that (1) is timely received by the Administrator; (2) (i) when submitted via paper has all the elements of the UB 04 or CMS 1500 (or successor standard) forms; or (ii) when submitted via an electronic transaction, uses only permitted transaction code sets (e.g. CPT4, ICD9, ICD10, HCPCS) and has all the elements of the standard electronic formats required by applicable Federal authority; (3) is a claim for which the Plan is the primary payor or the Plan's responsibility as a secondary payor has been established; and (4) contains no defect, error or other shortcoming resulting in the need for additional information to adjudicate the claim; and (5) that does not lack necessary substantiating documentation to completely adjudicate the claim.

A clean claim does not include a claim that is being reviewed for the Reasonable and Allowed Amount payable under the terms of the Plan. Additionally, any claim over $10,000 must be itemized and submitted to the Third-Party Administrator before it will be deemed a Clean Claim.

Filing a Clean Claim. A Provider submits a clean claim by providing the required data elements on the standard claim's forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a clean claim if the participant has failed to submit required forms or additional information to the Plan.

"COBRA"
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Coinsurance"
"Coinsurance" shall mean a cost sharing feature of this plan. It requires a participant to pay out-of-pocket a prescribed portion of the cost of covered expenses after the annual deductible is satisfied.

"Coordination of Benefits"
"Coordination of benefits" shall mean the method of determining which of two or more insurance policies will have the primary responsibility of processing and paying a claim and the extent to which the other policies will contribute.

"Copayment" or "Copay"
"Copayment" or "copay" shall mean a dollar amount the participant pays for pharmaceutical or vision expenses after the Plan makes its payment.

"Cosmetic"

"Cosmetic" shall mean any expenses associated with the treatment or procedure for the primary purpose of changing the person's appearance. Or those expenses that were incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury. The fact that a person may suffer psychological or behavioral consequences absent the treatment or procedure does not make it "non-cosmetic" nor a covered item by the Plan.

"Covered Expenses"
"Covered expenses" shall mean those medically necessary services, supplies and/or treatment that are covered under this Plan. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider's medical error are not considered a covered benefit. A finding of provider negligence and/or malpractice and any subsequent or affiliated service(s) shall be a covered expense.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as set forth elsewhere in this document.

"Creditable Coverage"
"Creditable coverage" shall mean that the participant had prior coverage under any of the following insurance types within 62 days or less prior to being covered under this Plan:
A group health plan; individual health insurance; student health insurance; Medicare; Medicaid; TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, or foreign country); Children's Health Insurance Program (CHIP); or, a state health insurance high risk pool.

"Custodial Care"
"Custodial care" shall mean care or confinement designated principally for the assistance and maintenance of the participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

"Deductible"
"Deductible" shall mean the aggregate amount for certain expenses for covered services that are the responsibility of the participant to pay each calendar year before the Plan will begin its payments.

"Dentist"
"Dentist" shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within his or her applicable geographic venue.

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. Your present spouse, thereby possessing a valid marriage license, not annulled or voided in any way. A dependent spouse shall therefore not be one whom is divorced from the Employee.

2. For the purpose of retiree coverage, your "spouse" is the person to whom you have been legally married for at least one year and a day (366 days) prior to the date your retiree benefits start.

3. An opposite-sex or same sex spouse who thereby possessing a valid marriage license, not annulled or voided in any way. A dependent spouse shall therefore not be one whom is divorced from the employee.

4. Your biological, legally adopted child, or a stepchild who is dependent on you for at least one-half his support annually. Such child will be covered to the end of the calendar month in which the child's twenty-six (26th) birthday occurs.

5. A child who is to be considered as an eligible dependent of yours as required by a Qualified Medical Child Support Order (QMCSO). *Coverage will continue until the end of the calendar month he or she turns 26 years of age.*

6. Your incapacitated child, whose incapacity commenced prior to age 19, and who was continuously covered since he/she became eligible for such coverage prior to attaining the limiting age as stated above, and who is mentally or physically incapable of sustaining his or her own living and who resides with you, and is dependent upon you for at least one-half his/her support.

   Warning: Written proof of your child's incapacity must be received by the Fund Office within 31 days of his/her nineteenth (19th) birthday.

   Such child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated above. "Proof of financial support" means a signed and submitted copy of your federal income tax returns showing that you claimed and continue to claim the child as your dependent.

   Your incapacitated child may remain an eligible dependent as long as he/she remains incapacitated and you maintain your eligibility.

   Under no circumstances will a pet or a service animal be considered a dependent of a participant.

   Important:

   A. The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

   B. To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

"Detoxification"

"Detoxification" shall mean the inpatient hospital or residential medical care to ameliorate acute medical conditions associated with substance abuse. There is a seven-day maximum for detoxification in a hospital or rehabilitation center.

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

"Diagnostic Service"
"Diagnostic service" shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a disease or injury. The diagnostic service must be ordered by a physician or other professional provider.

"Disease; Sickness; Illness"
"Disease; sickness; illness" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a sickness, illness or disease.

"Drug"
"Drug" shall mean a Food and Drug Administration (FDA)-approved drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a state restricted drug (any medicinal substance which may be dispensed only by prescription, according to state law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a physician and/or duly licensed provider. "Drug" shall also mean insulin for purposes of injection.

"Durable Medical Equipment" (DME)
"Durable medical equipment" shall mean equipment and/or supplies ordered by a health care provider for everyday or extended use which meets all of the following requirements:

1. Is related to the patient's physical disorder.
2. Can withstand repeated use.
3. Is primarily and customarily used to serve a medical purpose or to prevent or slow further decline of the patient's medical condition.
4. It is not merely for comfort or convenience, or, generally is not useful to a person in the absence of an Illness or Injury.
5. Is appropriate for use in the home.

"Eligible Dependent"
"Eligible dependent" shall mean an individual who meets Plan's definition of a dependent and who is eligible to receive the Plan benefits that are provided for dependents.

"Eligible Employee"

"Eligible employee" shall mean a person who has met and continues to meet the eligibility requirements for coverage under the Plan as an employee.

"**Eligible Family Member"**
"Eligible family member" shall mean you, an eligible employee or eligible retiree and any person in your family or household who meets the definition of a dependent.

"Eligible Retiree"
"Eligible retiree" shall mean a retired employee who has met the eligibility requirements established by the Trustees and who is entitled to receive the benefits provided by the Plan for retirees.

"Emergency"
"Emergency" shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (1) serious jeopardy to the health of the individual or, with respect to a pregnant woman, the woman's unborn child); (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

"Emergency Medical Condition"
"Emergency medical condition" shall mean 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 a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

An emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an emergency or acute condition did exist.

By way of illustration, but not by way of limitation, the Plan considers the initial and immediate treatment of the following conditions to be "emergency" treatment:

Chest pains
Convulsions
Difficulty breathing
Heavy bleeding
Large open wounds
Major broken bones
Major burns
Severe head injury
Sudden and unusual change in vision
Sudden weakness or trouble talking

The following would **NOT** be considered an "emergency" condition:

Coughs
Cuts, scrapes or bruises, including sports injuries
Diarrhea
Fevers (except an Infant with other symptoms and fever over 103 F)
Flu or cold
Minor broken bones (rib, finger, toe)
Minor infections
Sore throats
Sprains
Strains
Stomach pain
Rashes
Vomiting

"Emergency Services"
Emergency services" shall mean, with respect to an emergency medical condition, the following:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) 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.

2. 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"
"Employee" shall mean any of the following:

a) A person who is employed by a contributing employer who is required to make contributions to this Fund under the terms of a collective bargaining agreement between the employer and the Union;

b) A person accepted and registered as an apprentice during training conducted by the Electrical Training Center sponsored by the Lake County Indiana Electricians Joint Apprenticeship and Training Committee;

c) A person accepted and registered as an Indiana Plan participant who is referred out through the I.B.E.W. Local 697 referral hall and performs covered unit work.

d) A person who is employed by the Association;

e) A person who is employed by the I.B.E.W. Local 697;

f) A person who is employed by any Benefit Fund provided by Local 697 of the I.B.E.W;

g) A person employed by a labor organization, or an organization beneficial to labor or the industry with which the Union is affiliated.

h) A person employed by the Local Union No. 697, I.B.E.W. Credit Union;

i) A person employed by the Electrical Administrative Fund;

j) A person employed by any other trust or fund created by agreement between the Association and the Union;

k) Persons who qualify as "temporary employees"; or

l) Any contributing employer not the subject of a collective bargaining agreement while such employee is working within the territorial jurisdiction of the Union, but only at the option of the employer and the Trustees.

m) An individual not covered by a collective bargaining agreement who is working for an employer within the geographical jurisdiction of the Union, and whose employer has entered into a participation agreement with the Trustees under which the employer makes contributions to this Plan for such individual and other non-bargained for employees.

"Employer" or "Contributing Employer"
"Employer" or contributing employer shall mean a member of the Association or an employer within the territorial jurisdiction of the Union who acknowledges the Union as the collective bargaining representative of such employer's employees and abides by the terms of the collective bargaining agreement between the Union and the Association.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Exclusion"
"Exclusion" shall mean conditions or services that this Plan does not cover.

"Experimental" and/or "Investigational"
"Experimental" and/or "investigational" ("experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an approved clinical trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.

2. Are rendered on a research basis as determined by the United States Food and Drug Administration (FDA) and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is experimental if one of the following requirements is met:

1. If the drug, device or medical treatment has been prescribed for a condition for which there are no FDA-approved indications.

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

3. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or diagnosis.

4. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or diagnosis.

"Reliable evidence" shall mean one or more of the following:

1. Only published reports and articles in the authoritative medical and scientific literature.
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure.
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

Explanation of Benefits (EOB)
"Explanation of benefits" shall mean a statement a health plan sends to a participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An explanation of benefits may serve as an adverse benefit determination.

"FDA"
"FDA" shall mean Food and Drug Administration.

"Final Post-Service Appeal"
"Final Post-Service Appeal" shall mean a post-service appeal, which constitutes the last internal appeal available to the claimant, to be filed with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals. The term "Final Post-Service Appeal" shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the claimant; otherwise in accordance with applicable terms found

within the Plan Document and applicable law. The Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, reserves the right to allocate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Plan Appointed Claim Evaluator (PACE).

"Fund"
"Fund" shall mean the Lake County, Indiana N.E.C.A. – I.B.E.W. Health and Benefit Fund.

"Hearing Aid"
"Hearing aid" is a wearable instrument designed for the ear for the purpose of compensating for impaired hearing. It excludes other assisted listening devices such as amplifiers and FM systems.

"Habilitation/Habilitative Services"
"Habilitation/habilitative services" shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

"HIPAA"
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home Health Care"
"Home health care" shall mean the continual care and treatment of an individual if all of the requirements are met:

1. The institutionalization of the individual would otherwise have been required if home health care was not provided.
2. The treatment plan covering the home health care service is established and approved in writing by the attending Physician.
3. The home health care is the result of an Illness or Injury.

"Home Health Care Agency"
"Home health care agency" shall mean an agency or organization which provides a program of home health care and which meets one of the following requirements:

1. Is a federally certified home health care agency and approved as such under Medicare.

2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.

3. Meets all of the following requirements.

    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home.
    b. It has established policies governing the services it provides.
    c. It maintains written records of services provided to the patient.

d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (an R.N.) available.
e. Its employees are bonded, and it provides malpractice insurance.

"Hospice"
"Hospice" shall mean a public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of services at home or in an outpatient or institutional setting to a person suffering from a terminal medical condition. The agency or organization must be eligible to participate in Medicare; must have an interdisciplinary group of personnel that includes the eservices of at least one doctor and one R.N.; must meet the standards of the National Hospice Organization; an must provide the following services, either directly or under the arrangement; nursing care, home health aides, medical social services, counseling services and/or psychological therapy, physical, occupational and speech therapy, and palliative care.

"Hospital"
"Hospital" shall mean:

1. A medical institution, accredited by the Joint Commission (sponsored by the AMA and the AHA); or,

2. A medical institution, accredited by the Healthcare Facilities Accreditation program (HFAP); or,

3. A Medicare-certified facility in which there is no other facility within 20 miles, or the Plan is secondary to Medicare; or,

4. A medical facility accredited by the Healthcare Facilities Accreditation Program of the American Osteopathic Association; or,

5. A medical facility that primary function is not as a place for rest, the aged, and/or a nursing home, custodial, training institution or utilized for the care of drug addicts or alcoholics.

6. "Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "ambulatory surgical center."

"Hour"
"Hour" shall mean a worked hour for which a contributing employer is required to make and does make a contribution to this Plan in the amount specified by the employer's agreement with the Union or the Plan.

"Incurred"
A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Infertility Treatment"
"Infertility treatment" shall mean any services, supplies or drugs related to the diagnosis or treatment of infertility.

“Injury”
“Injury” shall mean an accidental bodily injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

“Initial Eligibility”
“Initial eligibility” shall mean the first time a participant becomes eligible for coverage under this Plan.

“Inpatient”
“Inpatient” shall mean a participant who receives care as a registered and assigned bed patient while confined in a hospital, other than in its outpatient department, where room and board is charged by the hospital.

“Institution”
“Institution” shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a hospital, ambulatory surgical center, psychiatric hospital, community mental health center, residential treatment facility, psychiatric treatment facility, substance abuse treatment center, alternative birthing center, or any other such facility that the Plan approves.

“Intensive Care Unit”
“Intensive care unit” shall mean a unit in a hospital providing intensive care for critically ill or injured patients that is staffed by specially trained medical personnel and has equipment that allows for continuous monitoring and life support.

“Intensive Outpatient Services”
“Intensive outpatient services” shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment.”

“Mastectomy”
“Mastectomy” shall mean the surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

“Maximum Allowable Amount” (MAA)
“Maximum Allowable Amount” (MAA) shall mean the benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Amount will always be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Amount will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator’s discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services [“CMS”]).

- Prices established by CMS utilizing standard Medicare payment methods and/or based upon supplemental Medicare pricing data for items Medicare doesn't cover based on data from CMS.
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care.
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings.
- Medicare cost data as reflected in the applicable individual provider's cost report(s).
- The fee(s) which the provider most frequently charges the majority of patients for the service or supply.
- Amounts the provider specifically agrees to accept as payment in full either through direct negotiation or through a preferred provider organization (PPO) network.
- Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP).
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply.
- The allowable charge otherwise specified within the terms of this Plan.
- The prevailing range of fees accepted in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by providers of similar training and experience for the service or supply.
- With respect to non-network emergency services, the Plan allowance is the greater of:

    - The negotiated amount for in-network providers (the median amount if more than one amount to in-network providers).
    - One hundred and thirty percent (130%) of the Plan's maximum allowable charge payment formula (reduced for cost-sharing).
    - The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Amount will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Amount will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (1) The national medical associations, societies, and organizations; and (2) The Food and Drug Administration (FDA). To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

When prices established or utilized by CMS are applicable as described above, the Maximum Allowable Charge will be determined based on multiplying the most applicable of the following by 130%:

- For inpatient hospital expenses, the Medicare Diagnosis Related Group ("DRG") scheduled dollar conversion amounts based upon the CMS weighted values.
- For outpatient hospital expenses, the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values, or the current Medicare allowable fee for the appropriate area.
- For physicians and other eligible providers, the current Medicare allowable fee for the appropriate area.
- For ambulatory surgical centers (ASC), the current Medicare allowable fee for the appropriate area.

"Medical Child Support Order"
"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that meets one of the following requirements:

1. Provides for child support with respect to a participant's child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).

2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medically Necessary"
"Medically necessary", "medical necessity" and similar language refers to health care services ordered by a physician exercising prudent clinical judgment provided to a participant for the purposes of evaluation, diagnosis or treatment of that participant's sickness or injury. Such services, to be considered medically necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the participant's sickness or Injury. The medically necessary setting and level of service is that setting and level of service which, considering the participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered medically necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the participant's sickness or Injury without adversely affecting the participant's medical condition. The service must meet all of the following requirements:

1. It must not be maintenance therapy or maintenance treatment.
2. Its purpose must be to restore health.
3. It must not be primarily custodial in nature.
4. Is not solely for the convenience of the individual, doctor or hospital.

5. Is consistent with the symptoms or diagnosis and treatment of the individual's condition, disease, ailment or injury.
6. It must not be a listed item or treatment not allowed for reimbursement by the Centers for Medicare and Medicaid Services (CMS).
7. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of medical necessity and/or an allowable expense.

For hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the participant is receiving or the severity of the participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a physician does not mean that it is "medically necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "medically necessary" does not mean that any other services are deemed to be "medically necessary."

To be medically necessary, all of these criteria must be met. Merely because a physician or dentist recommends, approves, or orders certain care does not mean that it is medically necessary. The determination of whether a service, supply, or treatment is or is not medically necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is medically necessary.

Off-label drug use is considered medically necessary when all of the following conditions are met:

1. The drug is approved by the Food and Drug Administration (FDA).
2. The prescribed drug use is supported by one of the following standard reference sources:
    a. Micromedex® DRUGDEX®.
    b. The American Hospital Formulary Service Drug Information.
    c. Medicare approved compendia.
    d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.
3. The drug is medically necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.
4. All other "on-label" treatments within the standard of care have been ineffective.

"Medicare"
"Medicare" shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with end-stage renal disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

"Mental or Nervous Disorder"
"Mental or nervous disorder" shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a mental or nervous disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment

of the disorder is covered by the Plan. For the purposes of this Plan, “mental or nervous disorders: includes autism, and attention deficit and hyperactivity disorders.

“Morbid Obesity”
“Morbid Obesity” shall mean a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

“National Medical Support Notice” or “NMSN”
“National Medical Support Notice” or “NMSN” shall mean a notice that contains all of the following information:

1. The name of an issuing state child support enforcement agency.
2. The name and mailing address (if any) of the employee who is a participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the alternate recipients (i.e., the child or children of the participant) or the name and address of a state or local official may be substituted for the mailing address of the alternate recipients(s).
4. Identity of an underlying child support order.

“Non-Bargained Employee”
“Non-bargained employee” shall mean any individual identified within a participation agreement between the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan and an employer or association.

“Non-Network” or “Out-of-Network”
“Non-network” or “out-of-network” shall mean the facilities, providers and suppliers that do not have an agreement with a designated network to provide care to participants.

“Nonresidential Treatment Program”
“Nonresidential treatment program” shall mean a structured, intensive care program certified by the Health and Human Service’s Department of Substance Abuse and Mental Health Services Administration. This program allows individuals to work, go to school, and carry on their regular daily activities while receiving treatment, services and support.

“Orthotic Device”
"Orthotic device" means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

“Other Plan”
“Other plan” shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the participant.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers’ compensation or other liability insurance company.

8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"Out-of-Area"
"Out-of-area" shall mean services received by a participant outside of the normal geographic area supported by the Plan's network, as determined by the Plan Administrator, at the time each participant becomes eligible for coverage under this Plan.

"Outpatient Surgical Center"
"Outpatient surgical center" shall mean a licensed facility that is used mainly for performing outpatient surgery, has a staff of physicians, has continuous physicians and nursing care by registered nurses (R.N.'s) and does not provide overnight stays.

"Partial Day Program"
"Partial day program" shall mean the structured, intensive day or evening treatment or hospitalization program, certified by the department of mental health or accredited by a national recognized organization.

"Partial Hospitalization"
"Partial hospitalization" shall mean medically directed intensive, or intermediate short-term mental health and substance abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

"Participant"; "Plan Participant"
"Participant" or "Plan participant" shall mean any member, employee, dependent or retiree who is eligible for benefits (and enrolled) under the Plan.

"Pharmacy"
"Pharmacy" shall mean a licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

"Physician"
"Physician" shall mean a legally qualified doctor or surgeon who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), provided that any such individual renders treatment only within the scope of his license and specialty.

Other Covered Providers - Although not included in the definition of or "physician" or "doctor," benefits are payable for services provided by the following types of licensed providers when the services are within the Plan's normal covered expense provisions and are rendered within the scope of each such individual's license and specialty, and if payment would have been made under this Plan to a doctor for the same services:

- A certified registered nurse anesthetist (C.R.N.A.)
- A chiropractor (D.C.)
- A Doctor of Dentistry (D.D.S. or D.M.D.)
- A podiatrist (D.P.M.)
- For medical services only, provided the services are performed within the scope of the person's license and the same services would have otherwise been performed and billed by a physician:
  ~ A physician's assistant (P.A.)
  ~ A certified surgical assistant (C.S.A.)

~ A registered nurse (R.N.) including a certified registered nurse anesthetist (C.R.N.A.)
~ A licensed nurse practitioner (N.P.)

- For covered mental health therapy only:
  ~ A clinical psychologist (Ph.D. or Psy.D.)
  ~ A licensed Masters-level clinical social worker or therapist (such as an M.S.W., L.C.S.W. or L.C.P.C.)
- For Vision Benefits only: A Doctor of Optometry (O.D.).

"Plan"
Plan shall mean the Lake County, Indiana NECA – I.B.E.W. Health and Benefit Plan, which is a self-funded program of health and welfare benefits that are described in this booklet.

"Plan Appointed Claim Evaluator (PACE)"
"Plan Appointed Claim Evaluator (PACE)" shall mean an entity appointed by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, would be deemed to be binding), claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, delegates fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, may otherwise exercise. The PACE's fiduciary duties extend only to those determinations actually made by the PACE. The PACE may perform other tasks on behalf of and in consultation with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, but the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by and make determination in accordance with the terms of the Plan and applicable law, in light of the facts, law, medical records, and all other information submitted to the PACE.

"Plan Year"
"Plan year" shall mean a period commencing on the effective date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Plan Provider Organization (PPO) Provider", "PPO Hospital", or "PPO Facility", "Designated Facility or "Designated Hospital"
"PPO provider", "PPO hospital", "PPO facility", "designated facility or "designated hospital" shall mean the Plan's preferred facilities. These facilities have either:

1. Contracted directly with the Plan to accept the Plan's referenced-based price as the Reasonable and Allowed Amount for any covered benefit and will not balance-bill the patient for any amounts in excess of the allowable amount.

2. Through the Plan's contract with a PPO network, the PPO provider will accept the negotiated rate as the Reasonable and Allowed Amount for any covered benefit and will not balance bill the patient for any amounts in excess of the allowable amount.

3. All other facilities, hospitals and/or physicians and medical providers are considered a "non-PPO facility", a "non-PPO hospital", a "non-participating provider" or a "out-of-network provider".

"Precertification"
"Precertification" shall mean the Plans required process which allows providers and/or participants to determine coverage and secure an authorization/approval from the Plan or its' designated affiliate utilization management and/or disease management company for a proposed treatment or service. Precertification does not guarantee reimbursement of services; however, the lack of precertification could result in non-reimbursement.

"Pregnancy"
"Pregnancy" shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered a sickness for the purpose of determining benefits under this Plan.

"Prescription Drug"
"Prescription drug shall mean any of the following: A Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a participant gains eligibility from the Plan, or dates occurring after a participant loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless continuation of benefits applies.

"Privacy Standards"
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"Prosthetic Device"
"Prosthetic device" means an artificial device designed to replace, wholly or partly, a permanently inoperative or malfunctioning body part or organ. Examples of covered Prosthetics include initial contact lens in an eye following a surgical cataract extraction and removable, non-dental Prosthetic Devices such as a limb that does not require surgical connection to nerves, muscles or other tissue

"Provider"
"Provider" shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "provider" as defined herein if that entity is not deemed to be a "provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination

of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

"Qualified Beneficiary"

A qualified beneficiary is someone who is or was covered by the Plan and has lost or will lose coverage under the Plan due to the occurrence of a qualifying event. The employee and/or employee's dependents could therefore become qualified beneficiaries if applicable coverage under the Plan is lost because of the qualifying event.

"Qualified Dependent"
A qualified dependent is an individual who has provided the Plan or has had provided on his or her behalf all requested and appropriate supporting documentation as deemed by the Plan and to which the employee or retiree has properly enrolled into the Plan.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified medical child support order" or "QMCSO" shall mean a medical child support order, in accordance with applicable law, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or eligible dependent is entitled under this Plan.

"Qualifying Event"
"Qualifying Event" shall mean a major life change that may affect either your qualification for coverage under this Plan or an occurrence that affects the need to provide coverage of an eligible dependent.

"Quarter of Coverage"
"Quarter of coverage" shall mean either the calendar quarter of January, February and March, or April, May and June, or July, August and September, or October, November and December, in which a participant and any eligible dependent has earned the right to be eligible to receive coverage under this Plan.

"Reasonable and Allowed Amount"
"Reasonable and Allowed Amount" or "Reasonable and Allowable Amount" (RAA) means the maximum amount payable by the Plan for a service, supply and/or treatment that is considered an expense incurred for a covered benefit described under this Plan. The Reasonable and Allowable Amount is the lesser of: 1) the charge made by the provider that furnished the care, service, or supply; 2) the negotiated amount established by a discounting or negotiated arrangement; 3) the reasonable and customary amount accepted for the same treatment, service, or supply furnished in the same geographic area by a provider of like service of similar training and experience as further described below; or 4) an amount equivalent to the following:

- For inpatient or outpatient facility claims, an amount equivalent to 130% of the Medicare equivalent allowable amount; service vendor.

The term 'Reasonable and Allowed Amount' shall mean an amount equivalent to the lesser of a commercially available database or such other cost or quality-based reimbursement methodologies as may be available and utilized by the Plan from time to time.

If there is insufficient information submitted for a given procedure, the Plan will determine the Reasonable and Allowed Amount based upon the discounted amounts typically accepted as

payment in full for similar services within a geographical area in which the service was provided. Determination of the reasonable and allowable amount will take into consideration the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that Provider.

The term 'geographic area' shall be defined as a metropolitan area, county, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, service or supply for which a specific charge is made. For covered expenses rendered by a physician, hospital or ancillary provider in a geographic area where applicable law may dictate the maximum amount that can be billed by the rendering provider, the Reasonable and Allowed Amount shall mean the lesser of amount established by applicable law for that covered expense or the amount determined as set forth above.

The Plan Administrator or its designee has the *ultimate discretionary authority* to determine the Reasonable and Allowable Amount, including establishing the negotiated terms of a provider arrangement as the Reasonable and Allowable Amount even if such negotiated terms do not satisfy the lesser of test described above.

"Rehabilitation"
"Rehabilitation" shall mean treatment(s) designed to facilitate the process of recovery from Injury, Illness, or Disease to as normal a condition as possible.

"Rehabilitation Hospital"
"Rehabilitation hospital" shall mean an appropriately licensed Institution, which is established in accordance with all relevant federal, state and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed medically necessary for daily living, that have been lost or impaired due to Sickness and/or Injury. To be deemed a "rehabilitation hospital," the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation for Rehabilitation Facilities, or Healthcare Facilities Accreditation Program, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a "rehabilitation hospital," the institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Residential Treatment Facility"
"Residential treatment facility" shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or substance abuse disorders or mental illness. Such facility must:

1. Provide 24-hour-a-day supervision by mental health treatment staff and has at least one R.N. on duty in the facility at all times.

2. Has every patient under the supervision of a doctor, and it has available at all times a doctor who is a staff member of an acute care hospital.

3. Be accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation for Rehabilitation Facilities or the Healthcare Facilities Accreditation Program or it is a participating facility with the Plan or through its network.

Group homes, halfway houses, wilderness programs, camps or institutions providing custodial care are not considered residential treatment facilities under this Plan.

"Room and Board"
"Room and board" shall mean a hospital's charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy which are medically necessary.

"Skilled Nursing Facility"
"Skilled nursing facility" shall mean a facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from injury or sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

2. Its services are provided for compensation and under the full-time supervision of a physician.

3. It provides 24 hours per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

4. It maintains a complete medical record on each patient.

5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, custodial care, educational care or care of mental or nervous Disorders.

7. It is approved and licensed by Medicare.

"Substance Abuse" and/or "Substance Use Disorder"
"Substance abuse" and/or "substance use disorder" shall mean any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as outlined below.

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more, of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household).
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Craving or a strong desire or urge to use a substance.
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

The fact that a disorder is listed in the DSM does not mean that treatment of the disorder is covered by the Plan.

"Surgery"
"Surgery" shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Temporary Employees"
A "temporary employee" or "traveler" is a member who is working outside of their home Local's jurisdiction for an employer that is signatory to that Locals collective bargaining agreement which requires contributions to be made to the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Plan.

"Termination of Benefits"
"Termination of Benefits" shall mean that you no longer meet the definition of being eligible for benefits under this Plan.

"Total Disability" (Totally Disabled)
"Totally Disabled" shall mean that you are not reporting for work; completely unable to perform your job duties as a result of your injury or illness and not receiving wages or benefits from an employer.

If a person receives an award of disability benefits from the Social Security Administration, that person is automatically considered to have met the definition of "totally disabled."

"Third Party Administrator"
"Third party administrator" shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

"Travelers"
"Travelers" shall mean:

a) A member of another I.B.E.W. Local that is signatory to the Electrical Industry Health and Welfare Reciprocal Agreement who is temporarily working for an employer with a

collective bargaining agreement with Local 697, and for whom that employer is making contributions to this Fund.

b) A Local 697 member who is working temporarily for an employer with a collective bargaining agreement with another I.B.E.W. Local that is signatory to the Electrical Industry Health and Welfare Agreement, and for whom that employer is making contributions to that Locals Health and Welfare Fund.

"Union"
"Union" shall mean the International Brotherhood of Electrical Workers, Local 697.

"Work Quarter"
"Work quarter" shall mean January, February and March, or April, May and June, or July, August and September, or October, November and December.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

DENTAL BENEFITS

The Plan pays 75% of the covered dental expenses incurred by you and your eligible dependents up to a maximum benefit of $2,000 per family each calendar year. The maximum applies even if your eligibility is interrupted during a calendar year.

Payments for orthodontia treatments are applied to the $2,000 calendar year dental maximum.

Dental services must be rendered in accordance with accepted standards of dental or orthodontic practice and must be received while a person is covered under this Dental Benefit.

Dental services must be performed by a licensed dentist (DDS), and orthodontic services must be performed by a dentist licensed to practice orthodontia.

For payment purposes, treatment is considered to have been incurred on the date the service is rendered. However, for the following services that require more than one visit, the incurred date is considered to be:

(1) for full or partial dentures, when the impression is taken for the appliances;
(2) for root canal therapy, when the tooth is opened; and
(3) for fixed bridgework, crowns and other gold restorations, when the tooth is first prepared.

Covered Dental Expenses Include

The following dental services and supplies are covered by this Plan but only up to the limits previously explained within the first paragraph.

The Plan covers the following dental treatments and supplies:

1. Oral exam and cleanings.
2. X-rays.
3. Space maintainers, fluoride and sealants for children.
4. Fillings.

5. Oral surgery including extractions.
6. Crowns.
7. Endodontic treatment (root canal therapy).
8. Periodontal treatment.
9. Prosthetics such as bridges and dentures.
10. Implants.
11. Emergency palliative treatment.
12. Anesthetics and analgesics.

Note: Payment for dental services do not accumulate toward the participants annual out-of-pocket expense limit.

DEPENDENDENT ELIGIBILITY VERIFICATION

From time to time and as often as it deems necessary, the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan will require Plan participants to verify their and their dependents eligibility status within the Plan.

Dependent eligibility verification is the process in which the Plan ensures that **only qualified dependents** are enrolled in the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan. National statistics shows that 5% to 8% of enrolled dependents in any group insurance program are typically ineligible to receive Plan benefits. The subsequent removal of these participants results in a 3% to 5% reduction of annual plan expense. This process will help reduce the escalation of benefit plan rate increases, which is good for everyone, including you as a Plan participant.

Failure to Respond or Respond Timely: Participants that do not respond or fail to respond within the stated time-period or those that do not provide all requested supporting documentation or provided all requested supporting documentation within the stated time-period, shall have the eligibility status of themselves and their entire family unit immediately terminated. Meaning: You and any dependent will be ineligible to receive benefits during this period. Participants are reminded that any claims incurred during any period of ineligibility will remain the responsibility of the patient.

Reinstatement of coverage will begin on the day following the day the Plan determines that the participant met his or her dependent eligibility verification requirement. The Plan will not back date a participant's eligibility for a failure to adhere to this provision.

FRAUD

Any participant who provides the Plan with any false dependent information or conceals or withholds information for the purpose of misleading the Plan or fails to update the Plan with information needed to establish eligibility under the Plan, shall be deemed to have committed a fraudulent act. The result of which will be the immediate termination of all coverage under this Plan for both the participant and their entire family unit of which the participant is a member. Further, the participant will be subject to this Plans full fraud provisions as well as may be subject to criminal prosecution under federal and state criminal statues, which may result in fine or imprisonment, or both, as provided by those laws.

Participants who commit an act of fraud against this Plan who wish to see reinstatement of their eligibility status may petition the Board of Trustees to do so under the Appeal provision of this Plan.

DIETICIAN

When used in this Plan, a "dietician" means a licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition.

Managing blood glucose levels or losing weight requires an understanding of how to balance food, exercise, and medication. For those reasons the Plan provides registered dietician benefits to participants with diabetes or for those participants who are in a physician-supervised weight loss program.

Everyone who has diabetes or who are in a physician-supervised weight loss program should be working with a dietitian. That includes, of course, the newly diagnosed, who generally need a crash course in eating for diabetes management or weight loss. To that end, the Plan allows up to six (6) visits with a registered dietician during the first twelve months of diagnosis.

The Plan also recognizes that participants who have had diabetes for years or whose physician supervised weight loss program is ongoing, can also benefit from some one-on-one time with a registered dietitian. Accordingly, and after the first twelve months from diagnosis, the Plan will allow three (3) visits per calendar year with a registered dietician.

In the long term, unhealthy eating patterns contribute to the risk of complications such as cardiovascular disease and high blood pressure. Talking to a registered dietitian will help you use what you eat and drink as a tool for blood glucose control now and your best health later.

Participating dietician charges will be subject to the deductible and payable at 90% of the Reasonable and Allowed Amount (RAA)

Non-participating dietician charges will be subject to the deductible and payable at 70% of 130% of the Plan's Reasonable and Allowed Amount.

Warning: Any visit to a dietician will be combined with any service performed by another dietician not to exceed the number of annual visits previously described with this section.

DIVORCE

If you and your spouse get divorced, your spouse will no longer be eligible for coverage as a dependent under this Plan effective as of the date the divorce is final.

Nevertheless, and if elected within sixty (60) days of the date of divorce, your former spouse may continue coverage under this Plan to up to thirty-six (36) months through this Plan's COBRA provision. Should a former spouse opt to exercise their right for continuation of coverage under this Plan, they must do so in writing and within the time-period.

In general, once you are divorced, stepchildren from your former marriage are no longer covered under the Plan. They may continue their eligibility under the Plan by choosing COBRA, continuation of coverage within sixty (60) days of the date of divorce, or if a Qualified Medical Child Support Order (QMCSO) is received within sixty (60) days of the date of divorce.

The Plan requires you to submit written notification of your divorce along with supporting documentation, such as a divorce decree and, if it exists a copy of any qualified domestic relations order.

Failure to notify the Plan in writing of your divorce immediately upon the effective date of the divorce, and any benefits are paid on behalf of your former spouse and/or former dependents, will be:

1. Deemed by the Plan as an act of fraud and abuse. And,

2. Your coverage and coverage for any eligible dependent will cease immediately. And,

3. Any monies in the participants Health Reimbursement Account will be forfeited. And,

4. Any payments for claims incurred from the date of divorce will remain the sole responsibility of the former participant(s). And,

5. The responsibility for the repayment to the Plan for any amounts the Plan paid on these erroneous claims as well as any legal fees incurred by the Plan to resolve this matter will remain that of the former participant(s).

Reinstatement back into the Plan, as well as any applicable criminal, fraud and abuse charges as permitted under federal and state laws, will be at the sole discretion of the Board of Trustees.

Note: The Plan will not allow any appropriated Health Reimbursement Account monies to offset any incurred debts for the reason that these debts were incurred by non-covered participants of the Plan.

DURABLE MEDICAL EQUIPMENT (DME)

Prior approval is necessary for durable medical equipment or supplies of $1,000.00 or greater. Physicians of patients seeking prior approval for durable medical equipment must certify in writing the medical necessity for the equipment and state the length of time the equipment will be required. The Plan may need proof at any time of the continuing medical necessity of any item.

Participating provider charges will be subject to the deductible and payable at 90% of the Reasonable and Allowed Amount.

Non-participating provider charges will be subject to the deductible and payable at 130% of the Medicare allowable amount multiplied by 70%.

Durable medical equipment is equipment/supplies that meets all the following requirements:

1. It is related to the patient's physical disorder.
2. It can withstand repeated use.
3. It is primarily and customarily used to serve a medical purpose or to prevent or slow further decline of the patient's medical condition.

4. It is not merely for comfort or convenience, or, generally is not useful to a person in the absence of an illness or injury.
5. It is appropriate for use in the home.
6. It is ordered by a physician (M.D. or D.O.)

Coverage is for standard equipment only and the decision to rent or purchase such equipment will be made solely at the Fund's discretion. Rental of the equipment will not exceed the purchase price for that piece of equipment.

Examples of durable medical equipment covered by this Plan include, but are not limited to:

- Automatic positive airway pressure (APAP) machines
- Blood sugar monitors
- Blood sugar test strips
- Breast pumps (up to a $150 maximum allowance per newborn child)
- Canes
- Continuous passive motion devices
- Continuous positive airway pressure (CPAP) devices
- Crutches
- Hospital beds
- Infusion pumps & supplies
- Lancet devices & lancets
- Nebulizers
- Oxygen equipment & accessories
- Pressure reducing beds, mattresses and mattress overlays
- Traction equipment
- Walkers
- Wheelchairs (up to $500 maximum allowance for the purchase or rental of a wheelchair or scooter)

Durable medical equipment may, at the Fund's sole discretion, be replaced if the:

A. Equipment is no longer useful and/or functional.
B. Equipment is at least five (5) years old or has exceeded its reasonable lifetime under normal use; or
C. Patient's condition has significantly changed so as to make the original equipment inappropriate in the judgment of the physician.

Warning:

Durable medical equipment that has been purchased by the Plan cannot be given, donated or discarded without the written consent or permission of the Plan. Participants who do not get the permission of the Plan will be responsible to remunerate to the Plan the full purchase price of said equipment.

Durable medical equipment that is for non-medical use, or of general benefit to the household, or for the convenience of caregivers, whether prescribed by a doctor or not, are not covered. Examples include, but are not limited to air conditioners, exercise devices, handrails, heating pads, humidifiers, purifiers, ramps, whirlpool baths, and other items of furniture.

ELIGIBILITY

Eligibility under the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan is comprised of two different components:

4. An hourly component and,
5. An enrollment component.

Employees wishing to be covered under the Plan must satisfy the requirements of both the enrollment provisions and the hour provisions of the Plan. Failure to meet both of those requirements will result in you and any eligible dependents being unable to receive benefits under this Plan.

You are eligible for coverage described in this manual if you are:

- Employed in a job category covered by an International Brotherhood of Electrical Workers, Local 697 Collective Bargaining Agreement that requires that contributions be made to the Health and Benefit Fund; or,

- Employed in a job category covered by another International Brotherhood of Electrical Workers Local's Collective Bargaining Agreement or a National Agreement which A) Requires contributions be made to that Locals Health and Welfare Fund, and B) Is signatory to the Electrical Industry Health and Welfare Reciprocal Agreement; or

- Employed by an entity that has entered into a participation agreement with the Trust under which the employer makes contributions to this Plan for such individuals and all of its non-bargained for employees; and,

- You and any eligible dependent are properly enrolled in the Plan.

Work Quarter and Quarter of Coverage

Coverage under the Plan is divided into four benefit periods and are known as work quarters. Each work quarter consists of three consecutive calendar months: January through March, April through June, July through September and October through December.

Calendar quarters in which the Fund received hourly contributions on your behalf are termed "Work Quarters".

A "quarter of coverage" is credited when the required number of hours or the premium expense equivalent is received by the Fund for the corresponding calendar "Work Quarter".

Work Quarter		***Quarter of Coverage***
January, February, March		July, August, September
April, May June		October, November, December
July, August, September		January, February, March

October, November, December		April, May June

Please note that the middle column is deliberately left blank to emphasize the fact that there exists an administrative "lag quarter" that separates a work quarter from its corresponding quarter of coverage. Meaning: Contributions received for covered worked performed in any work quarter do not provide coverage in the subsequent calendar quarter of coverage. Rather, it skips a quarter.

Hourly Requirements

Initial Eligibility Hourly Requirement for Apprentices, Indiana Plan Participants, Journeypersons, Non-Bargaining Unit Employees. Owners and Owners-in-Fact.

Apprentices, Indiana Plan participants and journeypersons seeking coverage under the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Plan for the first time can obtain their initial eligibility under this Plan in one of two ways; fast-tracked eligibility or standard eligibility.

- **Fast-Tracked Eligibility**. Initial eligibility for apprentices, Indiana Plan participants, journeypersons, non-bargained employees identified within a participation agreement, owners and owners-in-fact and retiree's returning to covered employment after retirement, may be expedited if:

    - Upon proper enrollment, the participant also provides the Plan with a letter of creditable coverage indicating that they had health insurance coverage within the prior sixty-two (62) calendar days of being eligible under this Plan; and,

    - During the prior six-month period in which the participant was not covered under this Plan, 160 hours of employer contributions were accumulated; and

    - During the month in which contributions were earned, you did not receive a monthly Pension benefit from the I.B.E.W. Local 697 and Electrical Industry Pension Plan.

    - The participant does not owe the Plan any monies. If you owe money to the Plan, your eligibility will not be established until the debt has been paid in full.

If those four conditions are met, initial coverage will begin on the first day of the first month following the month in which the 160 hours were received by the Plan. The initial period of coverage will be the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

- **Standard Initial Eligibility**:

    If you:

    1. Cannot provide a letter of creditable coverage indicating health insurance coverage within the prior sixty-two (62) calendar days of being eligible under this Plan, and

    2. Do not owe money to the Plan, and,

Then the following rules will apply.

- **Apprentices**. Apprentices who cannot provide a letter of creditable coverage indicating health insurance coverage within the prior sixty-two (62) calendar days of being eligible under this Plan, a requirement of at least 420 hours of employer contributions must be accumulated. Said accumulation will encompass the employer contributions made to the Health and Benefit Plan on your behalf in the immediate six-month period in which you were not covered under this Plan, prior to gaining eligibility.

  Upon meeting the aforementioned requirement, the participant's initial eligibility will begin on the first day of the first month following the month in which the 420 of accumulated hours of employer contributions were received by the Plan. The initial period of coverage will be the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

- **Indiana Plan Participants.** Indiana Plan participants who cannot provide a letter of creditable coverage indicating health insurance coverage within the prior sixty-two (62) calendar days of being eligible under this Plan, a requirement of at least 420 hours of employer contributions must be accumulated. Said accumulation will encompass the employer contributions made to the Health and Benefit Plan on your behalf in the immediate six-month period in which you were not covered under this Plan, prior to gaining eligibility.

  Upon meeting the aforementioned requirement, the participant's initial eligibility will begin on the first day of the first month following the month in which the 420 of accumulated hours of employer contributions were received by the Plan. The initial period of coverage will be the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

- **Journeypersons.** Journeypersons who cannot provide a letter of creditable coverage indicating health insurance coverage within the prior sixty-two (62) calendar days of being eligible under this Plan, a requirement of at least 420 hours of employer contributions must be accumulated. Said accumulation will encompass the employer contributions made to the Health and Benefit Plan on your behalf in the immediate six-month period in which you were not covered under this Plan, prior to gaining eligibility.

  Upon meeting the aforementioned requirement, the participant's initial eligibility will begin on the first day of the first month following the month in which the 420 of accumulated hours of employer contributions were received by the Plan. The initial period of coverage will be the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

- **Non-Bargaining Unit Employee as identified within a Participation Agreement.**

  The Plan requires that the entities employing non-bargained unit employees to:

- Specify their intent to provide coverage for the employee within 30 days from the date employment started, and

- To make their first contributions no later than the end of that 30-day period.

Upon receipt of four hundred and twenty (420) hours, initial coverage will begin on the first day of the first month following the month in which the 160 hours were received by the Plan. The initial period of coverage will be for one month.

- **Owners and Owners-in-Fact.** Owners and owners-in-fact who cannot provide a letter of creditable coverage indicating health insurance coverage within the prior sixty-two (62) calendar days of being eligible under this Plan, a requirement of at least 420 hours of employer contributions must be accumulated. Said accumulation will encompass the employer contributions made to the Health and Benefit Plan on your behalf in the immediate six-month period in which you were not covered under this Plan, prior to gaining eligibility.

  Upon meeting the aforementioned requirement, the participant's initial eligibility will begin on the first day of the first month following the month in which the 420 of accumulated hours of employer contributions were received by the Plan. The initial period of coverage will be the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

- **Retiree to Active Journeyperson**. Retired individuals who (1) have not attained the age of 70 ½ and (2) terminated their monthly pension benefit with the I.B.E.W. Local 697 and Electrical Industry Pension plan and (3) return to active employment and (4) perform unit work covered under a collectively bargained contract with the I.B.E.W., must re-satisfy either of the two initial eligibility rules.

  For initial eligibility calculations, the Plan will only consider those employer contributions made to the Health and Benefit Plan on your behalf in the immediate six-month period after you were neither covered under this Plan as a retiree, nor receiving a monthly pension benefit from the Local Union No. 697, I.B.E.W. and Electrical Industry Pension Fund prior to gaining eligibility.

Continued Eligibility

If you owe money to the Plan, your eligibility will not be continued until the debt has been paid and the following conditions met:

Apprentices: Continued eligibility will be granted provided:

- The Plan receives 324 hours of contributions on your behalf during a calendar quarter; or

- You make a self-payment equivalent to the monthly cost of the hourly employer contribution requirement.

Indiana Plan Participants: Continued eligibility will be granted provided:

- The Plan receives 420 hours of contributions on your behalf during a calendar quarter; or

- You make a self-payment equivalent to the monthly cost of the hourly employer contribution requirement.

Journeyperson: Continued eligibility will be granted provided:

- The hours of contributions received on your behalf during a calendar quarter total 420; or

- You make a self-payment equivalent to the monthly cost of the hourly employer contribution requirement.

Non-Bargaining Employees as identified within a Participation Agreement: Continued eligibility will be granted provided:

- The hours of contributions received on your behalf each month meet the required minimums as set forth within the Participation agreement; or,

- During a calendar quarter the hours contributed on your behalf total a minimum of 420; or,

- You make a self-payment equivalent to the monthly cost of the hourly employer contribution requirement.

Owner-in-Fact, and Owners: Continued eligibility will be granted provided:

- The Plan receives 420 hours of contributions on your behalf during a calendar quarter; or

- You make a self-payment equivalent to the monthly expenses of the number of hours required for continued coverage.

Temporary Workers or Travelers: Continued eligibility will be granted provided:

- The hours of contributions received on your behalf during a calendar quarter total 420; or,

- You make a self-payment equivalent to the monthly cost of the Local 697 Health and Benefit Plan hourly employer contribution requirement.

Local 697 participants are reminded that when working out of town, you should always keep track of the hours and corresponding contributions being made on your behalf to verify the accuracy and timing of the other Local's reciprocated contributions back to the various benefit funds of the I.B.E.W. Local 697.

Failure to Meet the Continued Eligibility Requirements

Failure to meet the continued eligibility requirements during any given calendar quarter will result in a termination of eligibility. Participants who find themselves in this position will first be offered

the option to make self-payments and upon exhaustion of that provision, they will be provided with the option to continue their coverage through the COBRA provision of the Plan.

Reinstatement of Eligibility

If your coverage terminates, it cannot be reinstated until you meet the Plan's reinstatement requirements as stated below:

Apprentice - Coverage will be reinstated on the first day of the first month following the month in which 324 hours of employer contributions are received on your behalf within a six-consecutive month period. Reinstatement coverage will be for the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

Indiana Plan Participants - Coverage will be reinstated on the first day of the first month following the month in which 420 hours of employer contributions are received on your behalf within a six-consecutive month period. Reinstatement coverage will be for the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

Journeyperson - Coverage will be reinstated on the first day of the first month following the month in which 420 hours of employer contributions are received on your behalf within a six-consecutive month period. Reinstatement coverage will be for the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

Non-Bargaining Employees – A non-bargaining unit employee will become reinstated on the first day of the calendar month that immediately follows the first 30-day period for which the employer makes contributions to the Plan on the employee's behalf for 160 hours of work.

Owners and Owner-in-Fact - Coverage will be reinstated on the first day of the first month following the month in which 420 hours of employer contributions are received on your behalf within a six-consecutive month period. Reinstatement coverage will be for the remainder of the calendar quarter in which you became eligible and the successive calendar quarter.

With the exception of their notional HRA accounts, participants are reminded that should their coverage be terminated and subsequently reinstated within the same calendar year, all other annual benefit limits or maximums as described within this document will remain in effect for that calendar year.

Warning: Reinstatement of coverage will not occur if you have an unsatisfied debt to the Plan.

Retiree Eligibility

In order to be covered under the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan during your retirement, a participant must meet the following eligibility requirements:

a) Must be receiving monthly Early, Regular, Normal or Disability pension payments from the Local Union No. 697 I.B.E.W. and Electrical Industry Pension Fund.

   With respect to journeypersons who worked under the telecom, residential or individuals working under a participation agreement and who are not entitled to a monthly benefit from the Local Union No. 697,

I.B.E.W. and Electrical Industry Pension Fund, you must be age 62 or older.

b) In the fifteen (15) years directly prior to retirement, you will have had to be covered under this Plan for a minimum of forty (40) calendar year quarters.

c) There must be no coverage gap between your coverage as an active employee and your coverage as a retiree. If you retire without electing this Plan's retiree coverage, you cannot enroll at a later date.

d) You must not owe any monies to the Lake County Indiana NECA – I.B.E.W Health and Benefit Plan.

Termination of Eligibility

Losing eligibility means that you are no longer a participant of the Plan. Should that occur, for whatever reason, including, but not limited to a shortage of hours, no or late self-payments, no or late COBRA payments, or late reciprocal contributions from another I.B.E.W. Local, you and any eligible dependent will no longer be eligible to receive benefits under the Plan.

Once terminated, you will no longer have the ability to use any HRA monies to make self-payments and your HRA debit card will be frozen. However, you will have ninety days to manually submit unpaid medical expenses that were incurred during the time of coverage under this Plan for reimbursement. After that ninety-day period, any monies left within your HRA will be forfeited.

Apprentices

Withdrawal or Expulsion from the Local 697 JATC program will terminate your eligibility under the Plan at the end of the month in which either of those events occurred.

Upon the cessation of your eligibility you will be offered to continue your coverage under the C.O.B.R.A. provision of this Plan. Be advised that C.O.B.R.A. premiums are un-subsidized and if elected, you will be required to pay at the current journeypersons C.O.B.R.A. rate.

Otherwise, should you fail to earn enough hours your eligibility under the Plan will cease at the beginning of the coverage quarter that corresponds to the work quarter that:

- The minimum number of required hours of employer contributions for your classification were not received, and/or,

- The participant failed to timely make the required self-payment.

The latter of which is always due no later than the close of the first business day of the quarter of coverage in which they would not be covered under this Plan. (See chart below)

Journeypersons and Employees.

You and eligible dependent's coverage under this Plan will terminate at the beginning of the coverage quarter that corresponds to the work quarter that:

- The minimum number of required hours of employer contributions for your job classification were not received and/or,

- The participant failed to timely make the required self-payment.

Warning: The latter of which is always due no later than the close of the first business day of the quarter of coverage in which they would not be covered under this Plan.

Insufficient Work Hours Received in Quarters		***Will Result in a Lapse in Eligibility for Benefits in Quarter of Coverage***
January, February, March		July, August, September
April, May June		October, November, December
July, August, September		January, February, March
October, November, December		April, May June

EMERGENCY ROOM FACILITY CHARGES

Knowing where to go for medical care can save you lots of time and money – not to mention, get you the best care for your situation.

To that end, knowing when to utilize the emergency room (ER) is important. If you are experiencing an emergency medical condition, call "911" or go to your nearest emergency room.

If you are unclear as to whether or not you need emergency care, call your doctor. If you do not have a doctor or your doctor is unavailable, and if:

- Your symptoms are severe and/or life-threatening, or
- If they occurred suddenly and without warning, or
- There is excessive bleeding, extreme pain, shortness of breath or broken bones, or
- Using your best judgment, you believe there may be serious impairment to bodily functions or serious dysfunction of a bodily organ/part without immediate medical attention,

Then immediately call "911" or go to your nearest emergency room.

Of course, you can call Teladoc. (1-855-TELADOC – 1-855-835-2362). The medical professional that assists you will be able to help you identify whether you're dealing with an emergency or can wait to schedule an appointment with a physician, specialist, or should go to an urgent care center.

What the Plan pays:

Level A Facilities

Facility charges associated with emergency medical condition that is rendered within a level “A” facility, will be paid at 100% of the Plan’s Reasonable and Allowed Amount. No deductible nor co-insurance will apply toward these level “A” facility charges.

Level B Facilities

Facility charges associated with an emergency medical condition that is rendered within a level “B” facility, will be paid at 90% of the Plan’s Reasonable and Allowed Amount and will be subject to both the annual deductible and co-insurance provisions of this Plan.

All Other Facilities

Facility charges associated with an emergency medical condition that is rendered within a non-participating facility, the Plan will pay 90% of the averaged percentage of the level B Reasonable and Allowed Amount. All emergency room charges for non-participating facilities, will be subject to the annual deductible and co-insurance provisions of this Plan.

Use of the Emergency Room for Non-Emergency Medical Conditions

Services rendered within any emergency room for non-emergency medical conditions will not be covered.

EMERGENCY ROOM PHYSICIANS

Participants are advised that:

1. Even though you may utilize the emergency room of a participating hospital, do not expect that every physician who might treat you in the ER, or charge you for some of the services you received in the ER (for example, the radiologist who interpreted your X-ray), is necessarily going to be an in-network provider within this Plan. In fact, and for a myriad of reasons, hospitals often sub-contract certain positions or duties to non-participating physicians or out-of-network physicians.

2. There is a difference between facility charges (what the hospital charges for the use of the emergency room) and physician charges (what the emergency room physicians who treat you charge). As such and depending upon the network affiliation of the hospital and/or treating physicians, participants are informed that they can get multiple explanation of benefits and/or bills from these entities.

3. The Plan does not have any control over the hiring practices and/or organizational practices of a participating hospital facility or a non-participating facility.

Participating provider charges for a true emergency medical condition will be paid at 90% of the Reasonable and Allowed Amount. Deductibles and annual out-of-pocket limits apply.

Non-participating provider charges for a true emergency medical condition will be paid at 90% of this Plan's Reasonable and Allowed Amount. Deductibles and annual out-of-pocket limits apply.

Non-participating provider charges for services rendered that do not meet the definition of this Plan's emergency medical condition, will be paid at 130% of the Medicare allowable amount multiplied by 70%. Deductible and annual out-of-pocket expenses apply.

ENROLLMENT

In order for you and your dependents to be covered under the Plan, you and they must be properly enrolled.

To be enrolled, you must complete in its entirety the Plans enrollment form and provide certain documentation as determined by the Plan and subsequently identified on the Plan's website, the Plan's enrollment form, or within the sections of this document titled "Birth", "Children" and "Marriage".

The Plan has the right to require participants to provide supporting documentation from time to time and as often as it determines reasonably necessary, as proof for enrollment and eligibility purposes.

Warning: Missing, incomplete or the untimely completion and/or untimely submission of the enrollment form and requested documents will result in both you and/or your dependents being unable to claim benefits from this Plan. Assuming you have met the hourly requirements, you and/or any eligible dependent will be enrolled in the Plan on the first day after the Health and Benefit Plan receives and deems complete the enrollment form and all supporting documentation proper. Any bills incurred prior to the Plans enrollment of you and/or any eligible dependent will remain the sole responsibility of the participant.

Changes in Participant Status. Participants must complete and submit a new enrollment form along with the proper supporting documentation if any of the following situations occur:

- Address change.
- Adoption of a dependent.
- Birth of a dependent.
- Death of a covered participant.
- Disability of an eligible dependent.
- Divorce of you or any covered dependent.
- Existence of other dental, medical, pharmaceutical or vision coverage with another insurance Plan or carrier.
- Family medical leave enrollment.
- Legal separation.
- Marriage of you or any eligible dependent.
- Medicaid enrollment or un-enrollment.
- Medicare enrollment or un-enrollment.
- Name changes.
- Receipt of court decree establishing guardianship.
- Receipt of a notice of a Social Security Disability Award.
- Receipt of a notice of termination of a Social Security Disability Award.

- Receipt of a Qualified Medical Child Support Order (QMCSO)
- When a child becomes disabled.

Parents of newborn children will be provided a ninety-day (90) grace period from the date of the child's birth to both enroll their child into the Plan and submit the proper and required documentation. Claims incurred after that time will remain the responsibility of the participant.

Participants are advised that the Plan is subject to federal laws, as well as state fraud and abuse laws which provide that criminal penalties may be imposed against those who receive or attempt to receive Health and Benefit Plan benefits by committing fraud and abuse against the Plan. Coverage for you and your dependents may terminate at any time if there is a misrepresentation on any of the enrollment forms or if you allow a fraudulent claim to be filed. Reinstatement, if any, will be at the sole discretion of the Board of Trustees.

Supporting Documentation:

- Submit only the supporting documentation listed within the form, website or this Summary Plan Description Book.

- Supporting documentation must be in English or accompanied by a complete English translation.

- Submit copies unless we request original documents. If you send an original document with your form, please let us know and the Plan will gladly make a copy and send you back the original. However, should you not let us know that it is an original, we may not recognize it as such, and as a result it may become part of your records and/or scanned into our system and the original document destroyed.

- If you have multiple attachments, make sure each attached page has your name and that each page is numbered and included the total amount of pages being attached (for example, "page 1 of 11")

EXCLUSIONS AND PLAN LIMITATIONS

No payment will be made for and/or no consideration will be given for:

- **Abortions**
- **Accidental Death and Dismemberment** benefits associated with:

    a) Active duty at a full-time status for more than 30 days in the armed forces of any country or international authority, except the National Guard or organized reserve corps duty.
    b) Car racing.
    c) Death during surgery.
    d) Death resulting from a mental or physical illness.
    e) Drug overdose or use of intoxicants unless taken under the advice of a physician.
    f) Felonious conduct.
    g) Internal conflicts, insurrection or rebellion of any country.
    h) Operating any vehicle under the influence of drugs or alcohol.
    i) Sickness, disease or bacterial infection, unless the latter was due to an accidental cut, wound, or due to botulism or ptomaine poisoning.

j) Suicide, attempted suicide or intentionally self-inflicted injury.
k) Travel, including but not limited to, getting in or out of a vehicle used for aerial navigation if the person is:
    - Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    - Performing, learning to perform or instructing others to perform as a pilot or crew member of any kind.
    - War or an act of war, whether or not declared

- **Accommodations** charges or fees for donors, family members or guests for any medical procedure unless otherwise approved by the Plan.
- **Adoption** fees, expenses or charges
- **Advance behavior therapy (ABA)** or similar services designed to change a person's behavior, unless an exception is clearly stated.
- **Air conditioners**
- **Alcohol** abuse treatments without prior approval.
- **Alternative medical treatments or programs** intending to provide personal fulfillment or harmony.
- **Anesthesia** services that were administered by the operating surgeon, his or her assistant or an employee of a hospital or similar institution.
- **Antihistamines** that are non-sedating, whether or not prescribed by a doctor.
- **Appeals** made by anyone or any entity other than a covered participant or the individual identified within a participant's notarized appointment of authorized representative form.
- **Appointments** that are missed or for any charges or fees incurred for missed appointments or late arrivals to appointments.
- **Approved Clinical Trials.**
- **Art therapy.**
- **Assistant surgeon** fees, except for procedures when this assistance is necessary for the successful outcome of the surgical procedure and not to exceed 25% of the Reasonable and Allowable Amount for that surgical procedure.
- **Balances** that remain after the Fund's payment for services performed by non-participating providers.
- **Bariatric benefits** due to failed eating and/or exercise regimens and/or due to motivations that are of a cosmetic nature.
- **Bariatric benefits on a person under the age of 18.**
- **Bariatric benefits that exceed the one per lifetime limit.** This would include any expense associated with the reversal of a bariatric surgery or any expense associated with the second stage surgery after a laparoscopic sleeve gastrectomy procedure is performed.
- **Bariatric surgery** that **has not been pre-approved** by the Plan's review organization.
- **Batteries** for hearing aids or for other non-imbedded medical devices.
- **Bereavement** counseling or services.
- **Biofeedback** counseling, treatments or testing.
- **Bioidentical hormone replacement therapy** that contain elements that <u>are not</u> approved for the purposes that they prescribed.
- **Birthing centers** that are nor part of a hospital or are not a freestanding licensed facility staffed by registered nurses and obstetricians.
- **Blood handling.**

- **Bodily injury, disease or illness** caused by any **act of war**, whether war is declared or undeclared.
- **Bodily injury, disease or illness** caused by any act of **international armed conflict** or any conflict involving the **armed forces of any international body** or **insurrection**.
- **Breast pump expenses** above the allowable limit.
- **Breast pump purchased** prior to the birth of a child.
- **Breast pump replacement parts.**
- **Cancelled appointments**
- **Children who are born** of an eligible individual acting as a **surrogate mother** will not be considered a dependent of the surrogate mother or her spouse.
- **Children** who are not legal dependents of the member.
- **Charges, expenses and fees**:
    a) For the **collection** of medical records.
    b) For the **completion** of medical forms.
    c) For the **copying** of medical records.
    d) For the **correction of nearsightedness, farsightedness or astigmatism**.
    e) For the **creation** of medical records.
    f) For **materials** which are chiefly for instruction, education or training.
    g) For **medical supplies** furnished in or by a federal, state or local government, agency, or program or by a hospital or institution owned thereby.
    h) For **patient lifts that exceed the limitations set forth by Medicare.**
    i) For **procedures, services, supplies or treatments** which are **not rendered for the care of, correction of or in connection with a specific accidental bodily injury or illness.**
    j) For **procedures, services, supplies or treatments** which are **not medically necessary.**
    k) For **services** and **goods associated with a provider's medical error, negligence and/or malpractice**.
    l) For **services** and **goods not covered by the Plan**.
    m) For **services beyond the scope of a practitioner's license**.
    n) For **services for which the covered person does not have to pay**, including, but not limited to when a provider of care does not usually collect charges in the absence of insurance coverage. This exclusion applies even if charges are billed.
    o) For **services incurred after coverage ends**.
    p) For **services incurred prior to the proper enrollment** of a dependent in the Plan.
    q) For **services incurred within a hospital emergency room** for non-emergency sicknesses or conditions.
    r) For **services not medically necessary** or not recommended, ordered or approved by a doctor.
    s) For **services or supplies provided** while a person is confined in an institution which is primarily **a place of rest**, a **place for the aged**, or a **nursing home.**
    t) For **services, supplies or treatments** while a person is confined in a **Veterans Administration (V.A.) hospital.** However, charges for care furnished by the V.A. for non-service-related disability, will be considered covered medical expenses to the extent:

- Required by law, and
- To the extent that such charges would have been considered covered medical expenses at the time they occurred had the V.A. not been involved, and
- Only to the extent of the reimbursement allowances and rules of this Plan.

u) For **services resulting from or occurring as a result of felonious conduct** committed by the patient or his family member(s).
v) For **services that fall under the federal False Claims Act**.
w) For **services which are chiefly for instruction, education or training**.
x) For **the treatment of non-accidental, self-inflicted injury or illness or attempted suicide**, unless such injuries result from an act of domestic violence or a previously diagnosed medical condition (e.g., depression)
y) For **training or room and board** while a person is confined in an institution which is primarily a school or institution of learning or training.
z) From **out-of-network providers that are in excess of the Fund's maximum allowed amounts, Reasonable and Allowable Amounts or usual, customary and reasonable amounts.**
aa) **Incurred by a person who is not covered under the Plan.**
bb) **That exceed the Plans maximum allowed amounts, Reasonable and Allowed Amounts or usual, customary and reasonable amounts.**
cc) **That have been waived.**
dd) **That you or a dependent are not legally required to pay.**
ee) **Which would not have been made if this Plan did not exist.**

- **Chelating therapy associated with foreign substances** associated with performing the daily duties or function of an apprenticing electrician or journeyperson electrician.
- **Claims** submitted after three-hundred and sixty-five (365) days from the date of service.
- **Claim** or claims that a participant and/or a dependent may make under any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the Common Fund doctrine will not be covered.
- **COBRA periods of coverage are not permitted to be used in the calculation of earning coverage in retirement.**
- **Comfort support animals or sessions or treatments with comfort support animals.**
- **Commodes.**
- **Common law** partners.
- **Compounded hormone replacement therapy** that contain elements that are not approved for the purposes that they prescribed.
- **Contraceptive devices, medications or services** other than oral medications or those services expressly stated as covered under this Plan.
- **Cosmetic surgery,** or for any expense or charge that results from cosmetic surgery other than those expressly stated as covered under the Plan.
- **Court-ordered treatments or services.**
- **Craniomandibular treatments**, unless proven to be medically necessary.
- **Custodial care.**
- **Dependent children pregnancies.**
- **Detoxification in a hospital or rehabilitation center greater than seven days.**

- **Developmental delays,** including charges for development and neuroeducation testing or treatment, hearing therapy, therapy for learning sensory deficit, developmental disability and related conditions, or for other special therapy not specifically included as a covered expense elsewhere in this booklet, whether or not such disorder is the result of any injury or illness.
- **Diabetic education.**
- **Diagnostic testing for non-emergency medical conditions** within a participating hospital emergency room will not be covered.
- **Dietician services** for conditions or medical maladies other than diabetes or physician-supervised weight loss programs.
- **Dietician visits** that exceed the Plan's limits.
- **Doula** services.
- **Durable medical equipment** without prior authorization.
- **Durable medical equipment** which, regardless of being prescribed by a physician or not, for non-medical use or of general benefit to the household, or for the convenience of caregivers, whether prescribed by a doctor or not, are not covered. Examples include but are not limited to, exercise devices, handrails, heating pads, humidifiers, purifiers, ramps, whirlpool baths, and other items of furniture.
- **Durable medical equipment maintenance and repair.**
- **Durable medical equipment replacement** if five years have not passed since the original equipment was purchased.
- **Drugs** not approved by the FDA.
- **Educational services,** including but not limited to classes, tapes booklets, etc., regardless of the purpose, health benefit or recommendation of the attending or treating physician or the qualifications of the individual providing the education.
- **Educational services for special education** or instruction for a learning disabled or handicapped child.
- **Educational therapy.**
- **Emotional support animals are not covered.**
- **Epidural** injections without prior authorization.
- **Exercise devices or equipment.**
- **Exercise programs or physical fitness programs** other than those described within this document.
- **Expenses in excess** of the Funds allowances as set forth within this document.
- **Experimental drugs, services, supplies and treatments** not recognized as accepted medical practice in the United States or any items requiring governmental approval not granted at the time service is rendered.
- **Facilities** for the aged.
- **Family counseling.**
- **Fees** from non-licensed entities or practitioners.
- **Fees resulting from** the confinement in or relating to treatments received in a facility of the aged, nursing home, or rest home.
- **First aid** products purchased off-the-shelf, whether or not recommended by a physician.
- **Fitness club fees** that exceed the reimbursement levels identified in this document.
- **Fittings** for hearing aids.
- **Food**

- **Food supplements**
- **Foster children** that are not placed with you by a state or federal court (or legally adopted).
- **Gender reassignment** regardless of the person's diagnosis. This exclusion applies to medical, surgical and prescription drug charges. Nothing in this exclusion shall operate to discriminate against any participant on the basis age, color, disability, national origin, sex or transgender status.
- **Genetic counseling.**
- **Genetic testing** that is not for the diagnosis or treatment of an existing medical condition. Prenatal genetic testing is not covered.
- **Grandchildren** that are not legally adopted.
- **Grand Rounds** services for retirees with Medicare as their primary insurer.
- **Growth hormone therapy or treatments** that are not approved by this Plan.
- **Habilitative services** except when specifically stated as covered.
- **Halfway house facility.**
- **Handrails.**
- **Health Reimbursement Account** credit when receiving loss of time or short-term-disability benefits.
- **Health Reimbursement Account** requests for the repayment of any out of pocket expenses incurred after a participant has been terminated from the Plan.
- **Heating pads**
- **Home care** without prior authorization.
- **Home health products,** such as, but not limited to:
    a) Arch supports
    b) Assistive listening devices,
    c) Back braces,
    d) Bandages, blood pressure instruments,
    e) Communication devices,
    f) Corrective shoes,
    g) Digestive aids,
    h) Emergency alert devices,
    i) Enema supplies,
    j) Exercise equipment,
    k) Eyecare products,
    l) Fitness equipment,
    m) Heating pads,
    n) Food,
    o) Formula,
    p) Home diagnostic tests or testing equipment,
    q) Hot water bottles,
    r) Hypo-allergenic pillows,
    s) Hypodermic needles,
    t) Hypodermic syringes (except for diabetic supplies)
    u) Incontinence products,
    v) Neck braces,
    w) Nutritional supplements,

x) Orthopedic shoes,
y) Rubber gloves,
z) Scales,
aa) Sleep aids,
bb) Sterile water,
cc) Stethoscopes,
dd) Support garments,
ee) Thermometers,
ff) Vitamins,

And all similar products even if they are aids to a patient's daily living, unless an exception is specifically noted in this booklet.

- **Home modifications or additions** to accommodate a medical condition or disability, such as but not limited to, stair lifts, elevators, pools, shower rails, spas and ramps.
- **Homeopathic medications supply and treatments.**
- **Hormone therapy** for growth hormone deficiency or short stature **(See also** bioidentical or compounded hormone therapy)
- **Hospital limitations:**
    a) **Confinements** for the treatment of non-acute illnesses.
    b) **Confinements** not related to injury, illness or surgery.
    c) **Confinements, services or treatments that are non-emergency related** that are received prior to precertification being granted by the Plan.
    d) **Confinements, services or treatments that are emergency related** that do not receive certification by the Plan within three business days of initial confinement, service or treatment.
    e) **Dental care** performed in a hospital or hospitalizations for dental care, unless prior approval is obtained and is certified by your physician as necessary to protect your life.
    f) **Mental or nervous inpatient treatments**, except as stated in the pages of this document.
    g) **Separate charges** by a salaried hospital physician or staff.
    h) **Take home drugs.**
- **Household help,** including but not limited to homemaker services, sitters, child care or home-delivered meals.
- **Housing or lodging** expenses.
- **Humidifiers.**
- **Hypnotism.**
- **Illnesses, or injuries** resulting from or arise from:
    a) An act of war, whether declared or not, or a conflict involving armed forces.
    b) An attempt to commit or commission of a misdemeanor or felony or participation in a public disturbance.
    c) An intentionally self-inflicted injury or illness, or a suicide attempt, unless the injury or illness resulted from a medical condition (including both physical and mental health conditions).
    d) Past or present military service**.**

e) The course of employment that would be compensable under workers' compensation, occupational disease, or similar laws, whether or not the right under the law is asserted.

- **Immunizations expenses** related to travel vaccinations.
- **Impotency** of any kind, including any complications arising from such conditions or treatments.
- **Infertility treatment services** including but not limited to hormone therapy, artificial insemination, or any other direct attempt to induce or facilitate fertility or conception**, including in-vitro fertilization, fertility drugs, GIFT procedures, artificial insemination, or treatments to reverse a sterilization procedure.**
- **Investigational services,** including treatments, supplies and drugs that are not recognized as accepted medical practice in the United States or any items requiring governmental approval not granted at the time service is rendered.
- **Jacuzzis**
- **Lap band adjustments** one year or more after the surgery.
- **Lasik surgery**
- **Learning disabilities**, delayed speech development, mental retardation, developmental delay, behavioral problems, or special education.
- **Life insurance** payments made to any beneficiary of a participant that was not covered.
- **Life insurance** payments made to any beneficiary of a participant that was covered under the COBRA provision of this Plan.
- **Life-partners.**
- **Loss of time benefits** for any period of disability during which you are not under the regular care of a M.D. or D.O. for the disability which resulted in the inability to work.
- **Marijuana** in any form, whether or not legally prescribed.
- **Marriage counseling.**
- **Massage therapy.**
- **Maternity clothes** or any other clothing or apparel.
- **Maternity services** and supplies provided by a hospital or birthing center that includes parent education, assistance and training in breast or bottle feeding, or the instruction on how to conduct maternal and newborn clinical assessments.
- **Medical services and supplies furnished or provided in or by:**
    a) **An individual who ordinarily resides in your home or is related to you by blood or marriage.**
    b) **A federal, state of local government**, agency or program or by a hospital or institution owned thereby unless required by law.
- **Mental health treatments** associated with, resulting from, or relating to, but not limited to, a participant's previous decision to undergo a vasectomy, transsexual surgery, gastric bypass or bariatric surgery.
- **Mental health in-patient treatments or services** performed prior to receiving precertification.
- **Mental health out-patient treatments or services** not pre-certified by the Fund.
- **Midwife** services performed by a non-licensed, nonregistered nurse mid-wife or a midwife that is a relative.
- **Missed appointments**
- **Music therapy.**

- **Myofunctional therapy.**
- **Naprapathy.**
- **Nursing homes.**
- **Nutritionist services – see "dietician services" above.**
- **Obesity, morbid obesity or any overweight condition** other than bariatric or gastric by-pass surgery, or a physician-assisted weight loss program.
- **Occupation-related** conditions as follows:
    a) Accidental bodily injury, illness or disease sustained while the person was performing any act of employment or doing anything pertaining to any occupation or employment; or
    b) Accidental bodily injury, illness or disease for which benefits are or may be payable in whole or in part under any workers compensation act or any occupational diseases act or any similar law.
- **Occupational related rehabilitation programs.**
- **Occupational therapy in excess of 17 visits without prior approval.**
- **Oocyte cryopreservation.**
- **Organ donor charges or fees** associated with a covered participant of the Plan donating an organ to a person not covered under this Plan in excess of the amounts listed within this document.
- **Orthoptics** or other vision therapies performed by an optometrist.
- **Orthotripsy without prior approval.**
- **Over the counter drugs or medicines** which are drugs that are not legally required to be dispensed by a licensed pharmacist according to the written prescription of a doctor (except for certain non-prescription diabetic supplies).
- **Panniculectomy.**
- **Penile implants** to improve sexual performance (unless medically necessary following a prostate surgery of which the Plan will allow only one implant or penile prosthesis per lifetime.)
- **Personal convenience items** such as telephones, TV's, cosmetics, newspapers, magazines, laundry, guest trays or beds or cots for guests or to the family members, or any other personal comfort items or items that are not medically necessary.
- **Pets** are not covered by the Plan.
- **Physical fitness or exercise programs** other than described within this document.
- **Physical retreat facility and/or treatment** expenses, such as, but not limited to educational classes or exercise classes.
- **Physical therapy** after 17 visits without prior approval.
- **Physical therapy** by a podiatrist and/or chiropractor.
- **Pregnancy related expenses for dependent children or for anyone but employees and their dependent spouses.**
- **Prenatal genetic testing**.
- **Preventive tests and services** other than described within this document.
- **Psychological treatments** without prior authorization
- **Purifiers**
- **Ramps**.
- **Reconstructive surgery** expenses, losses or charges**, except** for injuries received while covered under the Plan, or repair of congenital defects of newborn children.

- **Re-contouring** to remove loose skin.
- **Rehabilitative therapy** or any other type of therapy if either the prognosis or history of the person receiving the treatment or therapy does not indicate that there is a reasonable chance of improvement.
- **Reiki therapy or treatments.**
- **Relationship counseling.**
- **Repairing** of hearing aids.
- **Rest homes.**
- **Reversal surgeries,** relating to or resulting from the participants decision to reverse a surgery such as, but not limited to bariatric or gastric bypass surgeries, elective sterilizations or vasectomies.
- **Routine exams, tests and services** other than described within this document.
- **Routine foot care for non-diabetics,** including but not limited to treatment of bunions (except for open cutting operations) calluses, corns and toenails (except surgical removal of ingrown toenails). Routine foot care for Diabetics must be performed by a licensed podiatrist.
- **Sales tax.**
- **Service animals** are not covered.
- **Sexual dysfunction** including any complications arising from such conditions or treatments.
- **Sexual transformations,** regardless of the person's diagnosis. This exclusion applies to medical, surgical and prescription drug charges. Nothing in this exclusion shall operate to discriminate against any participant on the basis age, color, disability, national origin, sex or transgender status.
- **Shipping charges.**
- **Short-term disability benefits** for any period of disability during which you are not under the regular care of a M.D. or D.O. for the disability which resulted in the inability to work.
- **Siblings**, that are not adopted.
- **Smoking cessation** medications, services, supplies and treatments except as provided under this Plan.
- **Spa facility and treatment fees,** including, but not limited to, educational services and massage therapies and supplies.
- **Speech therapy** for:
    a) Articulation disorders
    b) Attention disorders
    c) Auditory processing disorders
    d) Behavior disorders
    e) Developmental delay disorders
    f) Educational problems.
    g) Fluency disorders
    h) Learning problems.
    i) Non-medical diagnoses
    j) Normal developmental variations.
    k) Psychosocial delays
    l) Self-correcting disorders

m) Stammering disorders
n) Stuttering disorders
o) Verbal apraxia

- **Speech therapy** without prior approval.
- **Substance abuse treatment**s that are nor pre-certified, approved or coordinated by the Fund.
- **Supplies** not approved by the FDA.
- **Surgeries** that are not medically necessary. (I.e., surgeries that are cosmetic in nature)
- **Surgical Trays.**
- **Surrogate pregnancies.** Including but not limited to those pregnancies where a covered participant is carrying and delivering a child for someone else.
- **Surrogate** parentage fees, expenses or charges.
- **Synagis Injections** that are received prior to precertification.
- **Telephone consultations that are not properly billed as such.**
- **Temporomandibular joint (TMJ)** treatments.
- **Therapies or programs** that are primarily supportive in nature, and/or that take place in a camp, farm, ranch, park or other outdoor settings without on-site doctors, nurses or master's level behavioral therapists or have a ratio of professional to patient greater than one of the aforementioned professions to every four patients. This exclusion applies to but is not limited to wilderness therapy.
- **Therapy and treatments** not approved by the FDA.
- **Therapy and treatments** not backed up by large, high-quality, controlled and randomized clinical trials.
- **Third party liability claims,** except as provided for under the Plan.
- **Throwaway medical equipment** such as tubes, masks, hoses, gloves or gauzes that are not billed directly by the providers.
- **Transplant donor searches.**
- **Transsexual surgery.**
- **Transportation expenses**, whether or not recommended by a doctor, unless specifically listed as a covered medical expense.
- **Travel expenses**, such as but not limited to vaccinations, (whether or not recommended by a doctor,) or food.
- **Tubal ligations.**
- **Vasectomies.**
- **Vehicle modifications and/or adoptive equipment** to accommodate a medical condition or disability, such as, but not limited to lowered floors, raised roof systems, secondary controls, scooter tie-downs, steering devices, or wheelchair lifts and/or wheelchair tie-downs.
- **Vitamins,** including over-the-counter vitamins.
- **Weight loss program dues or fees,** or food, food products or supplies, such as, but not limited to, programs such as Jenny Craig or Weight Watchers.
- **Wellness exams, tests and services** other than described within this document.
- **Wilderness therapy** of any sort and for any reason including, but not limited to, alcoholism, bulimia, depression, drug addition, mental health issues, physical rehabilitation or substance abuse.
- **Whirlpool baths**

FAMILY MEDICAL LEAVE ACT

The Family Medical Leave Act (FMLA) requires certain employers (but not all) to grant unpaid leave. In general, affected employers must grant you a short-term leave for specific reasons, such as the birth of a child or a serious family illness. Eligibility for this unpaid leave is determined by the employer, not by the Trustees of this Fund.

If you are granted a FMLA leave, your employer must provide the necessary documentation and make contributions to the Fund on your behalf. Failure of your employer to submit contributions on a timely basis will result in loss of coverage under this Plan.

Note: The Plan does not determine whether or not you are entitled to a family medical leave, or whether or not your employer must make contributions during your FMLA leave.

FITNESS MEMBERSHIP STIPEND PROGRAM

The Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan has designed this stipend program to help you make exercise a part of your life, as well as to help you pay for it.

Eligibility for Reimbursement

To be eligible for the Plan's stipend, you must:

A. Be a member of a health club, fitness center of gym that has weights and/or exercise machines that develop cardiovascular and muscular fitness.
B. Be a participant in the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan in the month in which you incurred a membership expense at a fitness center, gym, health club.
C. Made a minimum of at least eight (8) visits per month to that facility.

Level of the Stipend

Participants are advised that:

1. The Plan will only consider a maximum of 1 workout per day.
2. The frequency of your workouts will determine the level of reimbursement you will be entitled to receive.
3. The Plan's reimbursement will not exceed the actual monthly cost of your membership, or the stipend levels identified directly below, whichever is less.

MAXIMUM MONTHLY HEALTH CLUB BENEFIT

NUMBER OF VISITS	POLICY HOLDER ONLY	POLICY HOLDER AND SPOUSE
8 to 11 visits per month	$12	$24
12 or more visits per month	$25	$50

Determining Your Actual Monthly Membership Expense

The Plan determines the actual monthly cost of your membership by applying the following formula:

The cost of your annual gym membership fee plus any monthly gym fee / by the number of months in which you had met either the eight or twelve visit requirements in that calendar month.

Stipend amounts will be determined as follows:

- The stipend amount for months that the participant accrued eight to eleven visits will be capped at $12.00 per month.
- The stipend amount for months that the participant and spouse each accrued eight to eleven visits will be capped at $24.00 per month.
- The stipend amount for months that the participant accrued twelve (12) or more visits will be capped at $25.00 per month.
- The stipend amount for months that the participant and spouse each accrued twelve (12) or more visits will be capped at $50.00 per month.

Under no circumstances will the Plan's stipend exceed the annual maximum amounts listed directly below.

MAXIMUM ANNUAL HEALTH CLUB BENEFIT

NUMBER OF VISITS	POLICY HOLDER ONLY	POLICY HOLDER AND SPOUSE
8 to 11 visits per month	$144	$288
12 or more visits per month	$300	$599

Ineligible or Non-reimbursable Expenses

The Plan recognizes that activities such as, but not limited to:

- Archery
- Basketball
- Bicycling clubs
- Boot camps
- Chiropractic services
- Dance classes
- Diet instruction/coaching
- Golf
- Martial arts/karate
- Pilates classes
- Personal fitness instruction
- Racquetball
- Rock Climbing
- Rowing
- Tennis
- Sculling/rowing
- Sports leagues
- Swim clubs
- Swimming lessons
- Squash
- Yoga
- Wellness Program instruction

May assist you in improving your health, however, they nevertheless do not qualify for the payment of this Plan's stipend as they often do not require consistent, year-round attendance, nor do these activities incorporate all the elements of a comprehensive exercise program. Consequently, classes, membership or participation in any of the aforementioned activities or classes, membership or participation in programs that focus primarily on a single competitive or recreational sports activity, are not eligible for the stipend —even if the activity includes some elements of a comprehensive exercise program.

Benefits are Taxable

Per IRS rules, payments for fitness memberships are considered taxable income in the year that a participant receives the benefit. For that reason and because the current level of the Plan's benefit stipend is under the Internal Revenue Code threshold that requires the issuance of a 1099, the Plan is notifying Plan participants that:

- It is each participant's responsibility to declare as earned income on their annual tax filing any and all reimbursement you receive for this benefit, and
- That the Health and Benefit Plan will not be issuing 1099 forms.

How to Claim a Stipend.

Claims can be paid in many different manners:

1. Monthly, via direct deposit; or,
2. Once a quarter, via direct deposit; or,
3. Once a year by direct deposit.

All claims from the prior calendar year must be received no later than April 15th of the subsequent year in order to be considered for payment. Claims received after that time, will be denied for untimely submission and not paid.

Submitted stipend requests must consist of:

- A fully completed and signed claim form.
- A printout from the facility to prove the dates you exercised at said facility. Should your health club not provide a print-out, you will have to keep a log and have a club employee sign and date it at each visit (not after the fact). You must show proof of each visit, not just proof that you are a member. A fitness club quarterly log is available on the Fund's website, or you can request them directly from the Fund Office at 219-940-6181.
- An itemized receipt from the facility showing the amount you paid in membership fees for you and if applicable, your spouse.

FRAUD

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a participant's

responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of participants being canceled, and such cancellation may be retroactive.

The Plan will deem it fraud if a participant, or any other entity:

- Is aware of any instance of fraud and fails to bring that fraud to the Trustees or Fund Manager's attention.
- That makes or uses any false writing or document in connection with obtaining coverage or payment for health benefits, including, but not limited to falsifying or altering (1) a certificate of credible coverage to reduce or eliminate waiting periods, (2) a claim form, or (3) medical records.
- Permits a person who is not covered under the plan to use Plan identifying information to obtain covered services or payment under the Plan, whether said attempt was successful or not;
- Provides false or misleading information in connection with enrollment in the Plan;
- Provides any false or misleading information to the Plan as it relates to any element of its administration;
- Submits a claim for services or supplies not rendered;
- Submits a claim that misrepresents what was provided, when it was provided, the condition or diagnosis, the charges involved, or contains unnecessary services.
- Submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; or
- Withholds, omits, conceals, or fails to disclose any information in connection with enrollment;

Any participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The result of which will be the immediate termination of all coverage under this Plan for both the participant and their entire family unit of which the participant is a member. Additionally, the participant will be required to make full and immediate renumeration of any Plan losses, including, but not limited to, all legal expenses and administrative expense associated with the fraudulent act.

Further, the participant may be subject to criminal prosecution under federal and state criminal statues, which may result in fine or imprisonment, or both, as provided by those laws.

A determination by the Plan that a rescission is warranted will be considered an adverse benefit determination for purposes of review and appeal. A participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

GRAND ROUNDS

The NECA/IBEW Health and Benefit Plan has an agreement with Grand Rounds, an organization that provides diagnosis review, second surgical opinions and specialist referrals to Plan participants. The Plan pays for this service in full – **there is no cost to you**.

What is Grand Rounds?

Grand Rounds is a guide and resource for your medical and health care-related needs. Grand Rounds services include finding you the top doctors and specialists in this Plan's PPO network, booking doctor's appointments on your behalf, getting you remote second opinions from world-leading experts, answering any questions you may have about your medical conditions, and more.

When You Should Use Grand Rounds?

Use Grand Rounds when:

1. You need a primary care physician or specialist for an in-person visit. Grand Rounds can help you find trusted and experienced doctors within the Plan's network and can even set the appointment for you.

2. You'd like quick answers to medical questions. Grand Rounds can provide you with over-the-phone guidance and support from a Grand Rounds doctor.

3. You're unsure about a diagnosis, or you've been recommended surgery as a form of treatment. Grand Rounds can arrange for you to get a remote second opinion from a leading expert specializing in your area of need.

GRANDFATHERED STATUS

The Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan is a grandfathered plan.

Grandfathered plans are health plans that were in place before March 23, 2010, when the Affordable Care Act was signed into law. The Affordable Care Act permits these plans to maintain most of the same coverage levels that they did before the Affordable Care Act was enacted. Consequently, a grandfathered status plan might not include certain benefits that non-grandfathered plans are required to include. A few examples of this include:

- Grandfathered status plans are not required to cover all preventive services at a $0 copay.
- Grandfathered status plans are not required to cover all of the benefits healthcare reform has deemed to be "essential," such as certain types of testing and treatments.
- Grandfathered status plans have different member appeal rights.

Participants of the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan are kindly reminded that as a participant of a grandfathered status plan, you may not have the same benefits as someone with a non-grandfathered status plan.

Questions regarding which protections apply and which projections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 7200 Mississippi Street, Suite 300, Merrillville, IN 46410, telephone 219-845-4433. You may also contact the Employee Benefits Security

Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to grandfathered health plans.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

This Plan's Heath Reimbursement Arrangement (HRA) is not available to apprentices nor Indiana plan participants. It is only available to journeypersons and those individuals identified within an employer's participation agreement.

A journeyperson's or employees health reimbursement arrangement (HRA) is funded solely by employer contributions. Balances within these accounts become a tax-free benefit when utilized to reimburse eligible participants for qualified out of pocket medical, dental, pharmaceutical and vision expenses incurred while covered under this Plan.

Account Maximums

The Trustees determine both the maximum balance that can be accrued within a participant's account as well as the amounts permissible to be rolled-over from year to year. Please access the Plan's website or call the Fund Office to find out about the current maximums.

Allowable Reimbursable Expenses

Section 213(d) of the Internal Revenue Code sets which medical expenses are reimbursable through an HRA. Within that list, the Trustees can restrict categories of expenses. Other than those exceptions noted within the section of this benefit titled "Ineligible or Non-Qualified Expenses," the Trustees are permitting almost the entire listing of allowable expenses contained within Section 213(d) to be reimbursable. Such covered expenses would include, but are not limited to:

- Abdominal supports
- Abortion
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autollette (when used for relief of sickness/disability)
- Birth control pills (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Contraceptive devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dental treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit

- Guide dog
- Gum treatment
- Gynecologist
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal (in certain cases)
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room cost
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Registered nurse
- Self-payments made timely and only to this Plan
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchair
- X-rays

For more information see IRS Publication 502 for the applicable tax year.

Covered HRA Participants

HRA reimbursements will only be made if the individual was covered under the Plan at the time the expense was incurred.

Crediting - How Your Account Gets Credited

The following rules will apply when calculating an HRA credit.

A. If establishing initial eligibility for the first time or reestablishing eligibility after having lost coverage under the Plan, the Plan will begin to count only those hours in excess of 450 (or the equivalent as stated within section B) earned in the first full calendar quarter after the successive calendar quarter of coverage of initial or reinstated eligibility.

For example. Teresa met her initial eligibility requirement and subsequently became effective to receive benefits on February 1. In accordance to the Plan's eligibility provisions, Teresa would be granted coverage for the remainder of calendar quarter in which she became eligible and for the successive calendar quarter. In this example, Teresa would be provided coverage for February and March, (the remaining calendar quarter) and for April, May and June (the successive calendar quarter.)

The Plan would only tabulate only those hours contributed on her behalf for work she performed under covered employment in July, August and September (the calendar quarter after the successive calendar quarter of initial or reinstated coverage) to determine if credit should be provided to her HRA account.

B. Whether establishing credit for the first time or receiving credit as a matter of continuous employment and/or through reciprocity, all hourly contributions less than the current Local 697 Health and Benefit Plan inside hourly contribution rate in effect at the time the contribution was earned, (or those that are specifically set forth within a collectively bargained agreement or participation agreement,) will be pro-rated to determine if you have met the 450-hour requirement.

When hourly contributions are less than the current I.B.E.W. Local 697 inside journeypersons rate, the following formula will be used to calculate the number of hours needed to be made before the Plan provides any HRA credit.

$$\frac{\text{Hour threshold needed x Local 697 inside journeypersons rate}}{\text{divided by}}$$
$$\text{The hourly rate being contributed}$$

For example, if you were traveling and the Health and Benefit hourly rate within that jurisdiction was $9.62 per hour, the number of hours needed to be contributed prior to any credit being made to your HRA account would be 468. Using this example, the formula would look like as follows:

$$450 \times \$10.00 / \$9.62 = 468$$

C. The Plan will total the amount of employer contributions submitted on your behalf during each work quarter. If you worked greater than four hundred and fifty hours (450) or the equivalent as described above during that work quarter, the hourly rate or value of those "excess" hours will be credited in accordance to the following schedule:

Work Quarter in Which 450 Hours or Greater Were Earned		***Will be Credited in the Following Quarter of Coverage***
January, February, March		July, August, September
April, May June		October, November, December

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

Please note that the middle column is deliberately left blank to emphasis the fact that there exists an administrative "lag quarter" that separates a work quarter from its corresponding quarter of coverage. Meaning: Contributions in excess of 450 hours earned within a work quarter does not get credited in the subsequent calendar quarter of coverage. Rather, it skips a quarter.

D. The balance of your HRA account is solely dependent upon employer contributions. No interest will be credited to your HRA account and participants are not permitted to make self-contributions to the Plan.

E. Provided a participant remains eligible under the Plan, any unused amounts will carry over each quarter and each year. As such there is no "use it or lose it" rule provided you remain eligible for benefits under this Plan.

F. No HRA credits will be provided or credited whenever a participant is receiving loss of time, or short-term disability coverage under this Plan,

Death and/or Disability and Your HRA Account

In the event of your death, the balance in your account can be used by your surviving spouse or eligible dependents for qualified expenses, including the timely payment of this Plans healthcare premium self-payments (subject to the Health and Benefit Plan's eligibility rules).

If you do not have a surviving spouse, nor any eligible surviving dependents, then any balance within your HRA account will be forfeited.

NOTE: Dependent children must satisfy the definition of a dependent child for coverage under this Plan and must be properly enrolled in this Plan in order to receive benefits.

Debit Cards

You will be issued an HRA debit card through the Plan's third-party HRA administrator. Because HRAs are tax-advantage accounts the IRS requires that all debit card transactions be validated or substantiated to confirm that the funds were used for qualified medical expenses.

In most cases the substantiation that the transaction was for a qualified medical expense occurs automatically at the time you use the card. However, some transactions cannot be verified automatically. When a transaction cannot be automatically substantiated, either the Plan or its third-party administrator will request that you submit a copy of the receipt or explanation of benefits of the transaction in question.

Should this occur, participants will be provided a sixty (60) day period of time from the date of the notice to submit the requested supporting documentation. During the ninety-day period

your HRA card will be temporarily be deactivated and remain deactivated until such time within that sixty (60) day period documentation is submitted and deemed appropriate. For this reason, the Plan:

A. Strongly recommends keeping the paper receipts of every debit card purchase you make. And,

B. Reminds all participants that the "R" in "HRA" stand for reimbursement. Meaning; debit cards are not to be used for the prepayment of any out-of-pocket expense associated with any service, treatment or durable medical goods.

Regarding documentation, whether a receipt, an invoice, an explanation of benefits or itemized bill, all receipts must include the name of the patient, the providers name, the service or item being paid for, the date of the transaction and the dollar amount. If being used for prescribed over-the-counter medication, you must also include a letter of medical necessity detailing the condition being treated, medication and dosage and duration of treatment. Letters of medical necessity must be renewed every year.

Additionally, IRS rules state that the debit card can only be used at locations when the retailer or professional uses a certain type of medical coding. If your medical provider does not have these merchant category codes your card may be declined. However, you can still submit your reimbursement request if purchasing a qualified item or service through the Plan's third-party HRA administrator website. In many cases by using your debit card your purchase can be automatically substantiated by the HRA third-party administrator.

Debit Card Termination and Warning

The issuance and use of a debit card are not a right under this Plan. Rather it is a privilege. As such, should you:

1. Misuse the card or,
2. Fail to submit any requested documentation during that sixty (60) day period,

Your debit card will be permanently deactivated and going forward you will have to submit claims manually. Further:

3. If you lose eligibility under this Plan, your HRA debit card will be deactivated. You will have sixty (60) days to submit claims for reimbursable expenses that:

    a) Were incurred while a covered participant under this Plan, and

    b) Were incurred no more than three hundred and sixty-five days prior to the date of termination of eligibility.

HRA Website

Participants are encouraged to utilize the third-party administrators secured website whenever they wish to view their HRA balance, upload receipts, inspect the status of a payment or to report a lost or stolen debit card. As always, the Fund Office is available to help you and to answer your questions.

Ineligible or Non-Qualified Expenses

The Plan has determined several expenses to be ineligible or non-qualified for the Plan to provide reimbursement. These expenses would include, but are not limited to the following items:

- Acne treatments
- Advancement of payment for services to be rendered next
- Any expense or charges paid by any healthcare plan or third-party payor
- Any expense submitted and/or incurred during periods of non-eligibility
- Athletic club membership
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Bottled water
- COBRA payments
- Commuting expenses of a disabled person
- Cosmetic surgery and procedures
- Cosmetics, hygiene products and similar items
- Dietary supplements
- Educational Expenses
- Environmental control devices such as air purifiers and humidifiers
- Exercise equipment
- Fiber supplements
- Funeral, cremation, or burial expenses
- Health programs offered by resort hotels, health clubs, and gyms
- Herbs
- Hot tubs
- Household help
- Illegal operations and treatments
- Illegally procured drugs
- Lip balm (including Chapstick or Carmex)
- Maternity clothes
- Medicated shampoos and soap
- Non-prescription medication
- Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Scientology counseling
- Self-payments made after your coverage has been terminated.
- Social activities
- Special foods and beverages
- Specially designed car for the handicapped other than an autolette or special equipment
- Stop-smoking programs
- Suntan lotion
- Swimming pool
- Toiletries (Including toothpaste)
- Travel for general health improvement
- Tuition and travel expenses for a problematic child to attend a particular school
- Vitamins (daily)
- Weight loss programs and drugs for general well-being

For more information see IRS Publication 502 for the applicable tax year.

Losing Your HRA Balances

Participants who cease to be covered under this Plan are not permitted:

a) To use any HRA balances for reimbursements of services incurred after they have lost coverage;
b) To use any HRA balances to make COBRA payments
c) To use any HRA balances to make self-payments.

Should you lose eligibility, you will have sixty (60) days from the date of termination to manually submit out-of-pocket expenses that were incurred while you were covered under the Plan. After sixty (60) days, any remaining balances within a participants HRA account will be forfeited.

Warning:

(1) Forfeited balances will remain surrendered and will not be re-established. This includes scenarios where the participant has earned reinstatement of coverage in a subsequent coverage quarter or even the month following his or her loss of eligibility.

(2) The Plan's timely submission of claims policy also apply to HRA reimbursement request submissions. Consequently, requests for HRA reimbursements that exceed twelve months prior to the date of termination of coverage will not be paid.

Opting Out of the HRA Program.

The Affordable Care Act allows Plan participants or their surviving dependents an opportunity to permanently opt out of the HRA plan (so they can seek subsidized coverage through a health insurance exchange). Therefore, you may opt out of the HRA program at any-time, but you must do so by notifying the Plan in writing. If you opt out, the balance in your account is forfeited and you waive the right to future credits and reimbursements.

Participants may re-establish participation within the HRA program by notifying the Fund Office in writing of their desire to do so. However, all previous forfeited balances will remain surrendered and will not be reestablished. Further, accumulations toward future balances will be based upon the employer contributions received after written notification of your desire to re-establish participation is obtained by the Plan.

Retirement and Your HRA

If you retire and remain covered under this Plan, your HRA account will continue to exist and you may use it to cover your self-payment premiums or for reimbursements on other HRA covered expenses.

Self-Payments of Your Health and Benefit Plan Insurance Premiums

Participants that owe the Plan a self-payment as a result of a shortage of hours or to continue their retiree coverage under the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan, can utilize any available HRA monies to make that payment.

Whenever instructing the HRA third-party administer to make a self-payment on your behalf, make certain that your instructions are provided with sufficient time for the payment to get to the Fund Office by the close of business on the first business day of the month. Payments not received by the due date will result in the termination of your eligibility in the Plan.

Submitting HRA Claims.

While a covered participant under this Plan, HRA claims must be submitted no more than twelve (12) months after the date the charge was incurred.

Warning:

The HRA account is a Plan benefit. As such, all HRA accounts are notional, are not vested and subject to change. Meaning: Amounts in a participant's account remain general assets of the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan. Consequently, participants are not vested in the balances within their accounts.

Should your eligibility be terminated, you will no longer have the ability to use any HRA monies to make self-payments and your HRA debit card will be frozen. However, and with the exception of being able to use those monies to make self-payments, you will have sixty (60) days to manually submit unpaid medical expenses that were incurred during the time of coverage under this Plan for reimbursement. After that sixty (60) day period, any monies left within your HRA will be forfeited.

Participants are reminded that both the allowable expenses and maximum allowances can change, and that the Trustees reserve the right to eliminate or modify this benefit at any time and at their sole discretion.

HEARING AID BENEFIT

The Plan provides a $1,500.00 hearing aid benefit per participant, payable toward your covered hearing aid expenses once every three calendar years.

The Plan defines a "hearing aid" as a wearable instrument designed for the ear for the purpose of compensating for impaired hearing. It excludes other assisted listening devices such as amplifiers and FM systems.

Warning: No payment will be made for:

1. Hearing examinations or hearing aids required by an employer in connection with the person's occupation.
2. Charges for rental or purchase of amplifiers.
3. Replacement of a hearing aid due to theft, loss or any other reason within three consecutive years of purchasing and receiving the hearing aid.

HEARING EXAM BENEFIT

The Plan covers a hearing examination recommended by a physician and performed by an audiologist or certified hearing specialist once every two years.

Charges or fees for:

- Hearing exams performed by a participating provider will be subject to the deductible and payable at 90% of the negotiated rate.

- Hearing exams performed by non-participating provider will be subject to the deductible and payable at 70% of the Plan's Reasonable and Allowed Amount. (RAA)

Warning: The Fund will not pay for:

- More than one examination in a two-consecutive calendar year period.
- Charges made by a speech pathologist or any charges for speech therapy, speech readings or lessons in lip reading.

HIPAA PRIVACY

The following notice describes how the Plan uses and discloses a participant's personal health information. It also describes certain rights the participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling the Fund Office.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. For health care operations.
3. For treatment purposes.
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Establish safeguards for information, including security systems for data processing and storage.
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
6. Not use or disclose genetic information for underwriting purposes.
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528).

12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
13. Train employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    c. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third-Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain

and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the participant's information.
3. Other Covered Entities: The Plan may disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.
    b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration (FDA) or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities.
    c. Locate and notify persons of recalls of products they may be using.
    d. A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law.
3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect, when required or authorized by law, or with the participant's agreement, if the Plan reasonably believes he or she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal

investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the participant of the request or to obtain an order protecting such information and done in accordance with specified procedural safeguards.
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the participant's PHI in response to a law enforcement official's request if he or she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years.
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
11. Military and National Security: The Plan may disclose PHI to military authorities or armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a participant most of the PHI in a Designated Record Set when the participant requests access to this information. The Plan will disclose a participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the participant's personal representative if it has a reasonable belief that the participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the participant.

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed from Participants Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes.
2. Uses and disclosures for marketing.
3. Sale of PHI.
4. Other uses and disclosures not described in this section can only be made with authorization from the participant. The participant may revoke this authorization at any time.

Participant's Rights

The participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. Right to Receive Notice of Privacy Practices: The participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.

4. Accounting of Disclosures: The participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the participant of the basis of the disclosure, and certain other information. If the participant wishes to make a request, please contact the Privacy Officer.

5. Access: The participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the participant, their signature notarized and the recipient

must be clearly identified. The Plan must respond to the participant's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the participant's request. If the Plan denies the request, the participant may be entitled to a review of that denial.

6. Amendment: The participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.

7. Fundraising contacts: The participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

Patrick Keenan - Fund Manager
The Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan
7200 Mississippi Street
Suite 300
Merrillville, IN 46410

HOME HEALTH SERVICES

Precertification is required.

The Plan provides benefits for home health services provided in the home or other outpatient setting. Covered Services are limited to the following physician-prescribed home health services:

1. Part-time or intermittent skilled nursing care performed by a licensed nurse;

2. Physical therapy, occupational therapy, or speech therapy. Such services must be received as an alternative to inpatient confinement in a hospital, skilled nursing facility, or would have been covered if rendered outside the home;

Home health care must be provided in accordance with a home health care plan ordered by your physician.

The Plan may also cover other home health care services under its regular covered medical expense provisions. For example, the Plan may cover medical supplies and rental of durable medical equipment when provided by the home health agency.

Participating provider charges will be subject to the deductible, and payable at 90% of the Reasonable and Allowed Amount (RAA).

Non-participating provider charges will be subject to the deductible and payment will be made at 70% of the Funds Reasonable and Allowed Amount (RAA).

Warning: Covered services do not include meals delivered to your home, custodial care, companionship, or homemaker services

HOSPICE CARE

A hospice program provides pain relief and other support services for terminally ill people.

You can get hospice care as long as your doctor certifies that you are terminally ill and probably have less than six months to live. Should you be receiving hospice care longer than six months, the Plan will require that your condition to be re-evaluated and continuing hospice care to be certified through the Plan's disease and case management program.

To receive this benefit, your doctor must certify that you are terminally ill. A period of care starts the day you begin to get hospice care. It ends after the 180-day period is up.

Hospice care services must be administered by an agency that meets this Plan's definition of "Hospice."

Covered hospice care services shall include:

A. Outpatient services,
B. Medical supplies, bandages and equipment.
C. Drugs and biologicals used for pain and symptom control.
D. Professional services of a:

    a. Physician,
    b. R.N.,
    c. L.P.N.,
    d. Home health aides (such services may be furnished on a 24-hour basis during a period of crisis or if the care is necessary to maintain the patient at home) and
    e. Services of a psychologist, social worker, or family counselor for individual and family counseling.

Covered hospice care services do not include the following:

1. Services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house;

2. Services or supplies not listed as covered within this provision;

3. Services for curative or life prolonging procedures;

4. Services or supplies that are primarily to aid you or your dependent in daily living;

5. Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins, or minerals.

Participating provider charges will be subject to the deductible, and payable at 90% of the Reasonable and Allowed Amount (RAA).

Non-participating provider charges will be subject to the deductible and payment will be made at 70% of the Funds Reasonable and Allowed Amount (RAA).

HOSPITAL BENEFITS

Precertification is required for all inpatient care and any inpatient or out-patient surgeries.

NOTE: **Referenced Based Price:** The maximum Reasonable and Allowed Amount paid by this Plan for inpatient or outpatient hospital services is based on a reference-based price. Reference-based pricing works by reimbursing hospitals based on objective criteria; most commonly the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital, and a savings to the Plan

The Plan provides benefits for inpatient services at a hospital for evaluation or treatment of conditions that cannot be adequately treated in an outpatient setting.

Covered services and supplies include, but are not limited to services and supplies for:

1. Blood and the administration of blood and blood product;
2. Emergency rooms and their equipment and supplies, dressings, splints, and casts;
3. Electroshock or drug-induced shock therapy;
4. General nursing care;
5. Operating and treatment rooms and their equipment;
6. Other inpatient or outpatient hospital services and supplies furnished to a person which are required for treatment of the person's medical condition;
7. Semi-private room and board, and private room accommodations when only a private room is available.

Participating Facilities, Hospitals and Urgent Care Centers

Area hospitals and their affiliated facilities that have directly contracted with the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan are called participating facilities. These entities have agreed to accept a percentage of the Plan's determination of the Reasonable and Allowed Amount as payment for any covered procedure, treatment or service.

There exist three levels of participating facilities. They are as follows:

1. **Level A**. Level A facilities are hospitals and their affiliated facilities that have agreed to accept 100% of the Plan's determination of the Reasonable and Allowed Amount as

reimbursement for a covered service. Meaning, these entities will not balance bill you for any covered facility fees, services or supplies that are more than the contracted rate. The Plan does not apply its annual deductible requirement against claims from level A facilities.

2. **Level B**. Level B facilities are those hospitals and their affiliated facilities that have agreed to accept 90% of the Plan's determination of the Reasonable and Allowed Amount or contracted rates. Participants will not be billed for amounts more than the negotiated rate for covered services, but they will be responsible for the remaining 10% balance AND any annual deductible amounts that have not been previously satisfied.

3. **Level C**. Level C facilities are those facilities that are non-designated. Meaning: They consist of all non-level A and non-level B designated hospital and related hospital facilities. Level C facility claims will be paid in accordance to the following formula:

   70% of 130% of this Plan's Reasonable and Allowed Amount.

   Participants who utilize level C hospitals and related facilities will be responsible for the payment of their annual deductible as well as any amounts that exceed the Plan's payment.

   The Plan may, at its sole discretion, negotiate a payment with a level C facility.

A listing of the current level A and level B facilities, hospitals and urgent care centers can be found on the Plan's website: www.ibew697benefits.com.

Emergency Treatments Received at a Non-Designated Facility, Hospital or Urgent Care Facility.

Emergency room services received within a non-designated facility, hospital or urgent care facility will be paid in accordance to the following methodology:

90% of the averaged level B Reasonable and Allowed Amount reimbursement percentage.

The patient will be responsible for his or her deductible as well as the 10% coinsurance of the allowable amount.

Emergency Room Fees for Conditions that are Non-Emergency or that Do Not Meet This Plan's Definition of an Emergency.

Services, treatments and procedures that are neither an emergency nor meet this Plan's definition of an "emergency" will be paid in accordance to the following formula:

70% of 130% of this Plan's Reasonable and Allowed Amount.

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Warning: This will result in the patient being responsible for any unmet deductible charges, the 30% coinsurance AND any charges more than the allowable amount.

When Patient Is Stabilized?

These rules apply only until the patient's medical condition has been stabilized. If the patient stays at the non-designated facility or hospital after that, the allowable charges will be paid in accordance to the following formula:

70% of 130% of this Plan's Reasonable and Allowed Amount.

Warning: This could result with the patient being responsible for charges more than the allowable amount in addition to your deductible and the 30% coinsurance.

Specialty Care - In rare cases the Plan's review organization may determine that a patient's complex, severe and life-threatening medical condition requires specialized care at a non-designated facility that is equipped to provide that care. In such cases, the Plan will pay the covered expenses incurred for that treatment as if the facility was a Level B designated facility. The patient will be responsible for the deductible and 10% of the balance of the fee negotiated by the Plan. Like all inpatient care and surgeries, these cases must be pre-approved by the Plan's review organization.

Warning:

- The maximum Reasonable and Allowed Amount for inpatient or outpatient hospital services is based on a reference-based price.
- All admissions, except maternity and emergency admissions, must be approved in advance by either the Plan or its assigned review organization. Notification of emergency and maternity admissions must be made within 48 hours of the admission or as soon as reasonably possible.
- Emergency room services that do not meet this Plan's definition of an emergency will be paid at 70% of 130% of the Plan's Reasonable and Allowed Amount.
- Follow-up treatment will always be subject to the normal rules. If it is provided at a non-designated facility, hospital or urgent care center, it will **NOT** be paid like a designated hospital claim.
- The fact that a patient prefers to use a certain hospital, such as a teaching hospital, does not make it qualify as specialty care under this provision. This exception will apply only when the patient has a severe life-threatening condition requiring care that is so complex and specialized that it cannot be provided at a designated facility.
- Deductibles are waived only for level A facility claims. Co-insurance associated with any professional (i.e., doctors, surgeons, radiologists, anesthesiologist, pathologists, and emergency room physician's) charges will apply.
- Personal care or convenience items are not covered.

HOUR BANK

On October 1, 2018, balances within an employee's hour bank were combined with whatever balance existed within their MRP account to create the HRA.

Please reference the section of this book titled "Health Reimbursement Arrangement (HRA) for information concerning how you can utilize HRA monies to pay for any shortage of hours you may have incurred.

IMMUNIZATIONS

The Plan will cover immunizations that have been approved by the Center for Disease Control Prevention (CDC) and the U.S. Department of Health and Human Services.

When immunizations are provided by a participating provider, charges will be payable at 90% of the Reasonable and Allowed Amount (RAA).

When immunizations are provided by a non-participating provider, charges will be subject to the deductible and payment will be made at 70% of the Funds Reasonable and Allowed Amount (RAA).

Warning: The cost of travel related immunizations is not covered by the Plan.

INFANT FORMULA

Precertification required. The Plan will cover specialized infant formula for a child with an inborn error of metabolism. Inborn errors of metabolism are specific rare inherited conditions, such as PKU, that can be diagnosed with standard diagnostic tests. If the Plan's criteria are met, coverage will be provided for up to $250.00 per month to a maximum of 12 months.

Formula charges;

- Provided by a participating physician will be subject to the deductible and payable at 90% of the Reasonable and Allowed Amount (RAA).

- Provided by non-participating physician will be subject to the deductible and payable at 70% of the Plan's Reasonable and Allowed Amount (RAA).

Warning: The Plan does not consider maldigestion or intolerance to lactose, gluten, fat, soy or protein to be inborn errors of metabolism. As such, formula charges for formula utilized for those reasons are not covered by the Plan.

INFUSION THERAPY

Infusion therapy is the administration of drugs or nutrients using specialized delivery systems which otherwise would have required you to be hospitalized.

Precertification is required if the pharmaceutical cannot be obtained through this Plans pharmaceutical / drug program.

The Plan provides benefits for infusion therapy services and supplies only if the following criteria are met:

1. If you did not receive infusion therapy at home or in your physician's office, you would have to receive such services in a hospital or skilled nursing facility;

2. The services are ordered by a physician and provided by an infusion therapy provider or physician licensed to provide such services; and

3. Services are approved in advance by the Plan or its designated disease and case management provider.

NOTE: Most self-injectables are processed under this Plan's pharmaceutical benefit; however, and if approved by the Plan, selected self-injectables may be processed under your medical benefit.

If administered by a participating provider, charges will be subject to the deductible, and payable at 90% of the Reasonable and Allowed Amount (RAA).

If administered by a non-participating provider, charges will be subject to the deductible and payment will be made at 70% of the Fund's Reasonable and Allowed Amount (RAA).

LEGAL GUARDIANSHIP

The Plan uniformly extends eligibility to children for whom the participant or spouse is a legal guardian.

Legal guardianship requires a court order. As such, any child who lives with the participant, or whom the participant supports financially, is not in a legal guardianship relationship absent such a court order.

The child will become covered under this Plan on the day after the Plan receives a properly completed enrollment form and a copy of the court order or after the Plan receives a properly completed enrollment form and on the assigned day the court decrees, whichever is the latter.

Warning:

A. Missing, incomplete or the untimely completion and/or untimely submission of the enrollment form and court order will result in your dependents not being able to claim benefits from this Plan.

B. The participant will be able to cover the child for only the period during which they are the legal guardian. When the guardianship court order expires or is terminated, the child will lose active coverage. When that occurs, the child will experience a qualifying event and will be offered to continue coverage through COBRA on the date the guardianship ends.

LIFE INSURANCE BENEFIT

The Lake County Indiana NECA – I.B.E.W., Health and Benefit Plan life insurance benefit is provided under a group term life insurance policy issued by a life insurance company selected by the Trustees. Benefit payments are governed by the terms of the insurance policy. If there is an inconsistency or question of interpretation between the policy and this booklet, the terms of the policy will prevail.

Life insurance benefits will be paid the deceased participant's beneficiary(ies) for:

- A deceased employee that was actively working and covered under the Plan at the time of his death, or
- A deceased retired participant, under the age of sixty-five (65) who was covered under this Plan at the time of his death.

Benefit amounts are as follows:

COVERED INSURED	AGE	PAYMENT AMOUNT
ACTIVE EMPLOYEE	< = 69	$15,000.00
ACTIVE EMPLOYEE	70 < 74	$6,750.00
ACTIVE EMPLOYEE	75 < 79	$4,500.00
ACTIVE EMPLOYEE	80>	$3,000.00
RETIRED EMPLOYEE	< = 65	$15,000.00

Warning:

No benefit payment:

1. Will be made if the employee was not covered under the Plan at the time of death;
2. Will be made if the employee was covered under the COBRA provision of this Plan; or
3. Will be made to beneficiaries of retirees over the age of sixty-five (65). The beneficiary or beneficiaries of deceased retirees over the age of sixty-five (65) and who are on file with the Local 697 I.B.E.W. and Electrical Industry Pension Fund, are entitled to that Plan's death benefit. To find out more about that benefit, please reference that Plan's Summary Plan Description Book or contact the Fund Office.

Your Beneficiary

If you die while eligible for life insurance, your death benefit will be payable to the person you have named as your beneficiary(ies). If no beneficiary is on record, the proceeds of the policy will be paid as follows:

1) As decreed within a court order.

2) In the absence of a court order, benefits will be paid in the following order:

   a. Your spouse,
   b. Your children,
   c. Your parents,
   d. Your brothers and sisters, or
   e. Your estate.

In order for your beneficiary to receive this benefit, a certified copy of your death certificate and a completed application must be submitted to the Fund Office within twelve months after the date of your death.

LOSS OF TIME CREDIT

If you are receiving a short-term disability benefit from this Plan, you will be credited with up to a maximum of forty (40) weekly disability loss of time hours per week toward your Health and Benefit Plan eligibility until the earlier of the date you are no longer totally disabled or the end of your short-term disability benefit period.

The amount of weekly disability Health and Benefit Plan loss of time hours to be credited will be calculated by the following formula:

40 Hours - # of eight (8) hour days worked = # of weekly disability loss of time hours credited toward your Health and Benefit Plan.

Applying for Loss of Time Benefits

When you apply for short-term disability benefits, you are also applying for loss in time benefits. In accordance to the short-term disability provisions of this Plan, you and your physician must complete the Plans short-term disability claim form in which you both attest and certify that you are under the continuous care of a licensed physician and that you are unable to work. A properly completed claim form must be submitted within thirty days of the initial accident or injury or thirty days of the onset of the illness.

Unless you are receiving state unemployment benefits your total disability must commence while you are actively working in covered employment, or while you are on the active payroll of a contributing employer OR:

a. In the case of a disability caused by an accidental injury you must file: (1) within14 days after the date of termination, (2) within 14 days of your lay-off or (3) within 14 days of the last date of work prior to a vacation; or

b. In the case of a disability caused by an emergency illness, you must file: (1) within 72 hours after the date of termination, (2) within 72 hours of your lay-off or (3) 72 hours of the last date of work prior to a vacation.

Exclusion and Limitations

No loss of time benefits will be paid for any of the following:

1. An occupational injury or disease, arising out of, or as a result of any second job outside of the scope of the Local 697 collective bargaining agreement; from any activity for profit or wage, or any self-employment.

2. During any period in which you were not receiving this Plan's short-term disability benefit.

3. During any period for which you are not under the direct care of a physician who is an M.D. or D.O.

4. During any period for which you received:

    - Social Security retirement or disability benefits;
    - Unemployment compensation;
    - Any Pension benefits.

5. Any period of disability after this Plan's short-term disability benefits have been paid.

Warning:

1. If you became disabled while receiving any unemployment compensation benefits and subsequently were awarded this Plan's short term disability weekly benefit(s), you will not be credited with any weekly disability loss of time credits.

2. If you are awarded a Pension benefit of any type, including a Social Security Disability award, any loss of time credits for any period of time on or after the day your retiree benefits became effective will be reversed.

   Participants are advised that the reversal of loss of time credits may affect the amount of any required monthly self-pays.

Extending Loss of Time Benefits

Individuals who find themselves totally disabled after receiving twenty-six weeks of loss of time benefits may apply for up to another twenty-six weeks of coverage under the Plans short-term disability benefits provision. The maximum amount of time that a participant may extend their loss of time benefit is 26 weeks within any period of 52 consecutive weeks.

In order to receive these benefits, you must:

- Be unable to work.
- Be under the continuous care of a licensed physician who must certify that you are unable to work.
- Have applied for a Social Security Disability. And,
- Have fully completed a short-term disability application at the onset of the second period of 26 weeks of disability.

Successive periods of disability separated by less than two weeks of covered employment will be considered as one continuous period of disability unless they are from different and unrelated causes.

MANIPULATIVE THERAPY

Manual therapy, or manipulative therapy, is a physical treatment primarily used by physicians licensed as a Doctor of Osteopathic Medicine and medically necessary physical therapy services your physician orders to treat musculoskeletal pain and disability; it includes kneading and manipulation of muscles, joint mobilization and joint manipulation

The maximum payable for all manipulation therapy performed by a doctor or physical therapist is $40.00 per visit. All therapy rendered on the same day will be considered one visit. Meaning;

if more than one type of therapy is provided during a visit, the maximum the Plan will allow is $40.00 for that day's treatment.

Participating provider charges will be subject to the deductible, and the annual out-of-pocket maximums and payable at 90% of the negotiated rate up to the maximum of $40.00 for manipulations, adjustments or other services and treatments received.

Non-participating provider charges will be subject to the deductible and payment will be made at 70% up to the Fund's maximum Reasonable and Allowed Amount (RAA) of $40.00 for either manipulations, adjustments or other services and treatment received.

MARRIAGE

Provided you enroll your spouse within thirty (30) days from the date of your marriage, your spouse will be automatically eligible for coverage effective as of the date of your marriage. To enroll your spouse, you must submit:

- A completed enrollment form,
- Your marriage certificate, which has been certified by the state in which you were Married,
- A copy of your spouse's Social Security card, and
- A copy of your spouse's birth certificate.

Warning : Claims cannot be paid until you provide proof of dependency.

Further, if both you and your spouse are covered as participants, you and your spouses' health care coverage will be coordinated so the Plan will not pay more than 100% of the covered expenses for services and supplies

MASTECTOMY

Precertification is required for this benefit and any case management assistance will be provided in consultation with the participant and her attending physician.

Covered professional charges will be paid as follows:

- Mastectomies performed by a participating provider will be subject to the deductible and annual out-of-pocket expense and payable at 90% of the Reasonable and Allowed Amount (RAA).

- Mastectomies performed by non-participating provider will be subject to the deductible and annual out-of-pocket expense and will be paid at 70% of the Plan's Reasonable and Allowed Amount (RAA).

The federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, requires group health plans that provide mastectomy coverage to also cover breast reconstruction surgery and prostheses following mastectomy.

As required by law, the participant is being provided this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a medically necessary

mastectomy will also receive coverage for the following in a manner determined in consultation with the attending physician and the patient:

1. Reconstruction of the breast on which the mastectomy has been performed.

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

3. Prostheses and physical complications from all stages of mastectomy, including lymphedemas.

MATERNITY BENEFITS

The Plan provides benefits for maternity services. Covered services are limited to pre-natal, obstetrical and postpartum services in a hospital for employees and their spouses only.

A participant who is eligible for maternity benefits and her newborn infant are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarian section.

Covered charges will be paid as follows:

- Maternity benefits provided by a participating physician will be subject to the deductible and payable at 90% of the Plan's Reasonable and Allowed Amount (RAA).

- Maternity benefits performed by non-participating physician and or a licensed midwife will be subject to the deductible and payable at 70% of the Plan's Reasonable and Allowed Amount (RAA).

Warning:

A. The Plan does not cover pregnancy-related expenses for dependent children.
B. The Plan does not cover services provided by a doula.
C. The Plan does not cover services provided by a non-licensed nonregistered nurse mid-wife or for mid-wife services provided by a relative.
D. The Plan does not cover mid-wife in-home deliveries.
E. The Plan does not cover deliveries performed in another location other than a hospital or a birthing center that is:

    a. Part of or run by a hospital.
    b. A freestanding facility that is licensed, staffed by registered nurses and the delivery is supervised by an obstetrician.

MEDICAL CHILD SUPPORT ORDERS

Please refer to the section of this document titled "Qualified Medical Child Support Orders."

MENTAL AND NERVOUS DISORDERS

Precertification is required.

The Plan provides benefits for the treatment of mental and nervous disorders.

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 and will pay for only those services deemed medically necessary and which are delivered within the lawful scope of the licensed provider.

Covered providers include:

A. Community mental health centers or clinics
B. Hospitals
C. Licensed clinical social workers
D. Licensed professional counselors
E. Physicians
F. Psychologists
G. Psychiatric residential and nonresidential treatment facilities

The types of services covered are as follows:

- Group therapy
- Inpatient
- Intensive out-patient
- Office
- Out-patient
- Partial in-patient
- Residential

The Plan will only pay for the services rendered by participating providers or within participating facilities. Residential treatment must meet the following criteria:

1. The facility must meet the definition of an approved "residential treatment facility" as defined by this Plan; and,

2. The confinement must be pre-certified by the Plan or its review organization.

Participating provider charges will be subject to the deductible, and payable at 90% of the negotiated rate.

Warning: Services and/or treatment not pre-certified will not be covered by the Plan.

MILITARY LEAVE

Eligibility Freeze - If you leave employment with a contributing employer to enter active duty in the uniformed services of the United States for at least 30 days, any hours you have accumulated will be frozen during your period of active duty. After your release from active duty under circumstances entitling you to reemployment under federal law, your eligibility and accumulated hours will be reinstated on the date you return to work with a contributing employer, provided your return to work is within the time prescribed by federal law.

Self-Payments - You may also choose to make self-payments for continued coverage for up to 24 months, regardless of any coverage provided by the military or government. You can make self-payments while you are in the military to keep your dependents covered by this Plan, and you also make self-payments upon your return if you need to do because your frozen eligibility

is insufficient to reestablish coverage. However, the maximum period for which you can self-pay is 24 months during your entire military leave. You are only entitled to make these self-payments if you are covered under the Plan but leave covered employment for active duty in the U.S. military for at least 30 days. The payment amounts, rules and provisions for continued coverage during military leave are the same as COBRA coverage. It is your responsibility to contact the Fund Office if you want to make self-payments during or after your military leave.

For Additional Information

For more information about your self-payment rights during military service, contact the Fund Office.

For more information about the re-employment rights of persons returning to work from the uniformed services of the United States contact the Veterans' Employment and Training Administration of the United States Department of Labor.

MRP

On October 1, 2018, balances within an employee's MRP account were combined with any balances within your hour bank to create the HRA.

Please reference the section of this book titled "Health Reimbursement Arrangement (HRA)" for information concerning how you can utilize HRA monies to pay for unpaid dental, medical, pharmaceutical, shortage of hours expenses and vision expenses you may have incurred

NEWBORN CARE

Care for newborns include preventive health care services, routine nursery care, circumcision and treatment of disease and injury. Treatment of the latter includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities, which cause anatomical functional impairment.

Participating provider charges will be subject to the deductible, the annual out-of-pocket maximum and payable at 90% of the Plan's Reasonable and Allowed Amount.

Non-participating provider charges will be subject to the deductible, the annual out-of-pocket maximum and payable at 70% of 130% of the Plan's Reasonable and Allowed Amount.

OCCUPATIONAL DISEASE, ILLNESS OR INJURY

For the sole purpose of identifying workers' compensation claims that are not truly the obligation of the Welfare Fund, certain conditions, illnesses, procedures and therapies have been flagged. If the Health and Benefit Plan identifies one of these flagged items on a medical claim that was submitted on your behalf, adjudication of the claim will cease, and the Plan will forward to the participant a verification letter to confirm that the services rendered were not work related.

If the claim is not work related, complete and return the form. After receipt of the verification letter, adjudication on the claim will commence. If the claim is work related, then you will need to file a workers' compensation claim with your employer.

Should the Fund not receive the completed form within ninety (90) days of the date of issuance of the notice, the claim will not be paid. Payment for the services rendered will be the responsibility of the participant.

Claimants are reminded that they will be subject to the rules and provision of this Fund's Fraud and Abuse policy for any misrepresentations.

OTHOTIC DEVICES

The Plan will only cover orthotics when all of the following criteria are met:

1. The orthotic device is medically necessary to support or aid in the treatment of an illness or injury;

2. It is prescribed by a qualified physician.

3. Precertification is obtained.

Plan Payment

- Orthotic devices provided by a participating provider will be subject to the deductible and payable at 90% of the Plan's Reasonable and Allowed Amount (RAA).

- Orthotic devices provided by non-participating provider will be subject to the deductible and payable at 70% of the Plan's Reasonable and Allowed Amount (RAA).

Spring-loaded orthotic devices are eligible for coverage when the patient is not responding favorably to conventional methods for restoring joint motion such as exercise and/or physical therapy.

Static progressive stretch devices are eligible for coverage when the patient is not responding favorably to conventional methods for restoring joint motion such as exercise and/or physical therapy.

Continued coverage for orthotic devices is eligible when significant measurable improvement in joint range of motion is being made while using the device, but not to exceed three months (see "When Not Covered" section below.)

All medically necessary supplies, adjustments, repairs or replacement of covered orthotic devices are eligible for coverage.

Replacement of the orthotic is generally provided under the following conditions:

• After the device's normal life span; or

• Following malfunction of the device; or

• For growth adjustments.

Custom Foot Orthotics are considered medically necessary when all of the following criteria are met:

1. The custom foot orthotics are prescribed by a qualified physician; and

2. The orthotic device is medically necessary to support or aid in the treatment of an illness of injury, as described below:

- When there is a primary diagnosis of foot pain or a primary diagnosis of a foot condition (e.g., plantar fasciitis, pes planus, pes cavus) provided that:

    a) Documented objective clinical findings clearly link the prescription of custom foot orthotics to the primary diagnosis and/or chief complaint; AND

    b) The prescription of custom foot orthotics is consistent with the goals of the treatment plan.

- In the absence of a primary diagnosis of foot pain or a foot condition as described above, custom foot orthotics may be medically necessary when provided concurrent with Chiropractic Manipulative Therapy, provided:

    a) Documented objective clinical findings clearly link the prescription of custom foot orthotics to the primary diagnosis and/or chief complaint; AND

    b) The prescription of custom foot orthotics is consistent with the goals of the treatment plan.

- The clinical record provides evidence the foot orthotics have been customized from a mold or scan of the patient's foot.

- There is clear, clinical documentation indicating non-custom foot orthotics are not appropriate for the condition or injury.

Replacement of Custom Foot Orthotics Medically necessary replacement of custom foot orthotics is generally provided under the following conditions:

• Following malfunction of the device; or

• After the device's normal life span, provided there are objective clinical findings clearly linking the replacement of custom foot orthotics to the patient's current primary diagnosis and/or chief complaint; or

• For growth adjustments, provided there are objective clinical findings clearly linking the replacement of custom foot orthotics to the patient's current primary diagnosis and/or chief complaint.

Warning:

Orthotics are not covered if they are considered to be not medically necessary under the following circumstances:

1. Orthotics that are not prescribed by a qualified physician are not covered.

2. Spring-loaded orthotics and static progressive stretch devices are not covered when conventional methods of treating a stiff or contracted joint have not been attempted.

3. Spring-loaded orthotics and static progressive stretch devices are not covered for longer than 3 months of use.

4. Upgraded splints or orthotics including but are not limited to: decorative items; functionality or features beyond what is required for management of the patient's current medical condition are not covered.

5. Over the counter support devices are not eligible for coverage.

6. Elastic stockings and garter belts are not eligible for coverage.

7. Orthopedic shoes are not eligible for coverage unless one or both shoes are an integral part of a leg brace.

8. Orthotic devices are not covered for sport-related activities (example: a knee brace to prevent injury to the knees while playing football). However, an orthotic would be covered for the treatment of the initial, acute, sports-related injury.

9. Foot orthotics are considered not medically necessary when the criteria listed above have not been met.

10. Thoracic-lumbo-sacral orthotics incorporating pneumatic inflation are considered investigational.

11. Patient-controlled serial stretch devices, such as the ERMI Flexionater® and the ERMI Extensionater® are considered not medical necessary.

12. Custom made orthotic devices are not medically necessary unless there is clinical documentation indicating that a non-custom-made orthotic device is not appropriate for the condition or diagnosis

ORTHODONTIA

The Plan allows up to a per-person per-lifetime benefit allowance of $2,000.00 for orthodontia. However, benefits paid for orthodontia apply to the family's $2,000 annual dental benefit maximum, as well as to the person's $2,000 lifetime orthodontia maximum.

PARTICIPANT OBLIGATIONS

It is the participant's obligation at all times to:

1. Notify the Plan immediately of any life event that would affect their or their dependents' eligibility to receive benefits and/or accurately and correctly receive benefits from this Plan. Such life events would include, but is not limited to, participation in or coverage through another insurance program, the cessation of coverage in or through another insurance program, marriage, divorce, separation, birth, adoption, and death.

2. Without delay, to provide the Plan with the pertinent information needed to accurately and correctly determine their eligibility or the eligibility of any of their dependent(s).

3. Notify the Plan immediately of any change that would affect the Plan's ability to communicate properly with them or their eligible dependents. Such changes would

include, but is not limited to, a change in residence, a new e-mail address, or a change in a home or mobile phone number.

4. To take such action and execute such documents as the Plan may require in order to determine their and their dependents' annual and on-going participation within the Plan and/or to determine and coordinate the payment of benefits when covered by another insurance or health plan entity.

5. To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information needed to adjudicate a claim or to seek reimbursement.

6. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

7. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

8. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

9. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

10. To not settle or release, without the prior consent of the Plan, any claim to the extent that the participant may have against any responsible party or coverage.

11. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

12. In circumstances where the participant is not represented by an attorney, instruct the insurance company or any third party from whom the participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

13. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and participant over settlement funds is resolved.

PARTICIPANT'S RIGHTS

As a participant in the Plan, the participant is entitled to certain rights and protections under ERISA. ERISA provides that all participants are entitled to:

Receive Information About the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies 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.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the employee and eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The employee or eligible dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing the participant's COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the participants and beneficiaries. No one, including the employer, the union (if any), or any other person, may fire the employee or otherwise discriminate against the employee in any way to prevent the employee from obtaining a welfare benefit or exercising the participant's rights under ERISA.

Enforce the Participant's Rights

If a participant's claim for a welfare benefit is denied or ignored, in whole or in part, the participant has 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 the participant can take to enforce the above rights. For instance, if the participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the participant may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in a state or federal court. In addition, if the participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the participant is discriminated against for asserting his or her rights, the participant may seek assistance from the U.S. Department of Labor, or the participant may file suit in a federal court. The court will decide who would pay court costs and legal fees. If the participant is successful, the court may order the person the participant sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees, for example, if it finds the participant's claim is frivolous.

Assistance with the Participant's Questions

If the participant has any questions about the Plan, the participant should contact the Plan Administrator. If the participant has any questions about this statement or about rights under

ERISA, or needs assistance in obtaining documents from the Plan Administrator, the participant should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. The participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Reasonable and Allowed Amount or Plan limits. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the claimant or dependent on whose behalf such payment was made.

A claimant, dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or in accordance to a payment plan. When a claimant, or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the plan sponsor. The reductions will equal the amount of the required reimbursement plus any legal fees, auditing fees, collection fees as the Plan, in its sole discretion, deems appropriate to assess.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a claimant, provider or other person or entity to enforce the provisions of this section, then that claimant, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, claimant and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a claimant fails to comply with the Plan's Third-Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a claimant or by any of their covered dependents if such payment is made with respect to the claimant or any person covered or asserting coverage as a dependent of the claimant.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the claimant for any outstanding amount(s).

PAYMENT OF BENEFITS TO NON-U.S. PROVIDERS

A provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "non-U.S. provider."

Claims for emergency medical care, supplies, or services provided by a non-U.S. provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. The non-U.S. provider shall be subject to, and shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

Assignment of benefits to a non-U.S. provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the claimant is responsible for making all payments to non-U.S. providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the claimant be made.

If payment was made by the claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the claimant shall be that amount. If payment was made by the claimant using any currency other than U.S. currency, the Plan shall utilize an exchange rate in effect on the incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates.

PAYMENT OF BENEFITS

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. currency (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance, may alternatively be made to the claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the claimant be deceased, payment shall be made to the claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

PAYMENT RECOVERY

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Reasonable and Allowed Amount or Plan limits. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the claimant or dependent on whose behalf such payment was made.

A claimant, dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or in accordance to a payment plan. When a claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount

of the required reimbursement plus any legal fees, auditing fees, collection fees as the Plan, in its sole discretion, deems appropriate to assess.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a claimant, Provider or other person or entity to enforce the provisions of this section, then that claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, claimant and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third-Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a claimant or by any of his covered dependents if such payment is made with respect to the claimant or any person covered or asserting coverage as a dependent of the claimant.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the claimant for any outstanding amount(s).

PHARMACY BENEFIT

The Lake County Indiana NECA - I.B.E.W. Health and Benefit Health Plan has a contracted with SavRx, a national pharmacy benefit manager (PBM) to provide prescription drugs either at a network pharmacy or through the mail order program.

Sav-Rx is responsible for:

- Processing and paying Rx claims
- Negotiating discounts and rebates from manufacturers
- Contracting with pharmacy networks

How the Prescription Drug Program Works

The prescription drug program covers only those drugs that require a physician's written prescription. Prescriptions filled at a network pharmacy are limited to a 30-day supply. The mail order program is to be used for "maintenance drugs." Maintenance drugs are those drugs that are regularly taken on a long-term basis and are limited to a 100-day supply. Specialty drugs are limited to a 30-day supply.

The Plan employs a number of industry-standard management strategies to ensure appropriate drug utilization and the use of cost-effective drug therapies. These strategies would include, but are not limited to:

1. **Generic Substitution.** The Plan has a mandatory generic substitution policy that applies to both retail and mail order prescriptions.
2. **Step-Therapy**. The Plan utilizes a step therapy approach to many illnesses and diseases, such as, but not limited to, high cholesterol and gastrointestinal and esophageal acid problems. (In which the use of statin drugs and proton pump inhibitors respectively would be utilized. Please see the section of this benefit titled Step Therapy for more information.)
3. **Clinical programs and tools.** The Plan and/or its PBM utilizes various clinical programs and tools aimed at reducing inappropriate prescribing.
4. **Formulary Management**

These strategies and services are necessary in order to:

A. Advance the health outcomes of our members,
B. Monitor drug safety,
C. Improve the value of the Plan's Pharmacy program, and
D. Help the Plan contain rising drug costs

What You Pay

The Plan will pay for up to eighty percent (80%) of the cost of a covered pharmaceutical. The participant will be responsible for the greater of the amounts shown in the column titled "Your Co-Pay Responsibility."

Retail	**Your Co-Pay Responsibility**
Generic	20% or $10.00 Minimum
Formulary (Brand Name)	20% or $20.00 Minimum
Non-Formulary Brand	20% or $35.00 Minimum
Specialty Drugs	20% Minimum. **Pre-certification through the Plan's PBM and/or Specialty Drug PBM is required.**

Mail-Order (90-day supply)	Your Co-Pay Responsibility
Generic	20% or $10.00 Minimum
Formulary (Brand Name)	20% or $20.00 Minimum
Non-Formulary Brand	20% or $35.00 Minimum

A Note About Formulary Drugs

Formulary drugs are drugs chosen by the Fund that have been demonstrated to be safe, effective and affordable. For a current list of drugs on the Plans formulary list please go to www.SavRx.com, click "Formulary Lists" and under group ID input "IBEWLU697" (all caps), then enter your medical ID number.

A Note About Generic Equivalents

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. On average, generic medications can save about half the cost of the brand name medications, but for some medications this savings can be as great as 90%. Obviously, this can be a significant source of savings and can significantly reduce your co-pay.

Warning:

1. If you insist in choosing a brand name drug for which an alternative generic equivalent is available, then you must pay the difference in cost. Accordingly, you will pay both the co-payment and the difference in cost between the brand name drug and its generic equivalent.

2. Further, your physician or pharmacist can assist you in substituting generic medications when appropriate. Therefore, if you are already receiving or utilizing a brand name drug, you should discuss with your physician or pharmacist if a generic equivalent is available and appropriate for any prescriptions you need filled.

Mail-order program

Participants should use the mail order program when you need to have prescriptions filled for maintenance medications. Maintenance medications are prescription drugs that are used on an ongoing basis. These prescriptions can be used to treat chronic illnesses such as, but not limited to, arthritis, diabetes, high blood pressure, or cardiovascular disease.

The Sav-Rx mail order program provides a safe and convenient way for you to have your medications delivered right to your home. Moreover, the mail service program typically provides a cost-effective way for participants to receive a three-month (100-Day) supply of maintenance and long-term care prescriptions.

Pharmacy Benefit Plan Exclusions and Limitations

The following items are not covered:

- **Alternative treatments**: Drugs that are utilized as alternative treatments or deemed as an alternative treatment for an illness or disease are not covered.

- **Automatic Refills**: For the reason that automatic refill programs often result in stockpiling and payment for unneeded prescriptions, the Plan does not permit for prescriptions to be filled automatically. As such, your treating physician must either provide you or the pharmacy with a written script or call in the script.
- **Certain Criteria**. For some drugs, participants may need to meet certain criteria before their prescription drug coverage may be initially approved or approved for a refill. Failure to meet said criteria will result in a denial of coverage for that prescription.
- **Complex or rare diseases or illnesses.** The Plan reserves the right to enroll participants that have complex or rare diseases or illnesses into a specialty program. The requirements of this program may include, but is not limited to, the Plan purchasing the pharmaceutical directly and securely shipping the drug to your physician or hospital to administer. Failure to adhere to the terms of the specialty program will result in the Plan only paying up to the limit that it would have paid by purchasing the pharmaceutical directly.
- **Experimental drugs**: The Plan does not cover prescriptions that are considered or deemed experimental for the medical condition that is being treated.
- **Failure to provide requested information**: Prescriptions in which the patient or their physician fails to provide or provide timely the documentation or information needed to determine the clinical reason for the need, usage, dosage and/or effectiveness of that pharmaceutical, are not covered.
- **Hormone therapy.** Hormone therapy is not covered. without the express written consent of the Plan, will not be covered.
- **Limits.** Some drugs may have limits on how much medicine can be filled per prescription in a given time span. Requests for refills prior to the conclusion of the required timespan will not be filled without the express written consent of the Plan.
- **Nonadherence to taking prescribed medications**. The Plan will not pay for any expenses associated with or derived from a participant's decision to act against the medical advice of their treating physician and not take the medication as prescribed or in a manner not compliant to either the FDA guidelines or in a manner not recommended by the manufacturer.
- **Non-compliance to the Plan's specialty pharmaceutical program**. Payment for a pharmaceutical that either a physician, facility or a participant has decided not to participate or adhere to will be limited to the payment methodology as describe within that section of this benefit. Any balance between the charge and the Plan's payment will remain the responsibility of the participant.
- **Non-compliance to the Plan's step therapy program**. Participants are permitted to take any medication that their physician prescribes; however, if they fail to comply to the Plan's step therapy program the Plan will not cover the cost of that drug.
- **Off-label usage**: The Plan does not cover scripts that are written off-label.
- **Out-of-network pharmacy expenses:** If you use a pharmacy that does not participate in the Sav-Rx program, you must pay full price for your prescription and file a claim directly with Sav-Rx. Upon receipt of your claim submission, and provided that the drugs are a covered expense, Sav-Rx will reimburse you directly. Reimbursement of these types of expenses will be made as follows:

  80% of the pharmaceutical allowable reimbursement amount, and subject to the minimum co-payments listed previously.

- **Over the counter medications**: With the exception of smoking cessation drugs purchased over the counter, the Plan does not cover over-the-counter medication.

- **Specialty Drugs:** The full amount charged for any drug on the Plan's designated PBM's specialty drug listing or on the Plan's specialty drug PBM's specialty drug listing, unless pre-certified and secured through the Plan's designated PBM or specialty drug PBM. Only after a claimant contacts the Plans designated PBM or the Plan's specialty drug PBM, if said drug is unavailable though said PBM, the Plan may utilize its discretionary authority, based on medical criteria and in a non-discriminatory fashion, to approve an otherwise-eligible listed specialty drug from another source.

- **Wal-Mart and Sam's Club:** For the reason that they are not part of the labor friendly Sav-Rx network, the Plan will not make benefit payment toward any pharmaceuticals purchased through Wal-Mart and Sam's Club pharmacies.

Prior Authorization Program for Pharmaceuticals

The Plan requires prior authorization by the SavRx Clinical Department on certain classes of drugs. The prior authorization requirement will apply to, but is not limited to drugs for:

- Androgens for low testosterone
- Attention deficit stimulants
- Chemical dependency drugs
- Narcolepsy stimulants
- Oral dermatological
- Oral opioid pain medications
- Specialty Drugs
- Topical dermatological
- Topical pain medications

Specialty Drug Program

The Plan requires that Specialty Drugs be pre-certified by the Plan's PBM and/or Specialty Drug PBM.

Further, please be advised that quite often hospitals and physicians alike increase the expense of the drugs that they are administrating to you in their office or facility. This results in a higher out-of-pocket expense to you and the Plan. In instances where this occurs, and regardless of network affiliation of either the treating facility or physician, the Plan reserves the right to purchase the pharmaceutical directly and securely ship it to the treating physician or facility.

Should either the treating physician, treating facility or covered participant refuse to allow the pharmaceutical to be secured through the Plan's PBM or specialty drug PBM, then the Plan will pay for that drug or drugs that were administered only up to the amounts that it would have paid if it purchased the drug itself and only to the limits as outlined previously within this benefit.

Step Therapy

The Plan maintains a step therapy program. Step therapy requires the use of a more cost-effective drug prior to the approval of a less cost-effective brand name medication. Drugs that qualify for step therapy are often high priced and heavily advertised.

Drugs for a given condition will be dispensed using the most cost-effective sequence beginning with generic medications, which are the most cost-effective and comprise “first-step” category; formulary brand name medications fall within the “second-step” category; and non-formulary brand-name medications, which are the least cost-effective, fall into the “third-step” category.

In summary, the step therapy program steers participants toward taking a first-step medication prior to coverage of a second-step program, and to taking a second-step medication prior to coverage of a third-step medication.

The step program applies to drugs purchased at retail pharmacies or through the mail-order pharmacy.

The step therapy program will apply to, but is not limited to:

1. ARB antihypertensives and combination antihypertensives,
2. Glaucoma agents,
3. Lyrica,
4. Migraine Medications,
5. Nasal Sprays,
6. Osteoporosis medications,
7. Overactive bladder,
8. Proton pump inhibitors (PPI’s), a class of drugs used to reduce gastrointestinal and esophageal acid problems,
9. Sleep aids,
10. SSRI/SNRI antidepressants,
11. Statins, a class of drugs prescribed to treat high cholesterol; and
12. Tekturna

Warning: Because of its importance, the Plan is reiterating that second and third-step proton pump inhibitors and statins will not be covered unless your medication history shows compliance with the step therapy program, or unless you obtain a prior authorization from the Sav-Rx clinical team.

Therapeutic Interchange

Many brand name drugs have generic alternatives that are just as effective but cost much less than their brand counterparts. The Plan reserves the right to instruct its pharmacy benefit manager (SavRx) to contact participants who are taking certain brand name drugs to inform them about the generic alternatives available and how much money they can save by switching to the generic alternative(s).

Participants are reminded that therapeutic interchange suggestions are not intended to change your therapy, but rather to help you and your physician choose the best and most affordable treatment for your needs.

Utilization Management for Pharmaceuticals

Cost-Effectiveness Limit – When more than one viable alternative service or treatment protocol is available for diagnosis or treatment, the Plan and/or its designated PBM and/or its specialty drug PBM will evaluate the predicted health benefits, risks and costs of service that are comparable in safety and effectiveness for your medical circumstances. The patient can choose

the treatment they wish, but the Plan will only reimburse up to maximum allowable charge permitted under this Plan for the most cost-effective service. The most cost-effective alternative is one that meets both of the following conditions:

- The service that is the least costly of alternatives services that are equivalent in safety and effectiveness for your medical condition; and,

- The service is received in the least costly setting required for safe delivery of those services.

Examples: An inpatient Hospital stay is cost-effective only if you cannot be safely treated as an outpatient. Use of an ambulatory (outpatient) surgical center is cost-effective only if the surgery cannot be safely performed in a Physician's office or clinic setting.

PHYSICIAN BENEFITS (In-network and Out-of-Network)

Under the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan participants are free to choose to receive care from whomever they like. As such, it is expressly understood:

- That it is each participant's decision and choice to seek care from whomever they choose.

- That the delivery of medical and other health care services on behalf of any participant remains the sole prerogative and responsibility of the attending physician or other health care provider.

- That the participant, together with his or her physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

- That any physicians or other health care providers are not agents or employees of the Plan Sponsor, the Plan, the third-party administrator, vendor or any contributing entity.

In-Network Providers (Participating Physician or Participating Providers that are not Hospitals or Urgent Care Centers)

The Plan offers each participant a cost management feature in which a participant may lower their out-of-pocket expenses by using certain providers. These providers are individuals and entities that have contracted with a network. When a medical practitioner is a network provider for a plan, it means that the provider agreed to provide benefits or services to the plan's eligible participants at prices that the provider and the plan agreed on. In most cases these prices are offered at a lower cost to the plan and the plan's eligible participants than if providing the same benefit to someone without insurance, or someone with insurance through a plan in which the provider is out-of-network.

Generally, participants and their eligible dependents pay less when they use physicians that belong to the plan's network. Conversely, they will pay more in the way of higher out-of-pocket expenses if they use doctors outside of the network.

Choosing an In-Network Provider

The Trustees have tried to supply the participants with a PPO network robust enough to provide an in-network medical practitioner for just about any type of health care need you or your family may have. Nevertheless, the fact remains that some medical specialties may not be well represented within the network or in the area in which you reside or work. Consequently, you may find yourself needing to access an out-of-network provider for the services you seek. Participants who find themselves in this situation are reminded that payment for these services will be made in accordance to the out-of-network provisions of this Plan.

A list of Participating Physicians can be obtained, without charge, through the PHCS website (located at www.PHCS.com). The PHCS website provides details on each health-care professional, including:

A. Location
B. Specialties
C. Languages spoken
D. Hospital affiliation
E. Gender and more.

Participants are reminded that the network provider list changes frequently and that the network does its best in updating and maintaining the participation status of each physician on a daily basis, however, there are times where that is not possible. Therefore, it is recommended that a participant verify with the provider that the provider is still a network provider before receiving services.

Payment of In-Network Physician Claims

Unless otherwise stipulated within this document, payment of covered services provided by in-network physician will be subject to the deductible and annual out-of-pocket maximums and paid at 90% of the negotiated rate.

Balance Billing by Participating Providers

In the event that a claim submitted by a network provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that:

- ✓ The participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and
- ✓ The participant should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan.

Further, and with respect to covered services rendered by an in-network provider or participating provider being paid in accordance with a discounted rate, it is the Plan's position that, other than any applicable deductible, co-insurance or out-of-pocket maximums in which the participant may be billed for, the participant should not be responsible for the difference between the amount charged by the network provider and the amount determined to be payable by the Plan Administrator and should not be balance billed for such difference. Again, the Plan has no control over any network provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the network provider.

Payment of Out-of-Network Physician or Provider Claims

Unless otherwise stipulated within this document, this Plan's payment for covered services provided by an out-of-network physician or a non-participating physician will be subject to the deductible and annual out-of-pocket maximums and paid at 70% of 130% of the Plan's Reasonable and Allowable Amount (RAA) fee schedule. The patient will be responsible for any difference between the Fund's payment and the physicians charge.

Balance Billing by Out-Of-Network Providers

Balance billing is legal in many jurisdictions, and the Plan has no control over non-network providers that engage in balance billing practices.

In the event you receive a balance-bill for an amount in excess of the Reasonable and Allowable Amount payable, and based upon your specific circumstances and objectives, you should call all your provider and request a reduction in the remaining balance.

PREFERRED PROVIDERS: You can obtain an up-to-date list of the providers in the PPO Networks on their web sites at the following addresses:

- PHCS www.phcs.com
- SavRx www.savrx.com
- VSP Vision Care www.vsp.com

If you are a participant who has settled in, or traveled to or through an area that has limited or no participating medical facilities or practitioners, the Plan wants you to understand that:

1. With little or no demographical leverage by either the Plan or its contracted PPO network, it is very difficult to organize the regional providers to participate within the contracted PPO network.

2. Without a robust regional competition within the specialty of the physician you are utilizing, it is very difficult to get the physician to participate within the PPO network.

3. It takes money to establish and maintain a PPO network. In areas sparsely populated, the PPO networks cannot make profits that support their business.

If you need to find a participating physician or a participating medical professional, you can access the Plan's website and click on the word "Network" found on the left side of the landing page. The site contains details on each healthcare professional, including:

- Location.
- Specialties.
- Languages spoken.
- Hospital affiliation.
- Gender, and more.

PLAN PAYMENT PERCENTAGES FOR COVERED MEDICAL SERVICES

Unless otherwise stipulated within this book, and only after a participant meets the annual deductible requirement, the Plan will pay the following percentages of its Reasonable and Allowed Amount or negotiated amount for covered medical expenses.

TYPE OF PROVIDER	PAYMENT PERCENTAGE OF THE PLANS RAA
LEVEL A FACILITIES	100%
LEVEL B FACILITIES	90%
OUT OF NETWORK FACILITIES	70%
IN-NETWORK PHYSICIANS OR PROVIDERS	90%
OUT OF NETWORK PHYSICIANS OR PROVIDERS	70%
CHARGES FOR **EMERGENCY** SERVICES RENDERED BY NON-PARTICIPATING: • ANESTHESIOLOGISTS, • EMERGENCY ROOM PHYSICIANS • PATHOLOGISTS • RADIOLOGISTS PERFORMED WITHIN A PARTICIPATING LEVEL A AND LEVEL B FACILITY	 90% 90% 90% 90%
CHARGES FOR **NON-EMERGENCY** SERVICES RENDERED BY NON-PARTICIPATING: • ANESTHESIOLOGISTS, • EMERGENCY ROOM PHYSICIANS • PATHOLOGISTS • RADIOLOGISTS PERFORMED WITHIN A PARTICIPATING LEVEL A AND LEVEL B FACILITY	 70% 70% 70% 70%
CHARGES FOR **EMERGENCY** SERVICES RENDERED BY NON-PARTICIPATING: • ANESTHESIOLOGISTS • EMERGENCY ROOM PHYSICIANS** • PATHOLOGISTS • RADIOLOGISTS PERFORMED WITHIN A **NON-PARTICIPATING FACILITY**	 90% 90% 90% 90%
CHARGES FOR **NON-EMERGENCY** SERVICES RENDERED BY NON-PARTICIPATING: • ANESTHESIOLOGISTS • EMERGENCY ROOM PHYSICIANS** • PATHOLOGISTS • RADIOLOGISTS	 70% 70% 70% 70%

PERFORMED WITHIN A **NON-PARTICIPATING FACILITY**	

Warning: Even though you may utilize a participating hospital or facility, do not expect that every physician who might treat you in the ER, immediate care, in-patient or in an out-patient capacity is necessarily going to be an in-network provider within this Plan.

In fact, and for a myriad of reasons, hospitals often sub-contract certain positions or duties to non-participating physicians or out-of-network physicians. Such providers can be, but are not limited to: anesthesiologists, emergency room physicians, floating nurses, phlebotomists (and the laboratories they send their specimens), pathologists and radiologists.

The Plan wishes to remind participants that despite its numerous attempts to contract with these medical professionals, they are nevertheless free to decide to not join the network or contract directly with the Plan. Further, the Plan does not have any control over the hiring and organizational practices of a participating hospital facility nor a non-participating facility, nor the fee schedule of any outside contractor.

All of the percentages listed above are percentages of the Plan's Reasonable and Allowed Amount.

PRECERTIFICATION REQUIREMENT

Precertification is the process in which you and your provider can determine whether or not the Plan covers a requested procedure. Not every medical procedure requires precertification by the Plan. There are, however, several services that the Plan requires be pre-certified. Be advised that the Plan will not make payment toward any service that requires precertification, but in which precertification was not obtained. For your convenience, a complete list of services that require precertification is displayed directly below:

- ✓ Bariatric/gastric bypass
- ✓ Birthing Centers
- ✓ Cardiac rehabilitation
- ✓ Cat Scans
- ✓ Chemotherapy
- ✓ Corrective surgery
- ✓ Dental work performed in a hospital setting
- ✓ Durable medical equipment in amounts greater than $1,000.00.
- ✓ Epidural injections/nerve blockers
- ✓ Genetic testing
- ✓ Home health care
- ✓ Inpatient care
- ✓ Inpatient rehabilitation
- ✓ Inpatient surgery
- ✓ Mental Health benefits
- ✓ MRI's
- ✓ Neuropsychological testing
- ✓ Occupational therapy

- ✓ Orthotics greater than $1,000.00.
- ✓ Orthotripsy
- ✓ Outpatient surgery
- ✓ PET scans
- ✓ Pharmacogenetics
- ✓ Physical therapy treatments greater than 17
- ✓ Private duty nursing
- ✓ Prosthetics
- ✓ Pulmonary rehabilitation
- ✓ Physical therapy
- ✓ Radiation therapy
- ✓ Reconstructive surgery
- ✓ Sclerotherapy
- ✓ Skilled nursing benefits
- ✓ Speech therapy
- ✓ Surgeries of any type
- ✓ Synagis injections
- ✓ Trigger point injections
- ✓ Vein therapy

Participants and providers alike are informed that:

1. Precertification is not a guarantee of full reimbursement by the Plan; however, the lack of a precertification will result in non-reimbursement.
2. The Plan will not cover any service that is not medically necessary.
3. The Plan reserves the right to require a second opinion for any of the aforementioned procedures, services or treatments.
4. The Plan reserves the right to enroll the participant into any of its case management or utilization management programs.

Why the Plan requires precertification on certain procedures and not others.

The Plan requires precertification primarily for the reasons that:

- ✓ Certain types of medical conditions necessitate the coordination of services supplies and resources in a supportive, effective, efficient, and timely manner. Therefore, the early identification of participants who may have such needs is imperative in order for the Plan to assist in the coordination and continuity of their care.

- ✓ To assist participants in avoiding unnecessary out of pocked costs by understanding what is covered by the Plan.

How to Pre-certify

Call the toll-free number listed on your medical identification card whenever your medical provider recommends that you or your dependent undergo surgery, inpatient hospitalization, obtain a CT, MRI, PET Scans or any of the other procedures, services and treatments previous identified within this section.

Participants are advised that the process of acquiring a precertification often involves multiple conversations between the third-party administrator and your medical provider's office. It can also include the sharing and collecting of medical history and test results. As a general rule of thumb, precertification takes about five business days to occur. However, and depending on the type, medically necessity or gravity of the medical malady and subsequent recommended procedure, service or treatment, it can take longer. For those reasons, the Plan strongly suggests that precertification occur immediately upon the mutually agreed decision of you and your medical professional to receive any of the aforementioned procedures, services or treatments.

With that said, participants are informed that hospitals, doctors and outpatient facilities typically make the call on you or your dependents behalf. Nevertheless, it is not their responsibility to know the precertification requirements of this Plan. For that reason and for the reason that the procedure, treatment or service is going to be rendered on or to you or your loved one, it is your responsibility of making sure that the call is not only placed, but placed in a timely manner, and precertification is received.

When precertification is obtained from the third party administrator, a precertification number is issued to the medical provider. In turn, the medical provider will place this number on either the claim form or claim file and submit the claim for payment. Should your claim be denied based upon lack of a precertification number on said submissions, your medical provider should append the claim to include the precertification and resubmit.

PRETREATMENT ESTIMATES

Predetermination of benefits can help you avoid any financial surprises by letting you and your provider know in advance what services are covered and what the Plan's allowance is for any medical or dental services and/or materials.

The Plan highly recommends that every patient obtain a predetermination well in advance of any service or treatment being rendered or durable medical equipment being received. Receiving a predetermination is easy. All you need to do is request your medical and/or dental provider to submit a request for a pre-treatment estimate from this Plan.

As a reminder, this Plan's benefit payments are referenced based. This means that the Plan's reimbursement is constructed upon a known and accepted schedule of reimbursements amounts that it references and subsequently utilizes as a base in which to decide on what it will pay for most procedures, services or equipment. Currently, the Plan utilizes Medicare's reimbursement schedule as its base level of reimbursement. It is generally accepted that Medicare's reimbursement exceeds the expense of the delivery for almost all services, treatments or equipment. Further, this Plan adds a percentage to the base rate to help ensure that the provider is properly and profitably compensated.

If you request and receive a predetermination and there remains a difference between what the Plan's referenced based reimbursement amount is, and that of what the provider charges, you should contact the Plan Office right away and ask the Plan to try and negotiate with the provider. While the Plan cannot guarantee success in getting the claim reduced, it can guarantee that post service negotiations are seldom successful. As such, if you wish the Plan

to negotiate a claim and want to give the best chance of reducing your out-of-pocket expense, notify the Plan several weeks in advance.

It is the patient responsibility to know who is providing the treatment, including but not limited to what assistant surgeon, if any, is being utilized, who the anesthesiologist will be, who the radiologist, or pathologist will be, etc., and request of those professionals to supply the Plan with a request for a predetermination.

Should a participant request their provider to forward a predetermination to the Plan, they must inform the Plan of the name of each medical entity or professional it should expect to receive a request from. Upon receipt the Plan will communicate to the participant that it is in receipt of said request and provide the participant with an estimated time in which they can expect a response estimate from the Plan.

PROSTHETICS

Prosthetic Devices including custom made or custom fitted devices must meet all of the following criteria:

1) The item meets the definition of Prosthetic.

2) The item is furnished on a physician's order.

3) It is necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and not solely for the participant's comfort or convenience.

4) Precertification is obtained.

Plan Payment

Prosthetics provided, adjusted or repaired by a participating provider will be subject to the deductible and payable at 90% of the Plan's Reasonable and Allowed Amount (RAA).

Prosthetics provided, adjusted or repaired by non-participating providers will be subject to the deductible and payable at 70% of the Plan's Reasonable and Allowed Amount (RAA).

Prosthetics may be provided by a pharmacy that has employees who are qualified under the Medicare system and applicable Medicaid regulations to service and bill for prosthetics services.

Warning:

Prosthetics are limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the participant enrollee as determined by the participant's treating physician or podiatrist and prosthetist or orthotist, as applicable.

Repairs, replacement and adjustments to prosthetics are covered when determined medically necessary to restore or maintain the ability to complete activities and not solely for comfort or convenience.

Repair or replacement must be pre-certified. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary prosthetics are covered

when necessary to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device.

Extensive adjustments are subject to the deductible and co-insurance and will be covered as repair when, based on the manufacturer's recommendations, the adjustments (e.g., breaking down sealed components, performing tests that require specialized testing equipment not available to the member) is to be performed by an authorized technician.

Adjustment to and replacement of prosthetic devices when required by wear or a change in the member's physical condition and ordered by a physician will be subject to the deductible and co-insurance.

Repairs and replacements will not be covered when:

a) The repair is the result of misuse or loss by the participant, or,
b) The repair costs exceed the purchase price of a new prosthetic, or
c) When a change in the member's medical condition occurs.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notwithstanding any other provision of this Plan to the contrary, the Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as defined in ERISA Section 609(a).

Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial partner or legal guardian will be made to the alternate recipient's custodial parent or legal guardian.

Upon receipt of a QMCSO, the Fund Office shall notify the employee and each alternate recipient, as that term is defined in ERISA Section 609(a), of the receipt of such Order and its determination of whether the Order is a QMCSO as defined by the Plan.

A National Medical Support Notice is an order also issued by a state court or Child Support Agency. Receipt of this type of notice constitutes a Medical Child Support Order and requires the Fund to add a dependent child to your coverage.

RADIATION THERAPY

Precertification is necessary.

Radiation treatment performed in a free-standing therapy center by a physician will be paid as follows:

- Participating provider charges will be subject to the deductible and payable at 90% of the Reasonable and Allowed Amount.

- Non-participating provider charges and facility charges will be subject to the deductible and payable at 70% of the Plan's Reasonable and Allowed Amount.

Radiation treatments received in a level A hospital facility will be paid as follows:

- Facility fees will be paid at 100% of the Reasonable and Allowed Amount and will be not subject to the annual deductible.

- Physician charges will be paid in accordance to the network affiliation of the medical professional rendering treatment. Consequently:

    - If the physician rendering service is an employee of the hospital, then the Plan will not make any payment as that professional's salary is incorporated within the facility fee.

    - If the physician professional rendering service is a participating provider, then the Plan will pay 90% of the Reasonable and Allowed Amount.

    - If the physician or medical professional rendering service is a non-participating provider, then the Plan's payment will be subject to the deductible and will paid at 70% of 130% of the Plan's Reasonable and Allowed Amount.

Radiation treatments received in a level B hospital facility will be paid as follows:

- Facility fees will be paid at 90% of the Reasonable and Allowed Amount will be subject to the annual deductible and annual out of pocket maximums.

- Physician charges will be paid in accordance to the network affiliation of the medical professional rendering treatment. Consequently:

    - If the physician or professional rendering the service is an employee of the hospital, then the Plan will not make any payment as that professional's salary is incorporated within the facility fee.

    - If the physician or medical professional rendering the service is a participating provider, then the Plan's payment will be subject to the deductible and will be paid at 90% of the Reasonable and Allowed Amount (RAA).

    - If the physician or medical professional rendering the service is a non-participating provider, then the Plan's payment will be subject to the deductible and will be paid at 70% of the Plan's Reasonable and Allowed Amount (RAA) payment methodology.

Radiation treatments received in all other hospital facilities will be paid as follows:

- Facility fees will be subject the annual deductible and paid at 70% of the Plans Reasonable and Allowed Amount (RAA) payment methodology.

- Physician charges will be paid in accordance to the network affiliation of the medical professional rendering treatment. Consequently:

- If the physician or professional rendering the service is an employee of the hospital, then the Plan will not make any payment as that professional's salary is incorporated within the facility fee.

- If the physician or medical professional rendering the service is a participating provider, then the Plan's payment will be subject to the deductible and will paid at 90% of the Reasonable and Allowed Amount.

- If the physician or medical professional rendering the service is a non-participating provider, then the Plans payment will be subject to the deductible and will payed at 70% of the Plan's Reasonable and Allowed Amount (RAA).

RECIPROCITY

If you perform covered work partly or on a full-time basis within the jurisdiction of another I.B.E.W. Local Union and you wish to maintain you and any covered dependents eligibility with this plan, the employer's contributions for the work performed in the other Local's jurisdiction must be transferred to this plan.

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

Note: It generally takes a minimum of eight weeks before contributions made based on the number of hours you worked in another jurisdiction are submitted back to the Local 697 Fund Office. Keep in mind that it's your responsibility to keep track of your reciprocated hours. If there is a discrepancy between the number of hours worked and the number of hours reciprocated to the Fund Office, you must contact the jurisdiction (or local) where the work was performed to resolve any issues.

Reciprocity and Initial and Continued Eligibility under this Plan

Participants are permitted to use reciprocated hours to gain both initial and continued eligibility under this Plan. However, the participant must still meet all the Plans eligibility and enrollment provisions asset forth by the Plan.

Warning. If you owe money to the Plan, any reciprocal monies received on your behalf will be first used to satisfy that debt in full. Any remaining balance will be utilized toward gaining initial or continuing eligibility for coverage under this Plan.

REFERNCED BASED PRICING

The Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan pays benefits only to the extent that they are reasonable.

The bases of this Plan's determination of a reasonable and fair amount of a reimbursement is founded on objective criteria. In most cases the criteria will be the published Medicare costs

and pricing data, plus an additional percentage. Paying amounts more than the allowable Medicare limit ensures that you, and your Health Plan saves money and that your medical professional receives a suitable, but not an egregious profit.

This Plan's maximum allowable amount for any in-patient hospital, out-patient hospital, facility, out-of-network physician or out-of-network medical professional will be based upon on the aforementioned referenced-based-price methodology.

Under certain circumstances, and solely at the Plan's discretion, a value-based payment may be negotiated up front, before costs are incurred for elective-type procedures.

RESCISSION OF BENEFITS

Coverage under the Plan will not be rescinded with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, UNLESS the individual (or person(s) seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact.

If the Plan rescinds coverage in accordance with this provision, the Plan will provide you (and each affected participant) with at least thirty (30) days' advance notice before rescinding coverage.

RETIREMENT

Please refer to the sections at the back of this book

SECOND OPINIONS

One of the most important steps you can take for yourself or a loved one, is to make sure that the recommended medical procedure is necessary. Getting a second opinion is an excellent way to become more informed about the procedure and the expected outcome, and an excellent method to discover if there exists another alternative available for you.

If you elect not to utilize this Plan's Grand Rounds benefit for a second opinion, benefits for a second opinion will be paid according to benefits already outlined in the section of this book titled "Physician Benefits."

The Fund reserves the right to require a second opinion for any surgical procedure or disability. If a second opinion is required, the Fund reserves the right to refer you to a provider for that second opinion. If the Plan directs you to a second opinion, there will be no cost to you for the second opinion.

In the event that the first and second opinions differ, a third opinion will be required. The Fund will designate a new provider. The third opinion will determine whether or not the surgery is necessary or whether a disability payment should be continued. Should the Plan direct you to a second opinion, there will be no cost to you for the third opinion.

SHORT-TERM DISABILITY BENEFITS

Amount of Short-Term Disability Benefits

If you are an eligible active member or a covered employee of a contributing employer and you become unable to work due to a non-job-related accidental Injury or illness, you can receive a gross weekly income of up to fifty percent (50%) of your weekly salary (excluding any overtime) up to a maximum of $550.00 per week.

Short-term disability and loss of time weekly benefits will begin on either:

1. On the first day of disability due to an accidental injury; or
2. On the eighth day of disability due to illness; or
3. If later than the dates described within the first two provisions, on the date you came under the regular care of a M.D. or a D.O. physician.

The weekly loss of time benefits will continue only for the period in which you are continuously and totally unable to perform the duties of your employment up to a maximum of 26 weeks, whichever comes first.

Applying for Short-Term Disability Benefits

Unless you are receiving State unemployment benefits (See the section titled “Unemployment and Your Ability to Receive Short-Term Disability Benefits” below) your total disability must commence while you are a covered participant under the Plan, actively working in covered employment, or while you are on the active payroll of a contributing employer.

In order to receive these benefits:

1. You and your physician must complete the Plan’s short-term disability claim form in which you both attest and certify that you are under the continuous care of a licensed physician and that you are unable to work. And,

2. Must submit said documents within the time periods specified directly below:

    - In the case of a disability caused by an accidental injury you must file: (1) within14 days after the date of termination, (2) within 14 days of your lay-off or (3) within 14 days of the last date of work prior to a vacation; or

    - In the case of a disability caused by an emergency illness, you must file: (1) within 72 hours after the date of termination, (2) within 72 hours of your lay-off or (3) 72 hours of the last date of work prior to a vacation.

Eligibility for Short-Term Disability Benefits

To be eligible for the short-term Disability Benefits, you must meet **ALL** the following requirements:

1. You must be the member or an employee working under a signatory contractor or participation agreement.

2. You must be totally disabled as a result of a non-occupational (non-work related) accidental bodily injury or illness. For the purpose of these benefits, "total disability" means that you are not reporting for work; completely unable to perform your job duties as a result of your injury or illness and not receiving wages or benefits from an employer.

3. You must be under the regular and continuing care of a physician (M.D. or D.O.) who certifies your total disability.

4. You must be eligible for Plan benefits on the date your disability begins.

5. (This point is important, so we are repeating it in this section as well.) Unless you are receiving State unemployment benefits (See the section titled "Unemployment and Your Ability to Receive Short-Term Disability Benefits" below) your total disability must commence while you are actively working in covered employment, or while you are on the active payroll of a contributing employer OR:

    a. In the case of a disability caused by an accidental injury, you must file: (1) within 14 days after the date of termination, (2) within 14 days of your lay-off or (3) within 14 days of the last date of work prior to a vacation; or

    b. In the case of a disability caused by an emergency illness, you must file: (1) within 72 hours after the date of termination, (2) within 72 hours of your lay-off or (3) 72 hours of the last date of work prior to a vacation.

Exclusion and Limitations

No short-term disability benefits will be paid for any of the following:

1. An occupational injury or disease, arising out of, or as a result of any second job outside of the scope of the Local 697 collective bargaining agreement; from any activity for profit or wage, or any self-employment.

2. Any period for which you are not under the direct care of a physician who is an M.D. or D.O.

3. Any period for which you received:

    i. Social Security retirement or disability benefits;
    ii. Unemployment compensation;
    iii. Any Pension benefits.

4. Any period of disability on or after the day you received retiree benefits under this Plan.

5. Any period of disability after this Plan's short-term disability benefits have been paid.

6. If a properly completed **statement of continuance of disability form** is not received within fourteen calendar days of the disability benefit period established by their treating physician.

Extending Your Short-Term Disability Benefit

Individuals who find themselves totally disabled after receiving twenty-six weeks of short-term disability benefits may apply for up to another twenty-six weeks of coverage. The maximum amount of time that a participant may extend their short-term disability benefit is 26 weeks within any period of 52 consecutive weeks.

In order to receive these benefits, you must:

- Be unable to work.
- Be under the continuous care of a licensed physician who must certify that you are unable to work.
- Have applied for a Social Security Disability. And,
- Have fully completed a short-term disability application at the onset of the second period of 26 weeks of disability.

Successive periods of disability separated by less than two weeks of covered employment will be considered as one continuous period of disability unless they are from different and unrelated causes.

Loss of Time Credit - Maintaining Coverage with this Plan During Your Short-Term Disability

If you are receiving a short-term disability benefit from this Plan, you will be credited with up to a maximum of forty (40) weekly disability loss of time hours toward your Health and Benefit Plan eligibility until the earlier of the date you are no longer totally disabled or the end of your short-term disability benefit period.

The amount of weekly disability Health and Benefit Plan loss of time hours to be credited will be calculated by the following formula:

40 Hours – the number of eight (8) hour days worked = the number of weekly disability loss of time hours credited toward your Health and Benefit Plan.

If you became disabled while receiving any unemployment compensation benefits and subsequently were awarded this Plan's short term disability weekly benefit(s), you will not be credited with any weekly disability loss of time credits.

Please reference the section of this book titled "LOSS OF TIME" benefits for more information.

Notifying the Fund Office

If you cannot work because of an off-the-job accidental injury or illness, notify the Fund Office immediately. If you are unable to notify the Fund Office yourself, have someone else do it for you. The proper claim form will be sent to you for completion by you and your physician, or you can download the claim form by accessing the Plan's website at www.ibew697benefits.com.

Payment of Your Weekly Short-Term Disability Benefit

The Plan basis the amount of the benefit you will be entitled to receive upon the unemployment compensation rates for Indiana but will not exceed fifty percent (50%) of the employees' weekly salary (excluding any overtime) or $550.00 per week, whichever is less.

The Plan will direct deposit the weekly disability benefit to the account at the financial institution that you have listed within the short-term disability application.

Participants are informed that the Plan does not withhold taxes from the weekly short-term disability benefit payment. Further, weekly short-term benefits are considered income by the Internal Revenue Service (IRS). As such participants who receive short-term disability benefits will also receive a W2 form from the Plan so that they can include the amount of short-term disability benefits that they received in their gross income for federal income tax purposes. If you have a question about this, or about exclusions in the law, you should check with a competent tax advisor or attorney.

Pension Benefits and Short-Term Disability

If you are awarded a Pension benefit of any type, you are considered a retired participant of the Plan as of the effective date of that award. Should the effective date begin your Pension benefit during a time in which you received short-term disability benefits from this Plan, you will need to immediately remunerate back to the Plan any short-term disability monies received after the effective date of the award.

Additionally, be advised that any loss of time credits that were provided after the effective date of a disability pension benefit will be reversed. Participants are advised that the reversal of loss of time credits may affect the amount of any required monthly self-pay.

Short Term Disability Benefits due to pregnancy.

If a covered female employee of a contributing employer is disabled due to maternity or a pregnancy-related condition, the disability will be treated as a disability due to illness.

Social Security Retirement or Disability Benefits

Should you receive a Social Security retirement or disability award with an effective date that was during any period of time in which you received short-term disability benefits from this Plan, you will need to need to immediately remunerate back to the Plan immediately any short-term disability monies received after the effective date of the award.

Additionally, be advised that any loss of time credits that were provided after the effective date of a Social Security retirement or disability award, will be reversed.

Successive Periods of Short-Term Disability due to the same or related cause will be considered one period of disability unless you return to full-time work with a contributing employer for a continuous period of at least four weeks between the periods of disability.

Successive Periods of Short-Term Disability Benefits due to unrelated causes will be considered as one period of disability unless the second disability begins after:

1. Your physician certifies that you have completely recovered from the first condition.
2. Your physician certifies that you are released to return to full-time unrestricted work, and
3. You have returned to full-time employment with a contributing employer for at least four (4) weeks.

Warning: You cannot be receiving workers compensation, unemployment benefits or Social Security benefits or any other insurance compensation and be receiving this Plan's short-term disability benefits. If the Plan learns that you are receiving other insurance compensation while receiving short-term disability benefits from this Plan, the Plan will immediately terminate any further payments, you will be responsible to make restitution of the payments you had received to date and will be subject to all the provisions of this Plans Fraud provision.

Unemployment and Your Ability to Receive Short-Term-Disability Benefits

For the reason that participants who are receiving unemployment benefits have to be:

a) Able to work
b) Available to work, and
c) Actively seeking employment

They are not able to receive short-term disability benefits from this Plan. However, should a participant become totally disabled while receiving unemployment compensation they will be granted a limited short-term disability benefit provided:

a) You are eligible for benefits under this Plan.
b) You apply for the disability benefit while still receiving unemployment benefits.
c) If it were not for your work status, you would qualify for disability benefits under this Plan, and,
d) You submit proof of the amount of disability you are currently receiving as well as verification of the duration of the unemployment compensation to which you would have been entitled.

Warning

- If you became disabled while receiving any unemployment compensation benefits and subsequently were awarded this Plan's short term disability weekly benefit, you will not be credited with any weekly loss of time credits.

SMOKING CESSATION BENEFIT

The Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan makes tobacco cessation services available to all participants enrolled in or provided through a physician-supervised smoking cessation program. Coverage is limited to two (2) smoking cessation attempts of ninety (90) days per year.

Covered expenses include all seven medications and the three types of counseling recommended by the U.S. Public Health Service. It also includes benefits for physician's office visits, lab tests and prescription drugs, such as, but not limited to nicotine-replacement inhalers and nasal sprays.

Participating providers charges will be subject to the deductible and annual out-of-pocket limits and will be paid at 90% of the negotiated rate.

Non-participating providers will be subject to the deductible and annual out-of-pocket limits and will be paid at 70% of 130% of the Plans Reasonable and Allowable Amount.

Limitations

Nicotine replacement therapy and other smoking cessation agents are covered for all participants who prove they are enrolled in a physician-supervised smoking cessation program.

Smoking cessation agents fall into three general categories: nicotine replacement therapies (NRT), Zyban (bupropion), and Chantix (varenicline). All agents are first line therapies and will be covered for 12 weeks.

The products covered, and their daily maximum limits include:

• Nicotine gum – up to 24 pieces per day

• Nicotine patches – 1 patch per day

• Nicotine lozenges – up to 20 lozenges per day

• Nicotine inhalers – Dispensed in a pharmacy up to 168 inhalers per 30 days

• Nicotine nasal spray – 4 spray bottles per 30 days (this therapy is reserved for those who have failed other forms of nicotine replacement therapy.)

Note: Drugs in this category may be combined for concurrent use. • Bupropion – 300 mg. daily (NRT and bupropion will not be covered concurrently.) • Varenicline – 2 mg. daily

Warning: Adherence to the smoking cessation program will be determined by claims review with no more than a seven-day lapse between pharmacy fills of current therapy. If a lapse occurs, the Plan will count the period of time in which the participant was complying towards the maximum number of yearly attempts. Any expense associated with this program after the second failed attempt will remain the responsibility of the participant.

SOCIAL SECURITY DISABILITY AWARD COVERAGE

Participants that have:

1. Received a Social Security Disability Award,
2. Have a minimum of forty (40) calendar year quarters of coverage with the Health and Benefit Plan within the fifteen years prior to their disability award being granted,

Will be permitted to elect to continue their coverage under the applicable Retirement eligibility provisions of the Plan.

SPEECH THERAPY FOR ADULTS

Precertification is required before the Plan can make payment for this benefit.

The Plan pays for restorative speech therapy to a participant who had normal speech but suffered a loss of speech function as the result of a non-chronic disease, acute injury or surgery.

Participating provider charges will be subject to the deductible, and annual out-of-pocket maximums and payable at 90% of the Reasonable and Allowed Amounts. (RAA)

Non-participating provider charges will be subject to the deductible and annual out of pocket maximums and payment will be made at 70% of the Funds Reasonable and Allowable Amount (RAA).

SPEECH THERAPY FOR CHILDREN

Precertification is required before the Plan can make payment for this benefit.

The Plan pays for treatment of autism spectrum disorder, cerebral palsy or another congenital neurological or anatomical disorder, hearing deficit cause by an illness or dysphagia (swallowing disorder).

Participating provider charges will be subject to the deductible, and payable at 90% of the Reasonable and Allowed Amounts. (RAA)

Non-participating provider charges will be subject to the deductible and payment will be made at 70% of the Funds Reasonable and Allowable Amount (RAA)

Limitations: The Plan pays for up to fifty (50) visits per calendar year for habilitative speech for children under the age of twelve (12) and older than eighteen (18) months and only if:

1. The services are prescribed by a medical doctor (M.D. or D.O.);
2. The therapy is rendered one-on-one by a licensed speech-language pathologist;
3. Measurable and positive results are being achieved based on specific tests and measures performed on a regular basis (not to exceed three-month intervals); and
4. The child does not qualify for speech therapy services through Indiana's First Steps program or any similar government-funded or school-provided intervention program. (The Fund will assume that speech therapy for children under the age of 3 who are Indiana residents is available through First Steps. You will be required to submit a denial letter from First Steps in order to receive Plan benefits for a child under the age of 3 years of age.)

SUBROGATION (THE PLAN'S RIGHT TO RESTITUTION AND REIMBURSEMENT)

For the purposes of this section the meaning of the term ANY SOURCE shall include but not be limited to:

- Liability insurance coverage
- Uninsured motorist coverage
- Underinsured motorist coverage
- Homeowners insurance coverage
- Medical payments insurance coverage
- Payment by any third party, a representative of a third party or the insurance proceeds paid by a third-party insurer
- Any other payment by ANY SOURCE paid to you or your eligible dependents as full or partial settlement for a claim you or your eligible dependents have asserted for which the Lake County Indiana NECA-IBEW Health and Benefit Plan has paid benefits, incurred expenses or costs

If you or your eligible dependents receive benefits from the Lake County Indiana NECA-IBEW Health and Benefit Plan (hereinafter referred to as the Plan) for injuries caused by a third party or as a result of any accident, casualty or event from ANY SOURCE, or if

you or eligible dependents receive an overpayment of benefits from the Plan, the Plan has a legal and equitable right to obtain full restitution of the benefits paid by the Plan from:

1. Any full or partial payment made by ANY SOURCE.

2. You or your eligible dependents if any full or partial payment is made to you or your eligible dependents by ANY SOURCE.

This means that with respect to benefits which the Plan pays in connection with an accident, injury and/or death, the Plan has the right of full restitution from any payment received by you or your eligible dependents from ANY SOURCE whether or not the payment segregates or separately allocates an amount for restitution of the benefits paid or provided; or for the expenses or types of expenses covered by the Plan. Any payment received by you or your legal counsel for you or your eligible dependents from ANY SOURCE is subject to a CONSTRUCTIVE TRUST. Any payment by ANY SOURCE received by you or your eligible dependents must first be used to provide full and total restitution to the Plan to the extent benefits, expenses or costs were paid by or are payable under the Plan. The balance of any such payment must then be applied to reduce the amount of benefits, costs and expenses which are payable by the Plan for unpaid or accrued benefits, after the date of said payment, by ANY SOURCE to you or your eligible dependents. Then and only then will the remaining proceeds of said payment be available for your use or use by your eligible dependents, for payment of attorney's fees and/or your related costs. THE PLAN DOES NOT RECOGNIZE *THE MAKE WHOLE DOCTRINE* AND *THE MAKE WHOLE DOCTRINE* SHALL HAVE NO APPLICABILITY TO THIS PLAN.

You and your eligible dependents are responsible for all expenses incurred to obtain payment from ANY SOURCE including but not limited to attorneys' fees, cost of litigation or other costs incurred in the pursuit of the claim; provided further attorneys' fees, cost of litigation and other costs will not reduce or effect the amount due to the Plan as restitution. THE PLAN EXPRESSLY REJECTS THE *COMMON FUND DOCTRINE* WITH RESPECT TO PAYMENT OR REPAYMENT OF ATTORNEY FEES, COSTS OF LITIGATION AND/OR OTHER COSTS. THE *COMMON FUND DOCTRINE* SHALL HAVE NO APPLICABILITY TO THIS PLAN.

The Plan is entitled to full restitution of any benefit amount, cost or expense paid from all monies received by you or your eligible dependents from ANY SOURCE regardless of whether you or your eligible dependents have been fully satisfied, indemnified or whether there is full accord and satisfaction of the claim. The Plan through its attorneys and/or representatives may commence an action against appropriate parties including you or your eligible dependents or intervene in a proceeding filed by you or your eligible dependents or take and/or exercise any further necessary action to protect the Plan's legal or equitable rights to ensure or obtain full restitution.

By participating in the Plan, you and your eligible dependents acknowledge and agree to the terms of the Plan and the Plan's legal and equitable right to full restitution. You and your eligible dependents agree that you are required to cooperate in obtaining and/or providing all applicable documents requested by the Plan and/or its representatives, employees or attorneys including your signature on any document, agreement or

authorization requested by the Plan or its representatives in an attempt to obtain full restitution.

You and your eligible dependents are also required to:

- Notify the Plan at its fund office as soon as possible and in writing that the Plan may have a legal or equitable right to obtain restitution of any and all benefits, expenses or costs paid by the Plan as a result of an accident, casualty or event in which you or your eligible dependents were involved;
- Inform the Plan in advance and/or prior to you or your eligible dependents agreement to settle any claim and/or terminate or resolve any litigation in which the Plan has any interest;
- Notify the Plan in advance of any scheduled mediation or Court conducted settlement conference;
- Notify in advance the Plan of your trial date when your claim is set for trial and further agree that you will not resolve any claim from ANY SOURCE without the prior written consent and approval of the Plan or Plan attorney;
- Provide the Plan with all information requested by the Plan regarding your claim or any action taken on that claim;
- Fully cooperate with the Plan with respect to the Plan's enforcement of its legal and or equitable rights to restitution;
- Not disburse any monies you or your eligible dependents have received from ANY SOURCE without prior to written consent of the Plan Administrator or Plan's attorney;
- Take all other actions as may be required or necessitated to protect the interests of the Plan.

Provided further that the Plan reserves the right to review your claim or that claim of your eligible dependents and after reviewing same has the discretion to compromise its right of restitution if deemed by the Trustees, Plan Administrator and/or Plan counsel if it is determined that the compromise is in the best interest of the Plan.
In the event that you or your eligible dependents do not comply with the requirements of this section, the Plan may deny benefits to you or your eligible dependents or take other such action the Plan deems appropriate including but not limited to the right to offset future payments due to you or your eligible dependents to the extent that benefits, expenses and costs are due and owing to the Plan from that prior claim. This right of offset shall not affect or limit any other legal or equitable rights of the Plan to recover benefits, expenses or costs from amounts paid or owed to you or your eligible dependents.

Warning: Participants are reminded that:

- If they or their attorney fail to reimburse the Plan for all benefits paid or to be paid, as a result of a third-party injury or condition, or if they, their representative(s) or eligible dependents fail to timely notify the Plan, or execute and timely return back to the Plan documents, out of any proceeds, judgment or settlement received, the participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the participant(s).

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

SUBSTANCE ABUSE

Precertification is required.

The Plan provides benefits for the treatment of substance abuse. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 and will pay for only those services deemed medically necessary and which are delivered within the lawful scope of the licensed provider.

Covered providers include:

Drug and alcohol abuse treatment facilities
Hospitals
Licensed clinical social workers
Licensed professional counselors
Psychologists
Psychiatric residential and nonresidential treatment of facilities
Physicians

Types of services covered:

Day program services
Detoxification
Group therapy
Non-residential treatment programs
Office visits
Partial in-patient
Residential treatment programs

The Plan will only pay for the services rendered by participating providers or within participating facilities. Residential treatment must meet the following criteria:

1. The facility must meet the definition of an approved "residential treatment facility" as defined by this Plan. And,

2. The confinement must begin within thirty (30) days of a covered hospital confinement lasting at least three (3) days, and it must be due to the condition that required previous hospital confinement. And,

3. The confinement must be pre-certified by the Plan or its review organization.

Participating provider charges will be subject to the deductible, and payable at 90% of the negotiated rate.

Warning:

- Services and/or treatment not pre-certified will not be covered by the Plan.

- In-patient and out-patient treatments or services rendered in non-participating or out-of-network facilities are subjected to the deductible and payable at 70% of 130% of the Plan's Reasonable and Allowed Amount (RAA).
- The Plan does not cover treatments that are not completed in their entirety.
- Group homes, halfway houses, wilderness programs, camps or institutions providing custodial care are not considered residential treatment facilities under this Plan.
- Detoxification in a hospital or rehabilitation center greater than seven days.

TRANSPLANTS

In order to receive benefits,

1. Prior approval is required;
2. Treatment must be coordinated with the Plan's case management provider; and
3. All transplants must be performed at a center of excellence. A center of excellence is a hospital that has been specifically approved and designated to perform these procedures.

The Plan will cover only those transplants that it determines to be non-experimental and non-investigational. If alternative remedies are not available, benefits will be provided for the following transplant surgeries for the following body organs:

- Bone marrow transplants
- Cornea
- Heart
- Heart & Lung
- Kidney
- Kidney/Pancreas
- Liver
- Lung
- Pancreas

Recipient:

Participating provider charges will be subject to the deductible, and annual out-of-pocket maximums and payable at 90% of the negotiated rate.

Non-participating provider charges will be subject to the deductible and annual out-of-pocket maximums and payment will be made at 70% of the Funds reasonable allowable amount (RAA)

Donor:

If a person covered under this Plan donates an organ or tissue to a person who is not covered under this Plan, then this Plan will cover those expenses up to a maximum of $10,000.00 for all donor-related costs per transplant procedure.

Limitations:

The donor benefit is only payable if the expenses are not covered by another source, including, but not limited to, another healthcare plan.

Additionally, the Plan does not cover:

- Travel expenses, lodging, meals or other accommodations for donors or guests.
- Donor search fees.

If a participant of this Plan is the recipient of an organ transplant then the Plan provides coverage for the charges for the acquisition of the transplanted organ or tissue which includes the cost of the organ

TRAVELERS

Local 697 Members Working Outside Lake and Newton Counties, Indiana

It is recognized that some participants fail to qualify for eligibility or continued eligibility because they travel out of the I.B.E.W. Local 697 jurisdiction. In order to assist Local 697 members employed in covered work within another I.B.E.W. Local's jurisdiction, the Plan permits the employer's Health Fund contributions received for work performed in another I.B.E.W. Local Unions jurisdiction to be reciprocated back to the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan.

However, this process is not automatic. Consequently, the traveler must instruct that Local's benefit fund office to reciprocate these employer contributions back to the corresponding Local 697 Benefit Plan. To do this, you must:

1. Either register your reciprocity authorization with the Electronic Reciprocal Transfer System (ERTS) in the jurisdiction where the work is to be performed, or,

2. Attain, complete properly and submit the ERTS registration form to the Benefit Funds of your home Local prior to obtaining employment in another Local's jurisdiction. You should register

Once completed, the Health Fund contributions received for the covered work that you performed either partly or on a full-time basis within the jurisdiction of another I.B.E.W. Local Union will be sent back to the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan. In accordance with national I.O. Guidelines, contributions received from another I.B.E.W. Local Health Fund that participates in the I.O. Health Reciprocity Agreement will be credited to the employee as hours work.

Participants are informed that:

A. When working in another I.B.E.W.'s jurisdiction, they are subject to that jurisdiction's collective bargaining agreement.

B. If you do not arrange to have your employer's contributions transferred to this plan, you and your family's participation in this plan will end when you fail to work 420 hours in a work quarter or fail to make the required self-payments or COBRA payments.

C. It generally takes a minimum of eight weeks before contributions made based on the number of hours you worked in another jurisdiction are submitted back to the Local 697 Fund Office.

D. It's your responsibility to keep track of your contributed hours. If there is a discrepancy between the number of hours worked and the number of hours reciprocated to the Fund Office, you must contact the jurisdiction (or local) where the work was performed to resolve any issues.

E. If a traveler owes money to the Health and Benefit Plan, any reciprocated hours will NOT be applied to your initial or continued eligibility until the debt is paid. After the debt is satisfied, all contributions received from another I.B.E.W. Local Health Fund will be credited to the Employee as hours worked.

Warning: Remember, only the contributions made based on the number of hours worked after the date you register on ERTS or when the ERTS registration form is filed are subject to be transferred back to the Fund offices of your home Local.

TRIGGER POINT INJECTIONS

Precertification is required for trigger point injections. Approval is generally provided in sets of three injections. However, administration of future injections is predicated upon the treating physician providing the Plan or its designated disease or case manager with updated notes.

The Plan does not have any annual maximum limits on the amount of trigger points injections a participant may receive in a year. Nevertheless, should a patient's trigger point injection treatment no longer offer relief or rather "plateau", the Plan will require the inclusion of a pain management physician to work in conjunction with the treating physician to come up with another solution or options for the patient.

If the trigger point injection is administered by a participating provider, charges will be subject to the deductible, and payable at 90% of the Reasonable and Allowed Amounts.

If the trigger point injection is administered by a non-participating provider, charges will be subject to the deductible and payment will be made at 70% of the Funds Reasonable and Allowable Amount (RAA)

VISION BENEFITS

Your vision benefits are self-insured by the Fund through an administrative arrangement with Vision Service Plan (VSP). This Summary Plan Description is not meant to interpret, extend, or change the provisions of the VSP contract in any way. The provisions of the VSP contract may only be accurately determined by reading the actual contract document. A copy of the vision contract is on file at the Fund Office and you or your legal representative may read it at any reasonable time or request a copy. In the event of any discrepancy between this Summary Plan Description and the actual provisions of the vision contract, the vision contract provisions will govern.

Vision care services MUST be provided by a licensed optometrist or ophthalmologist. Examinations and prescribed lenses are considered covered expenses once a calendar year

between January 1st and December 31st (the “vision plan year”). Frames are considered a covered expense once every two consecutive calendar years.

The Plan provides vision care benefits as follows:

SERVICE	VSP (IN-NETWORK) DOCTOR	OUT OF NETWORK ALLOWANCE
Exam – Once every calendar year	Provided in full after a $5 co-pay.	$35.00
Frame – Once every two calendar years	Provided in full up to a maximum allowance of $140 after a $10 materials co-pay	$45.00
Lenses (Per pair, every calendar year)		
Single Vision	Provided in full after a $10 materials co-pay	$25.00
Lined Bifocal	Provided in full after a $10 materials co-pay	$40.00
Line Trifocal	Provided in full after a $10 materials co-pay	$55.00
Lenticular	Provided in full after a $10 materials co-pay	$80.00
Contacts		
Elective (Once every calendar year and In-lieu of eyeglasses)	Covered up to $120 allowance after a $10 materials co-pay	$105.00
Visually necessary (Once every calendar year)	Provided in full after $10 materials co-pay	$210.00
Safety Glasses (Employee Only)	Provided in full every calendar year when received in combination with an eye exam and eyeglasses or contacts	No Benefit

The Plan also provides the following extra discounts and savings:

Glasses and Sunglasses

- ✓ Average 20-25% savings on all non-covered lens options

- ✓ 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last vision examination.

Contact Lenses

- ✓ 15% off the cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

- ✓ 15% off of the regular price or 5% off of the promotional price. Discounts are only available from contracted facilities. If you utilize a non-VSP provider, you'll receive a lesser benefit.

Before you see a non-VSP provider, call VSP at (800) 877-7195 for more details.

The Plan's vision benefits are "excepted benefits" that are not subject to HIPAA or the Affordable Care Act. Accordingly, you have the right to opt-out of this coverage if you wish. To do so, please contact the Fund Office for the appropriate form. However, please note that there is no charge for the Fund's vision coverage and opting-out will not decrease your (or your employer's) premium costs.

RETIREE COVERAGE

Benefits and Provisions for Retired Participants who <u>are not eligible</u> for Medicare Benefits.

BENEFITS

Benefits for retired participants who are:

A. Under the age of sixty-five (65), and
B. Not eligible for Medicare Benefits,

Will be the same as the benefits that are provided to active members, except where noted directly below:

1. A retiree and any eligible dependents dental allowance in the year in which they retire, will be limited to the lesser of the unused active participant dental allowance for that calendar year or $500.00. Each subsequent calendar year they will be limited to a maximum dental benefit of $500 per family.

2. Retirees will not be entitled to any short-term disability benefits.

3. Retired participants may opt for a pair of safety glasses in lieu of regular frames once every twenty-four (24) months

Warning: The Plan's network and listing of participating facilities are subject to change, as such, please refer to the Plan's website for the link the provider network and the latest listing of participating facilities.

Further, retirees and their eligible dependents are reminded that all provisions within this document, including, but no limited to coordination of benefits, eligibility, enrollment, exclusions, fraud, and self-payments, will remain in effect.

COBRA

Should your eligibility terminate under the Plan, you will be offered the opportunity to continue your coverage under this Plans C.O.B.R.A. provision. The monthly amount of your COBRA payment and the length of COBRA coverage will be limited to the applicable terms set forth within this Plans C.O.B.R.A. provisions.

Further, Medicare entitlement is a terminating event under COBRA coverage. A person:

1. Who is receiving pension benefits; and,
2. Elects COBRA coverage; but,
3. Was not eligible for Medicare when the election of COBRA coverage is made; but,
4. Who later becomes eligible for Medicare,

will lose the right to make any additional self-payments for COBRA coverage as well as lose the ability to get into the Retiree Benefits Plan later, regardless of the length of your COBRA coverage period.

Retirement is a qualifying event under COBRA coverage. When you retire, you may be entitled to make self-payments for up to 18 months for continued coverage under the COBRA coverage rules. If you are receiving pension benefits and elect COBRA coverage, you cannot get into the Retiree Benefits Plan later, regardless of the length of your COBRA coverage period.

DEATH

In the event of your death, the Plan will extend coverage, free of charge, to your eligible surviving spouse and eligible dependent children for a maximum period of three calendar months from the end of the month in which you passed. After which time, the surviving spouse may elect to continue to make timely premium self-payments to continue coverage for themselves and any dependent children. Failure to either:

1. Elect to continue coverage through this Plan by the end of that third month and/or,
2. Failure to make timely self-payments by the end of the first business day of each month,

will result in the termination of any surviving dependents eligibility to receive benefits under this Plan. Please refer to the section of this provision titled “Termination of Eligibility.”

ELIGIBILITY REQUIREMENTS

In order to be covered under the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan during your retirement, a participant must meet ALL of the following eligibility requirements:

- Must be receiving monthly Early, Regular, or Disability pension payments from the Local Union No. 697 I.B.E.W. and Electrical Industry Pension Fund.

With respect to non-bargained employees' who are identified within a participation agreement between the Lake County Indiana, NECA – IBEW and their employer, and who are not entitled to a monthly benefit from the Local Union No. 697, I.B.E.W. and Electrical Industry Pension Fund, you must have attained the age of 62 or older.

- In the fifteen (15) years directly prior to retirement, you will have had to be covered under this Plan for a minimum of forty (40) calendar year quarters. Periods in which a participant was on C.O.B.R.A. will not county toward the forty (40) calendar year quarter requirement.

- There must be no coverage gap between your coverage as an active employee and your coverage as a retiree. If you retire without electing this Plan's retiree coverage, you cannot enroll at a later date.

- You must not owe any monies to the Lake County Indiana NECA – I.B.E.W Health and Benefit Plan.

Failure to meet each of these criteria will result in your inability to receive coverage during your retirement.

Eligibility Requirements for Dependents of Retired Employees

Coverage for those individuals who meet this Plan's definition of dependent, will start on the later of the same date that your retiree coverage began or on the first day of the month after the required documentation needed to establish proof that these individuals meets the Plan's definition of "dependent" has been deemed satisfactory, **AND** you properly enrolled them into the Plan.

Provided you maintain coverage your:

- Dependent child will be covered until the date they cease to meet this Plan's definition of dependent, or at the end of the calendar month in which they obtain the age of 26, whichever is first.
- Dependent child or spouse will be covered until the date that they enter the armed forces of any country on a fulltime basis.
- Spouse will be covered up to the date of their death.
- Spouse will be covered up to the date of your divorce.

Warning:

- Your "spouse" is the person to whom you have been legally married for at least one year and a day (366 days) prior to the initial date that your retiree benefits started.

- Participants and dependents are reminded that the Plan reserves the right to require participants to provide updates on their dependent status as often as it deems necessary. Should the Plan not receive the requested information within three months of the due date stated within the Plans request, the dependent's coverage for benefits will be suspended.

Failure to respond within six-months of the date of the initial request will result in the dependent's termination of eligibility with this Plan. Upon which, all claims incurred prior to the termination of benefits, but after the suspension will remain the responsibility of the participant to pay.

Continued Coverage as a Retiree

Once your retiree coverage starts, you must maintain continuous coverage for yourself and your dependents. If you let your coverage lapse, it will be a permanent lapse.

Once again, participants are advised that self-pay payments are due on the first business day of the calendar month. Failure to ensure that your self-payment is received by the close of business on the first day of the month will result in termination of coverage.

Termination of Eligibility

Coverage for retired participants will terminate upon:

- At age 65, or at such time that you are entitled to receive Medicare benefits, whichever, comes first. If you become Medicare eligible, please refer to the section of the Book titled: "Benefits and Provisions for Retired Participants who ARE eligible for Medicare Benefits."
- The last day of the last month for which a correct and on-time self-payment was made by or on behalf of you or any surviving eligible dependent.
- An act of fraud, as defined by this Plan. Or,
- Upon death.

Warning:

1. If you let your coverage lapse, it will be a permanent lapse.
2. Should your eligibility in this Plan terminate, it will result in your inability to receive Plan P benefits.
3. Upon the termination of your eligibility under this Plan, you will be offered the opportunity to continue your coverage under this Plans C.O.B.R.A. provision. The monthly amount of your COBRA payment and the length of COBRA coverage will be limited to the applicable terms set forth within this Plans C.O.B.R.A. provisions.
4. Upon the termination of your eligibility under this Plan, any remaining monies within the participants Health Reimbursement Account will be forfeited.

Termination of Surviving Dependents Eligibility

Provided you maintain coverage your:

- Dependent children will be covered up to the date they cease to meet this Plan's definition of dependent, or at the end of the calendar month in which they obtain the age of 26, whichever is first.
- Dependent children or surviving spouse will be covered until the date that they enter the armed forces of any country on a fulltime basis.
- Surviving spouse will be covered up to the date of their death.
- Surviving spouse will be covered up to the date of your divorce.
- Surviving spouse will be covered up to the date that they remarry.

RETIREE COVERAGE FOR THOSE WHO ARE ELIGIBLE FOR MEDICARE BENEFITS PART A AND PART B.

BENEFITS

The Plan becomes the secondary insurer behind Medicare for those retired participants who have met the eligibility requirements of the Plan. Retired participants will be provided the same benefits that are provided to active members AND covered by Medicare, except where noted directly below:

1. A retiree and any eligible dependents dental allowance in the year in which they retire, will be limited to the lesser of the unused active participant dental allowance for that calendar year or $500.00. Each subsequent calendar year they will be limited to a maximum dental benefit of $500 per family.

2. Retirees will not be entitled to any short-term disability benefits.

3. Retirees and any eligible dependents who have Medicare as their primary insurer will not have access to the Plan's Grand Rounds benefit, and

4. Retired participants may opt for a pair of safety glasses in lieu of regular frames once every twenty-four (24) months

Warning: The Plan's network and listing of participating facilities are subject to change, as such, please refer to the Plan's website for the link the provider network and the latest listing of participating facilities.

Further, retirees and their eligible dependents are reminded that all provisions within this document, including, but no limited to coordination of benefits, eligibility, enrollment, exclusions, fraud, and self-payments, will remain in effect.

COBRA AND MEDICARE

Retirement is a qualifying event under COBRA coverage. When you retire, you may be entitled to make self-payments for up to 18 months for continued coverage under the COBRA coverage rules. If you are receiving pension benefits and elect COBRA coverage, you cannot get into the Retiree Benefits Plan later, regardless of the length of your COBRA coverage period.

Medicare entitlement is also a terminating event under COBRA coverage. A person who is not eligible for Medicare when the election of COBRA coverage is made but who later becomes

eligible for Medicare will lose the right to make any additional self-payments for COBRA coverage.

CONTINUED COVERAGE AS A RETIREE

Once your retiree coverage starts, you must maintain continuous coverage for yourself and your dependents. If you let your coverage lapse, it will be a permanent lapse.

Once again, participants are advised that self-pay payments are due on the first business day of the calendar month. Failure to ensure that your self-payment is received by the close of business on the first day of the month will result in termination of coverage.

COORDINATING THIS PLAN'S RETIREE BENEFITS WITH MEDICARE

When a participant becomes Medicare eligible, this Plan requires that he or she enroll in both Parts A and B at that time. Participants that fail to either enroll in both Parts A and B of Medicare or enroll late will not be able to receive any benefits from this Plan for charges that would have been covered by Medicare. If you need information about Medicare enrollment or benefits, contact your local Social Security office.

Additionally, Medicare has rules governing when it is primary and when it is secondary. All plans, including this one, are required to follow those rules, and this Plan will always pay secondary to Medicare Parts A and B when it is allowed to do so by law. In general, if you are retired and you or any of your dependents are over the age of sixty-five (65) this Plan will be secondary to Medicare.

When this Plan is secondary, the benefits normally payable by the Plan may be reduced by the amount Medicare pays, but only if the total of this Plan's normal benefits and Medicare's payment will be more than 100% of covered expenses.

The Plan does not coordinate benefits with Medicare Part D prescription drug plans.

DEATH

In the event of a covered retiree's death, the Plan will extend coverage, free of charge, to their eligible surviving spouse and eligible dependent children, for three calendar months.

The three-calendar month term will begin after the month in which you passed. After which time, and provided that the surviving spouse submitted an application to the Fund Manager within ninety (90) days following the death of the covered retiree, the spouse may elect to continue to make timely premium self-payments to continue coverage for themselves and any dependent children. Failure to either:

1. Elect to continue coverage through this Plan by the end of the ninety (90) day period and/or,

2. Failure to make timely self-payments by the end of the first business day of each month,

Will result in the termination of any surviving dependents eligibility to receive benefits under this Plan. Please refer to the section of this provision titled “Termination of Surviving Spouse and Dependents Eligibility.”

ELIGIBILITY

Eligibility Requirements.

In order to be covered under the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan during your retirement, a participant must meet **ALL** of the following eligibility requirements:

- Must be receiving monthly pension payments from the Local Union No. 697 I.B.E.W. and Electrical Industry Pension Fund or receiving Social Security retirement benefits, or,

  If working for a contributing employer signatory to a participation agreement, but not entitled to a monthly Pension benefit from the Local Union No. 697 I.B.E.W. and Electrical Industry Pension Fund or receiving Social Security retirement benefits, must have obtained age sixty-two (62) or greater.

- In the fifteen (15) years directly prior to retirement, you will have had to be covered under this Plan for a minimum of forty (40) calendar year quarters. Periods in which a participant was on C.O.B.R.A. will not county toward the forty (40) calendar year quarter requirement.

- There must be no coverage gap between your coverage as an active employee and your coverage as a retiree. If you retire without electing this Plan’s retiree coverage, you cannot enroll at a later date.

- Cannot be receiving COBRA benefits.

- You must not owe any monies to the Lake County Indiana NECA – I.B.E.W Health and Benefit Plan.

- Must be enrolled in Medicare Parts A and B.

Failure to meet each of these criteria will result in your inability to receive coverage during your retirement.

Eligibility Requirements for Dependents of Retired Employees

Coverage for those individuals who meet this Plan’s definition of dependent, will start on the later of the same date that your retiree coverage began or on the first day of the month after the required documentation needed to establish proof that these individuals meets the Plan’s definition of “dependent” has been deemed satisfactory, **AND** you properly enrolled them into the Plan.

Provided you maintain coverage your:

- Dependent child will be covered until the date they cease to meet this Plan's definition of dependent, or at the end of the calendar month in which they obtain the age of 26, whichever is first.
- Dependent child or spouse will be covered until the date that they enter the armed forces of any country on a fulltime basis.
- Spouse will be covered up to the date that they become eligible for Medicare. Failure to enroll at the time he/she becomes eligible for Medicare will cause his or her coverage under this Plan to terminate. If enrolled timely in Medicare, then your:

    - Spouse will be covered up to the date of their death.
    - Spouse will be covered up to the date of your divorce.

Warning:

- Enrollment at the time of first being eligible to receive Medicare benefits is a prerequisite for eligibility under this Plan. Should you or your spouse not enroll in Medicare Part A and Part B when you or they first become eligible to enroll, then you or they will no longer meet the eligibility requirements of the Plan and coverage will terminate.

- If you or an eligible spouse decline Part B upon initial enrollment in Medicare, then this Plan will only coordinate its payment with Medicare so that the participant does not receive more than 100% of the allowable charge for those in hospital stays, skilled nursing care, hospice care, and home health-care services that are covered by this Plan **AND** covered by Medicare Part A.

- Your "spouse" is the person to whom you have been legally married for at least one year and a day (366 days) prior to the initial date that your retiree benefits started.

- Participants and dependents are reminded that the Plan reserves the right to require participants to provide updates on their dependent status as often as it deems necessary. Should the Plan not receive the requested information within three months of the due date stated within the Plans request, the dependent's coverage for benefits will be suspended.

  Failure to respond within six-months of the date of the initial request will result in the dependent's termination of eligibility with this Plan. Upon which, all claims incurred prior to the termination of benefits, but after the suspension will remain the responsibility of the participant to pay.

Returning to Covered Employment After Retirement

Participants who have attained the age of sixty-five (65) are permitted to return to active employment for thirty-nine (39) hours a month with no adverse impact on your eligibility for retiree coverage. Should you exceed that limit

You can work enough to re-satisfy the active plan's initial eligibility rules and become covered again as an active employee, in which case your retiree coverage will be on hold until you lose your active coverage.

While you are working, your employers' contributions that are in excess of the amount required to maintain eligibility will be added to a Health Reimbursement Agreement account in your name.

If you have a quarter where you would lose eligibility due to a shortage of hours, you can self-pay the difference. However, you cannot self-pay for the full 420 hours needed for active coverage.

(If you have a quarter with 0 hours, you will be considered "retired," and will need to self-pay to reinstate your retiree coverage.)

If you allow your coverage to lapse, you can only re-enroll in the Plan's retiree program if you re-satisfy the retiree eligibility requirements, including the rule requiring 40 quarters of active eligibility during the prior 15 years.

When you re-elect retiree coverage, you may elect coverage for the same dependents who were covered when you returned to work, provided any such person still meets the Plan's definition of a dependent.

Termination of Eligibility

Retiree coverage will terminate upon:

- The last day of the last month for which a correct and on-time self-payment was made by or on behalf of you or any surviving eligible dependent.
- An act of fraud, as defined by this Plan. Or,
- Upon death.

Warning:

A. If you let your coverage lapse, it will be a permanent lapse.

B. Should your eligibility in this Plan terminate, it will result in your inability to receive Plan P benefits.

C. Upon the termination of your eligibility under this Plan, you will be offered the opportunity to continue your coverage under this Plans C.O.B.R.A. provision. The monthly amount of your COBRA payment and the length of COBRA coverage will be limited to the applicable terms set forth within this Plans C.O.B.R.A. provisions.

D. Upon the termination of your eligibility under this Plan, any remaining monies within the participants Health Reimbursement Account will be forfeited.

Termination of Surviving Spouse and Dependent Eligibility

Provided that your surviving dependents make timely self-payments, coverage will be provided as follows:

- Dependent children will be covered up to the date they cease to meet this Plan's definition of dependent, or at the end of the calendar month in which they obtain the age of 26, whichever is first.
- Dependent children or surviving spouse will be covered until the date that they enter the armed forces of any country on a fulltime basis.
- Surviving spouse will be covered up to the date of their death.
- Surviving spouse will be covered up to the date that they remarry.

END-STAGE RENAL DISEASE

If a person is entitled to Medicare due to end stage renal disease, this Plan will be the primary plan for the first 30 months. Medicare becomes the primary plan after that.

HRA and RETIREMENT

Participants who have monies in their Health Reimbursement Agreement account will be allowed to keep their account and utilize them in accordance to this Plan's HRA provisions.

MEDICARE INSURANCE

Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care.

Medicare has two parts and they are:

- Hospital insurance (also called Medicare "Part A"), which helps pay for care in a hospital or skilled nursing facility, home health care and hospice care; and
- Medical insurance (also called Medicare "Part B"), which helps pay for doctors, out-patient hospital care and other medical services.

Hospital Insurance Part A

Medicare hospital insurance can help pay for inpatient care in a hospital or skilled nursing facility following a hospital stay, home health care and hospice care. Except for home health care, each is subject to a "benefit period," which measures your use of services covered by Medicare Part A.

A benefit period starts the day you enter a hospital. It ends when you have been out of the hospital or other facility primarily providing skilled care for 60 days in a row. If you remain in such a facility (other than a hospital), a benefit period ends when you have not received any skilled care there for 60 days in a row. There is no limit to the number of benefit periods for hospital and skilled nursing facility care. But special limits do apply to hospice care.

Inpatient Hospital Care

If you need inpatient care, hospital insurance helps pay for up to 90 days in any Medicare-participating hospital during each benefit period. Hospital insurance pays for all covered services for the first 60 days, **except for a deductible amount** that you must pay. For days 61 through 90, hospital insurance pays for all "covered services" **except for a daily co-insurance amount** that you must pay.

If you are out of the hospital for at least 60 days in a row, and then go back in, a new benefit period begins—your 90 days of coverage starts all over again and you pay another deductible.

What if you need more than 90 days of inpatient care during any benefit period? You can use some or all of your "reserve days." Reserve days are an extra 60 hospital days you can use if your illness keeps you in the hospital for more than 90 days. You have **only** 60 reserve days in your lifetime and you decide when you want to use them. For each reserve day you use, hospital insurance pays for all covered services **except for a daily coinsurance amount.**

Skilled Nursing Facility Care

If you need inpatient skilled nursing or rehabilitation services after a hospital stay and you meet certain other conditions, hospital insurance helps pay for up to 100 days in a Medicare-participating skilled nursing facility in each benefit period.

Hospital insurance pays for all covered services for the first 20 days. For the next 80 days, it pays for all covered services, **except for a daily coinsurance amount.**

Note*:* It is important to know that Medicare does not pay for "custodial care" when that is the only kind of care you need. Custodial care is the type of care many people receive in nursing homes. It is care that could be given by someone who is not medically skilled (for example, help with dressing, walking or eating).

Home Health Care

If your health problems cause you to stay at home and meet certain other conditions, Medicare can pay the full-approved cost of home health visits from a Medicare-participating home agency. There is no limit to the number of covered visits you can have.

If you need one or more of the services Medicare pays for, then hospital insurance also covers part-time or intermittent services of home health aides, occupational therapy, physical therapy, medical social services and medical supplies and equipment. A 20 percent co-payment applies to covered durable medical equipment (e.g., wheelchairs and hospital beds).

Hospice Care

A hospice program provides pain relief and other support services for terminally ill people. Medicare hospital insurance can help pay for hospice care for terminally ill beneficiaries if the care is provided by a Medicare-certified hospice and certain other conditions are met.

You can get hospice care as long as your doctor certifies that you are terminally ill and probably have less than six months to live. Even if you live longer than six months, you can get hospice care as long as your doctor re-certifies that you are terminally ill.

Hospice care is given in periods of care. As a hospice patient, you can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods. At the start of each period of care, your doctor must certify that you are terminally ill in order for you to continue getting hospice care. A period of care starts the day you begin to get hospice care. It ends when your 90 or 60-day period is up. If your doctor re-certifies that you are terminally ill, your care continues through another period of care.

Medicare Insurance (Part B)

Medicare Part B insurance helps pay for doctors' services and many other medical services and supplies that are not covered by the hospital insurance part of Medicare. Each year, you must pay an annual medical insurance deductible amount before Medicare begins paying. After you have paid the deductible, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year. Medical Insurance (Part B) covers:

- Inpatient medical care;
- Outpatient hospital care;
- Inpatient and outpatient medical supplies;
- Ambulance services;
- X-rays;
- Laboratory tests;
- Durable medical equipment such as wheelchairs and home orthopedic beds;
- Services of certain especially qualified professionals that are not doctors;
- Physical and occupational therapy;
- Speech therapy;
- Partial hospitalization for psychiatric medical attention;
- Home attention if you don't have Part A;
- Blood;
- Yearly mammograms;
- Pap smears;
- Pelvic and breast examinations;
- Diabetes glucose monitoring and education;
- Colorectal cancer screenings;
- Bone mass measurements;
- Flu and pneumococcal pneumonia shots.

You are responsible for paying the remaining 20 percent of the cost. This is called Medicare coinsurance.

You should contact the Social Security Administration Office nearest your home for complete information on Medicare benefits and exclusions or contact the telephone numbers and websites shown below.

Medicare's Internet Website **www.medicare.gov** Medicare's Toll-Free Number 1-800-633-4227 TTY: 1-877-486-2948 Social Security's Internet Website **www.ssa.gov** Toll-Free Number 1-800-772-1213 TTY: 1-800-325-0778