LOCAL 697

I.B.E.W.

HEALTH AND BENEFIT PLAN

OCTOBER 1, 2024

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HELLO

We are pleased to provide you with this updated Summary Plan Description (SPD) describing your health benefits under the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Plan ("The Plan").

This document also serves as the Plan Document. Further, this document supersedes and replaces any prior Summary Plan Description book and Summaries of Material Modifications previously provided by the Plan for the benefits described in it.

If you are a person who:

- Wants to base their decisions on facts, and not on word of mouth.
- Recognizes that better decisions are based upon understanding and awareness, and that better decisions, generally, produce superior outcomes.
- Embraces understanding, awareness, and accountability as character traits that move you, as well as all people, forward.
- View these traits as vital attributes that allow you to lead, succeed and enable you to help others who wish to do the same. And,
- Understands that these traits foster trust, which in turn unites us as a Union and community.

Then you will need to immerse and dedicate yourself to understanding the benefits, policies, and provisions of this Plan.

By the way, that does not have to be completed all at once. It can be done little by little and over several days or even weeks. The **important** thing is that you commit to doing it and then do it.

Regarding commitment, it is this Plan's belief that good health, like anything else, takes a strong commitment. Part of that commitment is recognizing the rights and responsibilities of all the parties involved in your health care. To that end, the Plan has provided you with the following list of commitments and responsibilities. Please read through them as they are what guides this Plan's relationship with you, your family, and your healthcare professional.

Patrick Keenan
Fund Manager
December 31st, 2023

Plan Commitments

The Lake County Indiana, NECA-IBEW Health and Benefit Plan is committed to:

- Recognizing and respecting you as a Plan Participant
- Providing you with information to help you become an informed participant of the Plan.
- Providing you with the benefits for which you have coverage.
- Preserving the privacy of your personal health information, consistent with federal law and Plan policies.
- Candid and clear conversations and communications.
- Encouraging your open discussions with your health care professionals and providers.
- Process claims as they are presented and in a timely manner.
- Sharing our expectations of you as a Plan Participant.

Your Responsibilities

It is the participant's responsibility to:

1. Read, learn, understand, and follow the requirements, provisions, rules, and guidelines set forth within this document.
2. Read all materials and communications concerning this Plan at the time of issuance.
3. Timely provide to the Plan accurate and complete information needed to administer your Health Benefit Plan, including, but not limited to:
    - Other health Benefit coverage and other insurance Benefits you or any eligible dependent may have in addition to your coverage with this Plan.
    - Changes in you or your dependents marital status.
    - Changes in dependent status. (Births, Adoptions, Separations, Divorce, Death)
    - Changes in your contact information.
4. Notify the Plan immediately of any change that would affect the Plan's ability to communicate properly with you or your eligible dependents. Such changes

would include, but is not limited to, a change of residence, a new e-mail address, or a change in a home or mobile phone number.

5. To keep your beneficiaries' elections current and to immediately provide the Plan with any changes in your beneficiary's contact information whenever they occur. Such changes would include, but are not limited to, changes of physical address, changes of email addresses and of course, phone numbers.
6. 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.
7. 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.
8. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
9. To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received.
10. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
11. 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.
12. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
13. 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.
14. 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.
15. Understand that the Health and Benefit Plan:
    - Is accountable for the administration of the benefits, provisions and rules listed within this document.
    - Can only adjudicate claims as they are presented.
    - Is not responsible for claim issuance and cannot make claim issuance corrections of any sort.

- Will not incur any expense, including time and/or material, remedying the effects of the decisions, actions, or sadly, lack thereof of any participant, provider or third party that is either illegal or which adversely affect the Plan. Or to phrase differently, decisions and/or actions, or lack thereof, that adversely affect the Plan do not bind the Plan to any action to mitigate the effects of that decision nor does it absolve you from any adverse consequence or from being accountable to cure any violation, including the full and immediate remuneration of any expense to the Plan.

16. Understand your health problems and participate with your health care professionals and providers, to develop mutually agreeable treatment goals.
17. Provide, to the extent possible, any and all information that your health care professional requires to provide the proper care.
18. Read, learn, and understand your benefits. It is in every participant's best interest to do so. If you have a question or if you do not understand what you read, **call the Fund Office before proceeding with any action.** The Office number is 219-940-6181.

Document Layout & Design

There are two things you need to know about this document and its design. First, this document serves both as the Summary Plan Description Book and the Plan Document.

Secondly, we like the alphabet. It helps form the basis of our language and communication for a lifetime. There are twenty-six letters in our alphabet, and we have used them in some very interesting combinations within this document. To that end, and with the exception of this section, and the ones titled "A Brief Overview of Your Health and Benefit Plan" and "General Plan Information" directly following this section, and the section titled "Subject Medical Bill Administration" in the addendum, the topics, rules, provisions, and benefit descriptions have been arranged in alphabetical order to facilitate understanding and use. For instance, if you wanted to enroll your newborn child or spouse 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.

While all benefits and provisions are important, you will notice that some are more descriptive than others, or that the Plan has emphasized the significance of certain rules or elements by repeating them or by utilizing the terms **important**, **note**, **remember** and **warning.**

After reading this document in its entirety, 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.

OR

Access the Funds website @ www.ibew697benefits.com.

A Brief Overview of Your Health and Benefit Plan

There are three **important** features that 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 Lake County Indiana, NECA – IBEW Health and Benefit Fund is a self-funded health benefit plan. The cost of the Plan is paid with employer contributions and investment income derived from those employer contributions. Employee self-payments are permitted in limited situations. Benefits under the Plan are provided through a Taft-Hartley Trust and are used to fund payment of covered claims and administrative expenses.

Thirdly, as a self-funded health benefit plan, the Health and Benefit Plan directly provides you and any eligible dependent the benefits contained within this document. As such, payment for the covered benefits is ultimately the sole financial responsibility of the Fund and paid directly from the assets of the aforementioned Trust and not an insurance company.

There are other advantages of participating with this Plan, such as:

A. The money the Plan spends on benefits is a form of tax-free income to you.
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.

Designated Hospitals and Their Included Facilities: This section refers to hospitals and their related facility charges that are incurred when a person utilizes a signatory hospital. 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 that have agreed to accept the Plan's determination of Reasonable Allowable Amount as payment in full for any covered expense. When utilizing a level "A" hospital or facility:

1. The participant will not be balance billed for any amounts in excess of the Plans determined Reasonable Allowable Amount for any covered service.
2. The incurred charges will not be subject to the Plan's annual deductible or co-insurance requirement.

Level B: hospitals are those 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.

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.

Out-of-network providers and out-of-network hospitals and facilities: An out-of-network provider and an out-of-network hospital or facility are those entitles 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.

Participating Physicians and Facilities / In-Network Physicians and Facilities: The Trustees have contracted directly 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 or facilities as defined by the Fund, the Fund will pay ninety percent (90%) of the negotiated fee for covered services that exceed your annual deductible.

General Plan Information

The Plan is sponsored by a joint labor-management Board of Trustees. The Board of Trustees serves as both the Plan Sponsor and the Plan Administrator. The Board is comprised of four Trustees appointed by the Union and four 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 and for the benefit of the eligible collectively bargained individuals, their eligible dependents, and 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. (Please reference the sections of this document titled "COBRA," "Continued Group Health Plan Coverage," "Eligibility," and "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 with 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:

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".

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, which 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

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

The Plan is governed by the requirements of the Employee Retirement Income Security Act (ERISA) as it applies to Employee Welfare Plans and all other applicable law. Any provision of this Plan that may be contrary to any such applicable law, equitable principle, regulation, or valid court order will be interpreted to comply with same.

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, procedures, 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.

The Trustees have the authority to amend the Plan, which includes the authority to change eligibility rules and other provisions of the Plan, to increase, decrease or eliminate benefits. 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 amend 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 a 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 a 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.

Fund Attorney

Fund Attorney:

Harold G. Hagberg,
Hagberg and Associates,
520 E 86th

Merrillville, IN 46307
Telephone: 1-219-864-9055.

Fund Consultant

Fund Consultant:

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

Get Plan Material

You can read Plan documents and material by making an appointment at the Fund Office during normal business hours. Also, copies of the requested material will be mailed to you if you send a written request to the Fund Office. There will be a charge for copying some of the material, so contact the Fund Office to find out the cost before requesting material. Your payment must be attached to your written request for the material. The Fund's Office address is: 7200 Mississippi Street, Suite 300, Merrillville IN 46410. The Fund's phone number is (219) 940-6181.

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 Vested Rights

Benefits under this Plan are NOT vested**.**

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 for surviving dependents of eligible participants who died prior to January 1, 2001. This class of benefits has been closed to new participants since that date. The eligibility requirements and benefits for this class 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 Administration Information

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.
Plan Status: Grandfathered
Applicable Law: ERISA
Plan Year: January 1st through December 31st
Plan Number: 501

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 29CFR §§ 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 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 covered under this Plan can be found within the section of this book titled "Definitions" under the terms "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.

Plan Trustees:

Union Trustees	**Employer Trustees**
Alec Davis	Rick Anderson
Phil Hernandez	Thomas Corsiglia
Frank Mikolajczyk	Edward Shikany
Daniel Waldrop	William Walton

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 of whether 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.

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

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. 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 the Plan Administrator with such information as requested and as may be necessary to implement this provision.

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.

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.

Third Party Administrator:

MagnaCare
P.O. Box 1001
Garden City, NY 11530
Payor ID: 11303

Unclaimed Plan Funds

In the event a benefits check issued by the Plan, or its 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.

SUMMARY SCHEDULE OF BENEFITS

FOR ACTIVE PARTICIPANTS AND EARLY RETIREE'S EXCEPT WHERE OTHERWISE NOTED

The following is a **SUMMARY** of participant benefits. In the event of a conflict between the SUMMARY and the actual BENEFIT DESCRIPTIONS, the rules, and provisions of the BENEFIT DESCRIPTIONS (Beginning on page 91) will control.

Covered Expense	In-Network	Non-Network	Benefit Limits
Acupuncture	Concurrent Review is required for all outpatient consultations / therapy after the seventeenth (17th) visit. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Concurrent Review is required for all outpatient consultations / therapy after the seventeenth (17th) visit. 70% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	The Plan covers acupuncture for chronic low back pain as an alternative to opioid medications. Out-patient Treatments beyond seventeen (17) visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered.
Alcohol Dependency*	Precertification Required for all partial day and inpatient stays. Concurrent Review is required for all outpatient therapy treatments after	Precertification Required for all partial day and inpatient stays. Concurrent Review is required for all outpatient therapy treatments after	Services obtained prior to precertification will not be covered. Out-patient Treatments beyond seventeen (17) visits or

Covered Expense	In-Network	Non-Network	Benefit Limits
	the seventeenth (17th) visit / treatment.	the seventeenth (17th) visit / treatment.	session that do not receive approval prior to that visit, treatment or session occurring will not be covered.
Level A Inpatient Facility	100% of the Reasonable and Allowed Amount.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Level B Inpatient Facility	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Level An Intensive Out-Patient Facility	100% of the Reasonable and Allowed Amount.		
Level B Intensive Out-Patient 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.		

Covered Expense	In-Network	Non-Network	Benefit Limits
Outpatient Physician	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
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. Subject to the Deductible and Annual Out-of-Pocket Maximum	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 ambulance provision.
Ambulatory Surgical Center	Precertification Required	Pre-certification Required.	Services obtained prior to precertification

Covered Expense	In-Network	Non-Network	Benefit Limits
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.	will not be covered.
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	If performed by a non-participating provider in a non-	

Covered Expense	In-Network	Non-Network	Benefit Limits
CNRA & Anesthesiologist both submitting bills. **CRNA Only**	Annual Out-of-Pocket Maximum 90% of the Reasonable and Allowed Amount. Payment is split 50% / 50%. Subject to the Deductible and Annual Out-of- Pocket Maximum 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	participating facility. Base Unit Maximum Allowed Amount + Time Unit Maximum Allowed Amount x 70% If performed by a non-participating provider in a non-participating facility. Base Unit Maximum Allowed Amount + Time Unit 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			The following items will not

Covered Expense	In-Network	Non-Network	Benefit Limits
Maximum*^ **Individual** **Family**	 $2,500.00 $5,000.00	 $5,000.00 $10,000.00	accumulate toward an individual's annual out-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

Covered Expense	In-Network	Non-Network	Benefit Limits
			quarterly premiums. Vision expenses that exceed the Plan's 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.	Precertification required.	Services received prior to receiving

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	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 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	Effective May, 1, 2023, up to 90% 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 for all partial and inpatient stays.	Precertification Required for all partial and inpatient stays.	Treatments or therapy received prior to precertification

Covered Expense	In-Network	Non-Network	Benefit Limits
Level A Facility **Level B Facility** **Out-patient Facility** **Physician or Licensed Treating Professional**	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment. 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-	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out- of-Pocket Maximum.	will not be covered. Out-patient Treatments / therapy beyond seventeen (17) visits or sessions that do not receive approval prior to that visit, treatment or session occurring will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
	Pocket Annual Maximum.		
Cardiac Risk Assessments	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	
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^	Precertification Required for all partial day and inpatient stays.	Precertification Required for all partial day and inpatient stays.	Services obtained prior to precertification will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment.	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment.	Out-patient Treatments beyond seventeen (17) visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered.
Inpatient Level A Facility	100% of the Reasonable and Allowed Amount.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Inpatient Level B Facility	90% of the Reasonable and Allowed Amount. Subject to the 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.		

Covered Expense	In-Network	Non-Network	Benefit Limits
Outpatient Physician	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.		
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 of $1,500.00.	70% of the Reasonable and Allowed Amount up to the maximum of $40.00. Subject to the Deductible, Out-of-Pocket Maximum & Annual Allowance of $1,500.00.	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.

Covered Expense	In-Network	Non-Network	Benefit Limits
			provision for exact details.
Co-Insurance*^ **Level A Facilities** **Level B Facilities** **In-Network Physicians**	 0.% 10% of the Reasonable and Allowed Amount + Deductible. 10% of the Reasonable and Allowed Amount.	Participants utilizing non-participating providers, will be responsible for the difference between 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	Precertification Required	

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 & Annual Maximum.	
Covid Shots **If shot is administered by an In-Network provider**	The Plan pays for Covid shots obtained and administrated by all participating pharmacies at 100% of the Reasonable and Allowed Amount. If administered within a participating provider's office the Plan will pay 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 when obtained and administrated by a non-participating pharmacy or provider.	Pharmacies found within or administered by Sam's Club and/or Walmart's are not participating pharmacies.
Deductible*^ **Level A Hospitals and affiliated Facilities.**	 $0.00 $0.00	 $200.00 per person. $400 per family.	Annual Limit $200.00 per person. $400 per family.

Covered Expense	In-Network	Non-Network	Benefit Limits
Level B Hospitals and affiliated Facilities. **In-Network Physicians and Facilities**	$200.00 per person. $400 per family. $200.00 per person. $400 per family.		The deductible does not apply to prescription drug coverage, or to Level A facility charges. Deductibles are not payable as secondary under this Plans Coordination of Benefits provisions
Dental Care	Participants are free to utilize the dentist of their choosing as this Plan does not provide a network of dentists to choose from. Benefits will be paid in accordance with the payment methodology listed under the "Non-Network" column directly to the right.	For active participants, the Plan will pay 80% of incurred charges up to the annual family maximum of $3,000.00. For retired participants of this Plan, the Plan will pay 80% of incurred charges up to the annual family maximum of $1,000.00.	There is no separate orthodontia benefit, as such, payments for orthodontia treatments incurred by an active participant of the Plan will be applied to the annual $3,000 family dental maximum. There is no separate orthodontia benefit for retirees covered by the Plan. Orthodontia treatments are applied to the $1,000 calendar

Covered Expense	In-Network	Non-Network	Benefit Limits
			year dental maximum
Dental Care Performed in a Hospital Setting	Precertification is Required	Precertification is Required.	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.
Level A Facility	100% of the Reasonable and Allowed Amount	Paid at 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	
Level B Facility	Paid at 90% of the RAA for medically necessary procedures. Subject to the Deductible and Out-of-Pocket Maximum		
Physician	Paid at 90% of the RAA for medically necessary procedures. Subject to the Deductible and Out-of-Pocket Maximum		
Detoxification^	Precertification Required for all inpatient stays.	Precertification Required for all inpatient stays.	Services received prior to receiving precertification are not covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Inpatient Level A Facility	100% of the Reasonable and Allowed Amount.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Inpatient Level B Facility	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
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.
Diagnostic Imaging/Testing Facility Charge **Level A Facility**	Precertification Required prior to January 1, 2024	Precertification Required prior to January 1, 2024. 70% of 130% of the Reasonable and	

Covered Expense	In-Network	Non-Network	Benefit Limits
Level B Facility	100% of the Reasonable and Allowed Amount 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	
Diagnostic Imaging /Testing Physician Charge	Precertification Required prior to January 1, 2024 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required prior to January 1, 2024. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	
Dialysis **Level A Hospital and related Facilities** **Level B Hospital and related Facilities**	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.	Services obtained prior to receiving precertification are not covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Facilities **Physician**	90% of the RAA. Subject to the Deductible and Annual Out-of- 90% of the RAA. Subject to the Deductible and Annual Out-of-Pocket. Maximum		
Dietician/Nutritionist **(Including self-management, e.g., nutrition education.)*^**	Concurrent Review is required for all outpatient consultations / therapy after the seventeenth (17th) visit. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Concurrent Review is required for all outpatient consultations / therapy treatments after the seventeenth (17th) visit. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximums.	Out-patient Treatments beyond seventeen (17) visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered.
Drugs*^	Subject to Annual Out of Pocket Maximum.	Subject to Annual Out of Pocket Maximum. Prescriptions filled by a Non-Participating pharmacy is limited to the in-	Generic substitution and step therapy apply. The balance between what the Plan pays, and the charge incurred at non-participating

Covered Expense	In-Network	Non-Network	Benefit Limits
Generic **Formulary Brand** **Non-Formulary Brand** **Specialty Drugs**	20% Co-Pay with a $10 Minimum. 20% Co-Pay with a $20 Minimum. 20% Co-Pay with a $35 Minimum. Pre-certification Required. 20% Co-Pay with a $35 Minimum	network negotiated rate. 20% Co-Pay with a $10 Minimum. 20% Co-Pay with a $20 Minimum. 20% Co-Pay with a $10 Minimum Precertification Required 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.	pharmacies will remain the responsibility of the participant. 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 and not secured through the Plan's PBM and/or specialty PBM, will be paid only up to the amounts that that the Plan would have paid if secured and purchased through the Plans PBM or specialty drug PBM. If a Specialty Drug is ultimately unavailable through the Plan's

Covered Expense	In-Network	Non-Network	Benefit Limits
			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. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximums.	Precertification required for supplies or durable medical equipment of $1,000 or greater. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket.	Equipment of $1000 or greater ordered or received prior to obtaining precertification will not be covered.
EKG **Level A Facility**	100% of the Reasonable and Allowed Amount.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and	

Covered Expense	In-Network	Non-Network	Benefit Limits
		Annual Out-of-Pocket Maximum	
Level B 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 Out-of-Pocket Maximum	
Physician	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Emergency Room Facility Charges*^	For Emergencies Only	For Emergencies Only	Services that do not meet the Plans definition of an "Emergency" will not be covered.
Level A Facility	100% of the Reasonable and Allowed Amount.	90% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	
Level B Facility	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum		

Covered Expense	In-Network	Non-Network	Benefit Limits
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 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	If pre-certification is not obtained, services will not be covered.
Facility/Facilities	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	Some facilities as listed herein require prior authorization.
Fitness Club Stipend*^	N/A	N/A	The Plan's payment will not exceed the levels identified directly below: 8 – 11 visits per month, per person

Covered Expense	In-Network	Non-Network	Benefit Limits
Policy Holder Only **Policy Holder and Spouse**			= $12.00 reimbursement. 12 or more visits per month, per person = $25.00 reimbursement. 8 – 11 visits 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.
FLU Shot	The Plan pays for flu shots obtained and administrated by all participating pharmacies. The Plan will pay at 100% of the	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum when obtained and administrated by a	Pharmacies found within or administered by Sam's Club and/or Walmart's are not participating pharmacies.

Covered Expense	In-Network	Non-Network	Benefit Limits
	Reasonable and Allowed Amount. If administered within a participating provider's office the Plan will pay 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum.	non-participating pharmacy or provider.	
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
Genetic Counseling	Not Covered	Not Covered	
Genetic Testing	Precertification required if test is for services not covered under the PPACA 90% of the Reasonable and Allowed Amount.	Precertification required if test is for services not covered under the PPACA 70% of 130% of the Reasonable and Allowed Amount.	Precertification required if test is for services not covered under the PPACA Genetic testing that is exploratory in nature is not

Covered Expense	In-Network	Non-Network	Benefit Limits
	Subject to the Deductible and Out-of-Pocket Maximum	Subject to the Deductible and Out-of-Pocket Maximum	covered. It will only be covered for the diagnosis or treatment of an existing medical condition is not covered.
Grand Rounds*^	Please see Included Health	Please see Included Health	Please see Included Health
GYM Benefit*^	See Fitness Club Description	See Fitness Club Description	See Fitness Club Description
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	
Hearing Exams	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	Routine hearing tests greater than once every two calendar years will not be covered.
Health Reimbursement Arrangement account – HRA*^	100% of those expenses that are listed under the Health Reimbursement Arrangement	100% of those expenses that are listed under the Health Reimbursement Arrangement	

Covered Expense	In-Network	Non-Network	Benefit Limits
	account (HRA) benefit description.	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	Pre-certification required after 180 days of care 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out of Pocket Maximum.	Pre-certification required after 180 days of care 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 180 days will be re-evaluated to determine if there is a need for recertification of hospice care.
Hospital – Inpatient*^ **Level A Hospital and affiliated Facilities.**	Precertification Required 100% of the Reasonable and Allowed Amount 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 Out-of-Pocket Maximum	Services received prior to precertification will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Level B Hospital and affiliated Facilities	Deductible and Annual Out-of-Pocket Maximum		
Hospital – Outpatient*^ **Level A Hospital and affiliated Facilities.** **Level B Hospital and affiliated Facilities**	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.
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.	
Immunizations for reasons of travel	Not Covered	Not Covered	
Included Health*^	100% of the telephone consultation. Not subject to the deductible and out of pocket maximums.	Not Applicable	Not Applicable

Covered Expense	In-Network	Non-Network	Benefit Limits
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 for injectables of $1,000.00 or greater. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	Precertification Required for injectables of $1,000.00 or greater. 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.	Precertification Required if the infusion cannot be obtained through this Plans pharmaceutical/drug program.	Infusions not secured though this Plans pharmaceutical/drug program without prior approval will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
	If administered by a participating provider, 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	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	
Inpatient Rehabilitation*^	Precertification Required	Precertification Required.	Services received prior to precertification will not be covered.
Level A Hospital	100% of the Reasonable and Allowed Amount.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	
Level B Hospital	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum		
Facilities	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum		
Physician			

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		
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 under the age of 65 and covered under this Plan will receive $15,000.00 and an additional $15,000.00 if death was caused as a result of an accident. Retirees who have obtained the age of 65 or greater please reference the section of this book titled Life Insurance.
Mammograms	100% of the Reasonable and	70% of 130% of the Reasonable and	

Covered Expense	In-Network	Non-Network	Benefit Limits
	Allowed Amount. Subject to the Annual Out-of-Pocket Maximum No-Deductible	Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Mastectomy	Precertification Required	Precertification Required	Benefit is limited to cancer patients.
Level A Hospital and affiliated Facilities	100% of the Reasonable and Allowed Amount. 100% 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.	Services obtained prior to precertification will not be covered.
Level B Facility and affiliated Facilities	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Physician	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		

Covered Expense	In-Network	Non-Network	Benefit Limits
Maternity Services **Level A Hospital and affiliated Facilities** **Level B Hospital and affiliated Facilities.** **Facilities** **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 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^	Precertification Required for all partial day and inpatient stays.	Precertification Required for all partial day and inpatient stays.	Services obtained prior to precertification will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Inpatient	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Out-patient Treatments / therapy beyond seventeen (17) visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered.
Intensive Out-Patient Level A Hospital	100% of the Reasonable and Allowed Amount.		
Partial Day Program Level A Hospital	100% of the Reasonable and Allowed Amount.		
Intensive Out-Patient Level B Hospital	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
	90% of the Reasonable and		

Covered Expense	In-Network	Non-Network	Benefit Limits
Partial Day Program Level B Hospital	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.		
MRI	Precertification Required for services rendered prior to January 1, 2024.	Precertification Required for services rendered prior to January 1, 2024.	Services received prior to receiving precertification are not covered.
Level A Hospital and affiliated Facilities.	100% of the Reasonable and Allowed Amount.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum	
Facilities	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Out-of-Pocket Maximum		
Level B Hospital and affiliated Facilities.	90% of the Reasonable and Allowed Amount. Subject to the Deductible and		

Covered Expense	In-Network	Non-Network	Benefit Limits
	Out-of-Pocket Maximum		
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 Annual Out-of-Pocket Maximum	Services received prior to receiving precertification are not covered. Services rendered for cosmetic reasons are not covered.
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^	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) unit of treatment. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) unit of treatment. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Out-patient Treatments beyond seventeen (17) units or session that do not receive approval prior to that visit, treatment or session occurring will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Occupational Therapy	Precertification is required for all inpatient treatments. Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment.	Treatments / therapy above 17 visits require precertification. Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment.	Out-patient Treatments / therapy beyond seventeen (17) visits or sessions that do not receive approval prior to that visit, treatment or session occurring will not be covered.
Level A Hospital and affiliated Facilities	100% of the Reasonable and Allowed Amount.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Level B Hospital and affiliated Facilities	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	
Out-patient Hospital and affiliated Facilities	90% of the Reasonable and Allowed Amount. Subject to the Deductible and	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and	

Covered Expense	In-Network	Non-Network	Benefit Limits
Facility and Facilities **Physician or Licensed Treating Professional**	Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Annual Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Annual Maximum.	Annual Out-of-Pocket Maximum 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	
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.	Subject to Annual Out of Pocket Maximum. 20% Co-Pay with a $10 Minimum.	Generic substitution applies. Prescriptions filled by a non-Participating pharmacy is limited to the in-

Covered Expense	In-Network	Non-Network	Benefit Limits
Non-Formulary Brand	20% Co-Pay with a $20 Minimum. 20% Co-Pay with a $35 Minimum.	20% Co-Pay with a $20 Minimum. 20% Co-Pay with a $35 Minimum	network negotiated rate. As such, the balance 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	Precertification Required. 70% of 130% of the Reasonable and	Services received prior to receiving precertification will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
	Allowed Amount. Prior Approval required. Subject to the Deductible and Annual Out-of-Pocket Maximum	Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
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.
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 Hospital and affiliated Facilities.** **Level B Facility and affiliated Facilities**	100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum	

Covered Expense	In-Network	Non-Network	Benefit Limits
	Amounts. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Facilities	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Physician	90% 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	Routine physicals are paid at 70% of 130% of the Reasonable and Allowed Amount. Subject to the	

Covered Expense	In-Network	Non-Network	Benefit Limits
	Out-of-Pocket Maximum. No Deductible	Deductible and Out-of-Pocket Maximum	
Physical Therapy Inpatient Facility Charges **Level A Hospital and affiliated Facilities.** **Level B Hospital and affiliated Facilities**	Precertification Required 100% of the Reasonable and Allowed Amount. 90% of the Reasonable and Allowed Amounts. 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.	Inpatient treatments are limited to one consecutive stay immediately after discharge from a hospital. Services received prior to receiving 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**	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment.	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment.	Treatments beyond seventeen (17) visits / sessions that do not receive approval prior to any visit, treatment or session occurring

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.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	will not be 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.	70% of 130% of the Reasonable and Allowed Amount.	

Covered Expense	In-Network	Non-Network	Benefit Limits
	Subject to the Annual Out-of-Pocket Maximum No Deductible	Subject to the deductible & Annual Out-of-Pocket limit applies	
Occupational Therapy **Level A Hospital and affiliated Facilities.** **Level B Hospital and affiliated Facilities** **Out-patient Facility**	Precertification is required for all inpatient treatments. Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment. 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	Precertification is required for all inpatient treatments. Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment. 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. Out-patient Treatments / therapy beyond seventeen (17) visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Physician or Licensed Treating Professional	Annual Out-of-Pocket Maximum. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Annual Maximum.		
Radiation Therapy **Level A Hospital and affiliated Facilities.** **Level B Hospital and affiliated Facilities**	Precertification is required for all inpatient treatments. Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment. 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 is required for all inpatient treatments. Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment. 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. Out-patient Treatments / therapy beyond seventeen (17) visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered. Services received prior to precertification is obtained will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Out-patient Facility **Physician or Licensed Treating Professional**	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 Annual Maximum.		
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	Precertification is required for all inpatient treatments. Concurrent Review is required for all outpatient therapy treatments after	Precertification is required for all inpatient treatments. Concurrent Review is required for all outpatient therapy treatments after	Services received prior to precertification is obtained will not be covered. Out-patient Treatments / therapy beyond seventeen (17)

Covered Expense	In-Network	Non-Network	Benefit Limits
	the seventeenth (17th) visit of treatment.	the seventeenth (17th) visit of treatment.	visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered. 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.
Level A Hospital and affiliated Facilites	100% of the Reasonable and Allowed Amount.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	
Level B Hospital and affiliated Facilities	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum		
Out-patient Facility	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Physician or Licensed Treating Professional	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Annual Maximum.		
Respiration Therapy	Precertification is required for all inpatient treatments.	Precertification is required for all inpatient treatments.	Services received prior to precertification is obtained will not be covered.

Covered Expense	In-Network	Non-Network	Benefit Limits
Level A Hospital and affiliated Facilities **Level B Hospital and affiliated Facilies** **Out-patient Facility** **Physician or Licensed Treating Professional**	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment. 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 Annual Maximum.	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	Out-patient Treatments / therapy beyond seventeen (17) visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered

Covered Expense	In-Network	Non-Network	Benefit Limits
Routine Well-Baby Care during initial confinement	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.	
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
Shingle Shot	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.	
Short Term Disability*^	N/A	N/A	Up to fifty percent (50%) of your

Covered Expense	In-Network	Non-Network	Benefit Limits
			weekly salary (excluding any overtime) up to a maximum of $700.00 per week
Skilled Nursing Facility*^	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.
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	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment. 90% of the Reasonable and Allowed Amount. Subject to the Deductible and	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment. 70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and	Out-patient Treatments / therapy beyond seventeen (17) visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered

Covered Expense	In-Network	Non-Network	Benefit Limits
	Out-of-Pocket Maximum	Out- of-Pocket Maximum	
Sterilization Procedures	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 is obtained will not be covered. For employees and their spouses only. Reversals of vasectomies and tubal ligations are not covered.
Substance Abuse Benefits^ **Inpatient Level A Hospital and affiliated Facilities**	Precertification Required for all partial day and inpatient stays. Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment. 100% of the Reasonable and Allowed Amount 90% of the Reasonable and	Precertification is required for all partial and inpatient stays. Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit of treatment. 70% of 130% of the Reasonable and Allowed Amount.	Out-patient Treatments / therapy beyond seventeen (17) visits or session that do not receive approval prior to that visit, treatment or session occurring will not be covered

Covered Expense	In-Network	Non-Network	Benefit Limits
Inpatient Level B Hospital and affiliated Facilities	Allowed Amount Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Intensive Outpatient Level A Hospital and affiliated Facilities	100% of the Reasonable and Allowed Amount		
Intensive Outpatient Level B Hospital and affiliated Facilities	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Partial Day Program Outpatient	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Intermediate Outpatient	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
Synagis Injections	Precertification Required	Precertification Required.	Services received prior to precertification is

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.	70% of 130% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.	obtained will not be covered.
Telemedicine / Telehealth thru Included Health	100% of the expense of the consultation. Not subject to the deductible.	Not Applicable	Restricted to only **non-Medicare** eligible participants and their covered dependents.
Telemedicine through a non-Teladoc or Included Health physician*^	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	Not Applicable
Telemedicine Therapy*^	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment. Deductible and Annual Out-of-Pocket Maximum apply.	Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment. Deductible and Annual Out-of-Pocket Maximum apply.	Services received prior to precertification is obtained 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	70% of 130% of the Reasonable and Allowed Amount.	
Transplants	Precertification Required.	Not Covered	Precertification Required.
A Local 697 participant who receives an organ.	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
A Local 697 participant who donates to another covered Local 697 participant.	90% of the Reasonable and Allowed Amount. Subject to the Deductible and Annual Out-of-Pocket Maximum.		
A Local 697 participant who donates to a non-covered participant.	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.		

Covered Expense	In-Network	Non-Network	Benefit Limits
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**	 $5 co-pay then provided in full $10 materials co-pay, then provided in full	 $35.00 $45.00	

Covered Expense	In-Network	Non-Network	Benefit Limits
	up to a maximum allowance of $140.00.		
Annual lenses	$10 co-pay then provided in full	$25	
Single vision	$10 co-pay then provided in full	$40	
Lined bifocal	$10 co-pay then provided in full	$55	
Lined trifocal	$10 co-pay then provided in full	$80	
Lenticular			
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 N/A	

Covered Expense	In-Network	Non-Network	Benefit Limits
Safety Glasses (Employee Only) **Retiree Vision Benefit**	Provided in full every calendar year when received in combination with an eye exam and eyeglasses or contacts. Are the same as the benefits listed above, with the exception that a retiree can elect to have safety glasses in lieu of regular frames every other year.	Are the same as the benefits listed above, with the exception that a retiree can elect to have safety glasses in lieu of regular frames every other year	
Weight Loss Programs*^	90% of the Reasonable and Allowed Amount. Subject to the deductible and Annual Out-of-Pocket Maximum	70% of the Reasonable and Allowed Amount. Subject to the deductible & Annual Out-of-Pocket Maximum	Physician Supervised weight loss programs only
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	70% up to the maximum Fund allowance of $500. Subject to the	Maximum benefit payable for rental and/or purchase of

Covered Expense	In-Network	Non-Network	Benefit Limits
	Deductible and Annual Out-of-Pocket Maximum.	Deductible and Annual Out-of-Pocket Maximum	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 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	

"^"-Signifies a mental health and/or substance abuse treatment

"*"- Signifies a medical condition and/or treatment

"^*" Signifies a condition that this Plan considers both mental health and/or substance abuse and/or medical treatment.

BENEFIT DESCRIPTIONS

ACCIDENTAL DEATH AND DISEMBERMENT 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 principal 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 of the initial loss. The dismemberment coverage of the policy works on a "per-member" basis and will only pay 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

Exclusions within this Plan's Accidental Death and Dismemberment Benefit

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 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 required for all partial day and inpatient stays.

Concurrent Review /Precertification required for all outpatient treatments of greater than seventeen (17) days.

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 or 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 be pre-certified.

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.

Warning: *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.*

Warning #2: *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 MAXIMUM

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 PHYSICALS

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.

Appeal Timing

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.

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 of 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".

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 obtains 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 consider 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.

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 appeal, the limitations period is three years from the date of the Plan's notice advising you of the determination of your appeal. Also, if your claim is denied and you fail to file a timely 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. **Note: AN APPEAL IS A CONDITION PRECEDENT TO 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.

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.

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 on 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 decided on your appeal, the Plan will send you 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, the Plan will notify you of the decision on appeal within 30 days of the Plan's receipt of the appeal.

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.

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.

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** (See section within this specific provision titled "Hourly Requirement") and,
3. **A Local 697 JATC registration requirement componen**t. (Please refer to the section within this specific provision titled "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:

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. The specific requirements are the exact same for apprentices as they are for journeypersons and employees. Moreover, they are clearly outlined within the section of this document titled **"Enrollment."** Find, read, understand this requirement, and make certain that you take the appropriate steps to ensure your proper enrollment.

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.*

Warning #2: *You are advised that:*

- *The Benefit Fund Office is a separate entity than the JATC school, the Local 697 Union Office and the Local 697 FCU.*
- *These offices **do not** share your personal information and documentation with or amongst each other.*
- *You are solely responsible for making certain that you provide the Plan with the needed documentation as outlined and explained within the "Enrollment" provision of this Plan.*

Warning #3 *All apprentices are advised that their failure to adhere to the enrollment, eligibility or JATC registration requirement at any time while covered under this Plan may result in a loss of coverage for themselves or any eligible dependents under this Plan.*

Health and Benefit Plan 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 contributions/self-payments are made for the required number of hours during a "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 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.

Included Health

All apprentices need to familiarize themselves with the Included Health benefit and download their app. Please reference the "Included Health" benefit description within this document for more information.

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:

1. 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,
2. 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 324 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 requirements, the participant's initial eligibility will begin on the first day of the following month in which the 324 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.

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.

Termination of Eligibility

Eligibility for benefits under this Plan will cease for you and any dependent if any of the following events occur:

A. **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 two events occurred.

B. **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 in which:

   - 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.

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

C. **You intentionally or unintentionally act fraudulently** or make material misrepresentation of fact.

Upon the cessation of your eligibility, you will be offered the chance 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.

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 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 the providers: error, fraud, or misstatement, said provider shall, as part of its assignment of 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

Participants are reminded that all surgeries require pre-certification / prior approval.

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 refuse 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 assistant surgeon 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. Your precertification request should include:

- 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 the patient's history 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.

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)

Participants are reminded that they must comply with all presurgical recommendations of their physicians in order for this surgery to be effective.

Warning:

- *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 requires that the participant pre-certify / prior approve the gastric by-pass.*
- *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, and/or decision not to follow the prescribed diet and lifestyle changes.*
- *Panniculectomy or the "re-contouring" to remove loose skin is not a covered benefit of the Plan.*
- *Surgeries that are the result of 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:
    3. Marital status changes,
    4. Number of dependents changes,
    5. 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.

Important: Did you know that incomplete information can make it difficult for the Plan 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, and 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 sixty-day (60) 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 policyholder's 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 sixty (60) 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 sixty (60) 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.*

Remember: While covered under this Plan and until the dependent obtains the age 26, the employee is responsible to timely notify and provide the Plan with accurate and complete information needed to administer their dependents Health Benefit Plan, including, but not limited to:

- Other health Benefit coverage and other insurance Benefits the eligible dependent may have in addition to your coverage with this Plan.
- Changes in the dependent's marital status.
- Changes in the dependent's status. (Births, Adoptions, Separations, Divorce, Death)
- Changes in the dependents contact information.

Failure to timely notify the Fund Office in writing of any of the above will result in the employee being responsible for the immediate and full remuneration of any erroneous payments made by the Plan and may result in the loss of eligibility for not only that participant but for the entire family.

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 or non-participating provider will be subject to the deductible and paid at 90% of the Plan's 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 REHABILITATION

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 provides you and your eligible dependents with a health care benefit plan that financially protects you from significant health care expenses and 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 participants, and other family members', needs and personal support systems.

Warning: ***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 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 participants improved and/or maintained functional status.
   2. The participants improved and/or maintained clinical status.
   3. The participants 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 participants improved safety.
   7. Improvement in the reduction of out-of-pocket expenses when possible.

CERTIFIED REGISTERED NURSE ANESTHETISTS - CRNA

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 charge 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 charge 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 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 not be subject to the annual deductible.
- Physician charges will be paid in accordance with the network affiliation of the medical professional rendering treatment. Consequently:
    a. 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.
    b. 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).

c. 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 and will be subject to the annual deductible and annual out of pocket maximums.
- Physician charges will be paid in accordance with 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 to 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 pay 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).

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.

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 also to 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 of the pharmaceutical that the physician is administrating. If a physician or a hospital refuse to allow the Plan to purchase directly, 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. Regarding the latter, employees are reminded that if they enroll a dependent into the Plan they are assuming full responsibility to timely provide to the Plan accurate and complete information needed to administer your dependents Health Benefits up to and through the month that the child obtains the age of twenty-six (26). Such information would include, but is not limited to notifying the Plan of:

- Other health benefit coverage and other insurance benefits you or any eligible dependent may have in addition to your coverage with this Plan.
- Changes in you or your dependents status. (Births, Adoptions, Marriages, Separations, Divorce, Death)
- Changes in their contact information.

Enrolling your child.

Parents wishing to enroll their child must provide:

1. A completed enrollment form.
2. 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, National Medical Support Notice and in case of a stepchild, the judgment of divorce and/or other court-imposed documents stipulating the biological parent(s) responsibility to provide insurance coverage.)
3. A copy of the child's Social Security card.
4. 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.
5. Any and all other information required by the Plan.

A "child" must meet one of the following descriptions in order to be covered by this Plan.

1. Your biological, or legally adopted child.
2. A stepchild.
3. 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*.
4. 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 a 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.

Note: The Plan recognizes that modern families are more complex than the traditional families this Plan may have seen in the past. However, and as it relates to stepchildren, the Plan reminds you that there is typically no legal base that necessitates an insurance Plan to provide coverage for anyone who is not your biological or adoptive child. Meaning; despite any and all bonds that you may have built between you and them, and regardless of whether or not you consider them your child, or the fact that they live in your house, are provided for by you, and that you may love them completely, they are nevertheless not your legal children.

To put it simply, and not unlike the responsibility you have to provide health insurance for your biological or adoptive child, it is the stepchild's biological parents that are responsible for providing health insurance coverage for the child or children in question.

With that said, this Plan does and will provide coverage to your spouse's children from a prior marriage provided:

- You present to the Plan a copy of your spouse's judgment of divorce and/or document that stipulates a court-imposed obligation to provide coverage of either party. It is these documents that will dictate this Plan's obligation, if any, and will inform the Plan whether or not it is that stepchild's primary insurance provider or secondary insurance carrier. And,
- You present to the Plan a letter of credible coverage from the stepchild's other insurance company, a copy of the stepchild's medical identification card, proof of the other biological parent's date of birth and any other information that this Plan requires in order to adjudicate the stepchild's claim properly. And,
- You present the stepchild's birth certificate (which should list both the mother and father)
- You present a copy of the stepchild's Social Security Card

In the absence of a court document that stipulates either parties' obligations, you must provide the Plan with a completed and notarized Special Enrollment form signed by you and your spouse stating that there are not outstanding court orders that require the biological parent or parents to maintain and /or provide health insurance.

Warning: *Be advised that this Plan is not accountable nor responsible to provide coverage to a stepchild or pay the claims of a stepchild when a biological parent has a court-imposed obligation and:*

- *One of the biological parents finds it easier, convenient, or less of a hassle to submit claims to this Plan in lieu of following the court-imposed obligation,*
- *One of the biological parents will not enforce the court-imposed obligation for any reason,*
- *One or both of the biological parents find it less costly to submit claims to this Plan versus adhering to the court-imposed order or correctly submitting the claim or claims to the other insurance company,*
- *One of the biological parents finds it easier to submit claims to the Plan because they cannot locate or contact the other biological parent,*
- *The other biological parent fails to maintain coverage, or,*
- *The other biological parent elects to utilize a medical practitioner that does not accept his or her insurance,*
- *Both biological parents and/or their attorneys failed, for whatever reason, to have such situations accounted for within a court-imposed document.*

While the Plan is empathetic to any of the aforementioned or similar scenarios, it reminds you of the following:

- That, and unless stated otherwise.
  A. The court order does not oblige you to provide the other biological parents' child with access to your insurance coverage. **Remember**: By enrolling said child into this Plan you are assuming full responsibility to keep the Plan notified in a timely manner of anything that would affect this Plan's ability to adjudicate the claims of said individual until the end of the month said individual obtains the age of 26.
  B. That the court order does not obligate this Plan to provide access to coverage under this Plan to anyone other than your enrolled spouse or enrolled biological or adoptive child.
- The absence of a court-imposed document does not obligate this Plan to provide coverage. The fact that the Plan will cover the stepchild is something the Plan does gladly providing you adhere to the enrollment rules and provisions of the Plan.
- This Plan cannot make payment toward claims it is not responsible to make, and,
- This Plan will neither mediate nor be involved in any discussions between biological parents, their attorneys, or any respective insurance company or any other party on these matters, nor is the Plan responsible to provide solutions or advice. It should go without saying that regardless of either party's feelings on

the matter, this is an adult situation where the biological parents must work with each other to resolve the issue of adhering to the court-imposed order.

In instances where the stepchild's birth certificate fails to list a biological parent, you must enroll the child AND submit a completed and notarized Local 697 Health & Benefit Plan Special Enrollment form signed by you and your spouse stating that there are not outstanding court orders that require the biological parents to maintain and /or provide health insurance.

When does your child get 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 with a sixty-day (60) 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 - Timely submission of documentation & forms / Updating the Plan of changes:

Failure to submit properly completed forms and all supporting documentation in their entirety within the sixty (60) 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 sixty (60) 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.*
4. *While covered under this Plan and up to the age twenty-six (26), you as the employee are responsible to timely provide to the Plan accurate and complete information needed to administer your family's benefits, including, but not limited to:*
    - *Other health Benefit coverage and other insurance Benefits your children may have in addition to your coverage with this Plan.*
    - *Changes in your child's marital status.*
    - *Changes in your child's dependent status. (Births, Adoptions, Separations, Marriages, Divorce, Death)*
5. *Changes in your child's contact information*

Warning #2 – Consequences of Missing & Incomplete Information & Coordination of Benefits for children

- *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.*
- *Should this Plan erroneously pay a claim or claims because the participant failed to adhere to the rules of the Plan, coverage for you and all covered dependents will be terminated. Reinstatement will be at the sole discretion of the Board of Trustees. Note: Applicable criminal and fraud charges as permitted under federal and state laws will apply.*
- *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.*

Once again, failure to timely keep the Plan informed can result in the loss of coverage to you and your family. Further, if this Plan erroneously pays a claim or claims because the employee failed to adhere to the rules of the Plan, coverage for you and all covered dependents will be terminated. Reinstatement will be at the sole discretion of the Board of Trustees. Note: Applicable criminal and fraud charges as permitted under federal and state laws will apply.

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 Concerning Services Other Than Adjustments Rendered by a Chiropractor

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 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 be paid as usual. However, should the medical provider or a participant fail to submit requested information, or submit said information on a timely basis, then the processing of the claim could be lengthened. Failure to submit the requested information within three-hundred and sixty-five days (365) of its initial request will result in the claim being denied.

CLAIMS 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 (365) 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 the 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 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.

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 within this section of provision titled "Claim Processing Time Periods," except that the additional information needed to decide an urgent care claim will be requested within 24 hours.

Warning – Time Constraint for the Submission of Requested Information

It is your responsibility to see that the missing information is provided to the Claims Administrator. If you do not provide the missing information within one hundred and eighty (180) calendar days from the date of issuance of the request, the Claims Administrator will decide on your claim without it and your claim could be denied as a result.

Up and until the aforementioned time limits, the 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 Claim Administrator has received a response to its request.

Claim Processing Time Periods

The amount of time the Plan can take to process a claim depends on the type of claim. 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 claim requests will be addressed within twenty-four (24) hours if the concurrent care is urgent and if the request for the extension is made within twenty-four (24) hours prior to the end of the already permissible and/or 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.

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 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.

Plan Extensions

The time periods preciously outlined within the section of this provision titled "Claim Processing Time Periods" 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 mor 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 Claim 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.

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.

A Qualifying Beneficiary

Generally, three groups of participants (known as qualified beneficiaries or QB's) are eligible for COBRA coverage: members / employees or former members and employees, their spouses, and their dependent child(ren).

A Qualifying Event and Maximum Time of Continued Coverage

One of several types of "qualifying events" must occur in order to trigger COBRA as outlined within the chart below. If you have a qualifying event, you are then eligible to buy COBRA for the maximum coverage period as determined by both your beneficiary status and the qualifying event.

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:

d. Your divorce from your spouse.
e. A dependent child's loss of dependent status.
f. 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.

Additional and Important COBRA Coverage Rules

1. COBRA coverage may not be selected 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. You are not required to stay on COBRA for the entire allowable coverage period, nor will you always be able to if different coverage comes along.
5. 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.
6. 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.
7. You do not have to show proof that you and/or your dependents are insurable in order to be entitled to COBRA coverage.

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.

Warning: COBRA coverage does not include life and AD&D insurance, this Plan's Health Reimbursement Arrangement Credit Benefit (HRA), Short Term Disability or Loss or Time Benefits.

COBRA self-payment covers all people 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.

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.

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 to 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 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.

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.

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.

Other Coverage Options

There may be other coverage options for you and your family since you are now 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 decide 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.

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 to 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 for 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.

CONCURRENT REVIEW

Concurrent review decisions are reviews for the extension of ongoing care.

Concurrent review provides the opportunity to evaluate the ongoing medical necessity of care being provided and supports the health care provider in coordinating a patient's care across the continuum of health care services.

- Inpatient concurrent review is done telephonically, or via Fax.
- All data and relevant information are obtained, including but not limited to medical records, communications with practitioners or other consultants.
- Relevant information is reviewed using utilization management criteria.
- Inpatient concurrent review is continuous for the duration of the inpatient stay.
- Urgent concurrent review decisions are made, and the practitioner notified, within 24 hours of receipt of the request. Approval decisions are determined by medical management staff and given to practitioners via oral, electronic, or written notification by facility case managers or discharge planner. Denial decisions are given orally or electronically and in writing to practitioners, facility, and customer by medical management staff.
- Requests to extend a course of treatment previously approved that does not meet the definition of urgent care will be handled as a new request; for example, pre-service or post-service and the appropriate time frames followed.
- All potential denial decisions based on medical necessity related to concurrent review are reviewed by the Medical Director.

COMMUNICATIONS OF BENEFITS

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
- Push notifications
- 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, if any, are provided as a courtesy and will be at the discretion of the Fund. Participants are informed that reminder notices 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.

If you wish an interpretation of the Plan or any of its communications, you should address your request in writing to the Fund Manager. Participants are reminded that it is the rules, provisions and guidelines within this document that remain binding, and to which will be relied upon in any dispute concerning your benefits. Consequently, oral statements by Fund Employees can neither change nor modify the written provisions, policy, or rules of this Plan.

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, and returned mail, returned electronic communications, unopened mail, unopened 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 mailing address, e-mail address or other electronic addresses.

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.

This Coordination of Benefits (COB) provision will apply anytime a covered person has health care coverage under more than one Plan. If you or any member of your family are covered by this plan and any other plan you MUST file all your claims with each plan that provides coverage.

Participants are advised that:

1. The employee must notify the Health and Benefit Fund Office in writing if any member of their family, covered by this Plan, is covered under any other plan. Additionally, the employee must provide a copy of any medical identification card provided by any other plan that provides coverage, which must include the start date of said insurance and/or any other documentation required or requested by the Fund Office to properly coordinate this plan's coverage with the coverage of any other health plan.
2. If an employee intentionally or unintentionally:
    a. Fails to provide the information delineated in paragraph one (1) directly above or fails to cooperate with the Fund Office of this plan in any respect regarding additional coverage, or,

b. Fails to timely notify the Fund Office in writing of another plan's coverage, termination of coverage, and/or fails to timely provide the supporting documentation necessary to properly coordinate benefits, the Fund Manager may immediately or retroactively terminate the coverage available to that employee and any dependent(s) covered under this plan. Reinstatement, if any, will be at the sole discretion of the Board of Trustees

3. If this Plan has incorrectly paid any claim because of the employee's failure to provide information in accordance with these Coordination of Benefit Rules, the employee, will be responsible for the immediate reimbursement of any overpayment together with interest and all associated costs including attorney's fees expended by the Plan to secure said reimbursement.

Coordination of Benefit - Determining Which Insurance Carrier Pays First.

The rules for coordination of benefits determine the order in which each plan will pay a claim for benefits.

The plan that pays first is called the primary plan or primary insurer or primary insurance 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(s) that pays after the primary plan is the secondary plan(s) or secondary insurer or secondary insurance plan(s). The secondary plan(s) may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense.

The following rules govern the order in which each Plan will pay a claim for benefits.

Coordination of Benefits Rules.

When an individual is covered by this Plan and any other plan (two (2) or more plans, the rules for determining the order of benefit payments are as follows:

1. **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.
2. **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.

3. **Automobile**. Automobile "no fault" and traditional automobile "fault" type insurance contracts will always be primary.
4. **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.
5. **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.
6. **Court Decree**. 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 dependent child will pay third.

D. 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.

E. 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.

7. **Deductibles**. Deductibles are not payable as secondary under this Plans Coordination of Benefits provisions.

8. **Dependent Child.** Regardless of the parents marital, relationship, living arrangement or location status, and irrespective of any court decree stating otherwise, the primary and secondary insurance coverage for the dependent shall always be determined as follows:

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

b. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

9. **Dependent with primary and secondary coverage under this Plan**. In the case that a participant is covered under this Plan as a dependent of two employees, the combined benefits from this Plan will pay up to but never exceed 100% of this Plan's allowable expenses.
10. **Employee with primary and secondary coverage under this Plan.** In the case that a participant is covered under this Plan as an employee AND as a dependent, the combined benefits from this Plan will pay up to but never exceed 100% of this Plan's allowable expenses.
11. **Longer or shorter length of coverage.** The plan that covered the person as an employee or retiree longer is primary.

    Note: 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.
12. **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.
13. **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.

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 employees 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. Participants are reminded that deductibles are not an allowable expense and as such not payable as secondary under this Plans Coordination of Benefits provisions.
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 a 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 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

As with any surgery, pre-certification / prior approval is required.

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.

COVID TESTING REIMBURSEMENT BENEFIT

From Saturday January 15th, 2022, to May 11th, 2023, the Health and Benefit Fund covered eight (8) at-home COVID tests per month for active participants and for non-Medicare eligible retired participants.

Participants who wish to be reimbursed for the purchase of at-home tests on or after January 15th, 2022, but prior to May 11th, 2023, must submit their receipt for said

purchase along with the fully completed signed Covid Test Reimbursement form (Found within the Healthcare tab, under the section titled "Forms and Instructions") into the Lake County Indiana, NECA – I.B.E.W., Health and Benefit Fund Office, Suite 300, 7200 Mississippi Street, Merrillville In, 46410.

What you need to know:

1. The Federal mandate that required private insurance providers and Medicare to provide 8 free at-home COVID-19 tests per month ended on May 11th, 2023. Tests procured after May 11th, 2023, will not be reimbursed.
2. Pursuant to Federal law, tests utilized for employment purposes **are not covered**.
3. For the reason that some receipts may not clearly indicate how many tests were purchased, **it is recommended that purchasers save not just receipts but also the boxes that the tests come** in as the Plan may require the boxes as proof of purchase as well as need the box to verify the quantity that was purchased.
4. You do not need a prescription or doctor's order to purchase the at-home tests.
5. You do not have to be symptomatic to buy the test or to be reimbursed for the test.
6. **Reimbursements are made via direct deposit.**
7. Reimbursement requests that are submitted without a fully and properly completed Covid Test Reimbursement Form will be denied.

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 active 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 by making survivor self-payments. Provided that your surviving dependents make timely survivor self-payments, coverage will be provided as follows:

1. 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.
2. Dependent children or surviving spouse will be covered until the date that they enter the armed forces of any country on a fulltime basis.
3. Dependent children will be covered to the last day of the month in which the surviving parent's death occurred.
4. The surviving spouse will be covered up to the date of their death.
5. The surviving spouse will be covered up to the date that they remarry.

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 to make survivor self-payments at any future date. Similarly, if they choose to make survivor self-payments, your surviving dependents will lose the right to elect COBRA coverage (unless their survivor coverage terminates within the first 36 months after your death, in which case they 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 no later than 4:30 P.M. on the last business day of the month preceding the coverage month. If the payment is not received by the Fund Office on or prior to 4:30 P.M. on that day, coverage will terminate. If survivor coverage terminates, it cannot be reinstated.

Death of a Covered Retiree

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, the spouse may elect to continue to make timely premium self-payments to continue coverage for themselves and any dependent children. Failure to make timely self-payments by 4:30 P.M. on the last business day of that three-calendar month period of coverage will result in the termination of any surviving dependents eligibility to receive benefits under this Plan. Otherwise, and 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.
- Dependent children will be covered to the last day of the month in which the surviving parent's death occurred.
- The surviving spouse will be covered up to the date of their death.
- The surviving spouse will be covered up to the date that they remarry.

DEDUCTIBLE

Services covered under the medical benefits are subject to an annual deductible based on the calendar year. The key word in the prior sentence 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 satisfies 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 remainder 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.)

Remember: This Plan does not apply the deductible for facility charges incurred within a Level A facility, or for those services provided by Included Health (formally Grand Rounds).

How the Plan Coordinates Your Deductible with Other Insurance Coverage

It doesn't. Meaning, the Plan neither offsets, pays for nor will coordinate any deductible incurred under this Plan nor any other. Please reference the section of this book title "Coordination of Benefits" for more information.

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.

"Actuary"

A professional responsible for, among other things, valuing Plan assets and liabilities and calculating the cost of providing Health and Benefit Plan benefits.

"Administrative Lag Quarter"

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

"Administrator/Plan Administrator"

"Administrator/Plan Administrator" means the individual or organization(s) selected by the Board of Trustees to handle claims and day-to-day administration on behalf of the Fund**.**

"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.

"Actively Employed"

"Actively employed" shall mean any participant that performs work covered under the Collective Bargaining Agreement, Participation Agreement and/or traditionally covered by a IBEW 697 apprentice, and/or journeyperson and

"Adverse Benefit Determination"

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

1. A denial of 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 upon 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.

The 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.

"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 that is manufactured and distributed by only one pharmaceutical manufacturer, or as defined by the national pricing standard used by the Prescription Benefits Manager.

"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 an 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 a hospital or facility that has been specifically approved and designated by the Plan or its third-party administrator to perform certain procedures, such as but not limited to, organ transplants, and to whom the Plan has obtained a case or event rate agreement prior to services being rendered.

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 the Plan's out-of-network payment methodologies.

Additional information about this option, as well as a list of centers of excellence, will be given to cover 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 payer or the Plan's responsibility as a secondary payer 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.

"Concurrent Care Decision"

"Concurrent Care Decision" shall mean the decision by the Plan to reduce or terminate benefits otherwise payable for a course of treatment that have been approved by the Plan (other than by Plan amendment or termination) or a decision with respect to a request by a claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the Plan.

" Concurrent Claim"

A claim is a type of preservice claim. 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 or allowed by the Plan.

"Concurrent Review"

"Concurrent Review" means the process of assessing the continuing medical necessity, appropriateness, or utility of additional days of hospital confinement, outpatient care, and other health care services.

"Contributions"

"Contributions" means payments made to the Fund by contributing employers on behalf of their employees. Contributions may also include, where applicable, payments made directly by eligible employees and their dependents to purchase coverage pursuant to Plan rules.

"Contribution Period"

When employers first became obligated by agreements to contribute to a Fund for work in Covered Employment.

"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 from the treatment or procedure does not make it "non-cosmetic" nor a covered item by the Plan.

"Covered Employment"

A Participant is considered to be working in Covered Employment if he/she works in a job that his employer is required by a collective bargaining agreement with the Union or a participation agreement with the Fund to make contributions on his behalf.

For periods before the date that Plan P contributions were first required under the Collective Bargaining Agreement, Covered Employment means work, which if performed during the Contribution Period, would have resulted in contributions being paid to the Fund.

"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.

"Deficit Hours"

"Deficit hours" shall mean the number of hours below the quarterly requirement for continued eligibility under this Plan that the Fund did not receive on an employee's behalf for work in covered employment.

"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.

"Dental Injury"

"Dental Injury" shall mean an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. Dental injury does not include chewing injuries.

"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 persons:

1. Your present spouse.
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. Your biological, legally adopted child, or a stepchild. Such a child will be covered to the end of the calendar month in which the child's twenty-six (26th) birthday occurs.
4. 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.*
5. Your incapacitated child, whose incapacity commenced prior to age 19, and
6. 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 a 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. To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

B. All dependents have to be properly enrolled into the Plan.

"Designated Providers"

"Designated Providers" shall mean a hospital or facility that has been specifically approved and designated by the Plan or its third-party administrator to perform certain procedures, such as but not limited to, organ transplants, and to whom the Plan has obtained a case or event rate agreement prior to services being rendered.

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 the Plan's out-of-network payment provisions.

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

"Detoxification"

"Detoxification" shall mean the inpatient hospital or residential medical care to ameliorate acute medical conditions associated with substance abuse.

"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.

"Disability Claim"

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

"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.

"Dispensing Limit"

"Dispensing Limit" means the monthly drug dosage limit and/or the number of months the drug usage is needed to treat a particular condition.

"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.

"Drug List/Drug Formulary"

"Drug List/Drug Formulary" shall mean a list of prescription drugs, medicines, medications, and supplies approved by the Prescription Benefit Manager. This list is subject to change.

"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.

"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 an agreement between the Association and the Union.

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

l. 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. This would include any sole proprietor, company, partnership, or corporation which is signatory to a CBA with a Union or a written participation agreement requiring contributions to be made to this Plan on behalf of employees. Other IBEW Local Unions shall be considered employers only to the extent they are obligated to make contributions to the Fund in accordance with the National Reciprocity Agreement or a reciprocity agreement directly between the Fund and that Local Union Benefit Fund.

"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 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.

"Errors"

"Errors" shall mean charges based on billing mistakes, improprieties or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard; it is in the Plan Administrator's, or its designees, sole discretion to determine what constitutes an error under the terms of this Plan.

"Excess Charges"

"Excess Charge(s)" shall mean a charge or portion thereof billed for care and treatment of an Illness or Injury that is not payable under the Plan because it exceeds the Allowable Charge or is determined by the Board of Trustees to be based on Invalid Charges in accordance with the terms of this Plan Document.

"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.

"Facility or facilities"

Facilities include clinics, dialysis centers, outpatient care centers, physical therapy centers and specialized care centers. **FACILITIES DO NOT INCLUDE HOSPITALS.**

"FDA"

"FDA" shall mean Food and Drug Administration.

"Fund"

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

"Generic Drug/Generic Medication"

"Generic Drug/Generic Medication" shall mean a drug that is manufactured, distributed and available from several pharmaceutical manufacturers and identified

by the chemical name, or as defined by the national pricing standard used by the Pharmacy or Prescription Benefit Manager.

"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, tests 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."

"Invalid Charges"

"Invalid Charge(s)" are charges (a) that are found to be based on Errors (as defined in this Document), Unbundling, Misidentification or Unclear Description; (b) charges for fees or services determined not to have been Medically Necessary or reasonable; (c) charges found by the Plan Administrator to be in excess of the Maximum Allowable Charge, or (d) charges that are otherwise determined by the Plan Administrator to be invalid or impermissible based on any applicable law, regulation, rule or professional standard.

"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 of providing 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 their 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 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 included in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

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 this or another health and benefit 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 specific conditions, 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 neither have nor 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.

"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 as defined under this Plan.

Important: To establish participation status an individual must meet both the hourly requirements of the Plan and the enrollment requirements of 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 P"

The nickname given to the Plan's Retiree Self-Payment Credit Benefit and to the hourly portion of Collectively Bargained Health and Benefit Fund contributions that the Plan utilizes to calculate and provide a Retiree Self-Payment Credit benefit, if any, to a participant that satisfies the Health and Benefit Plans eligibility requirements for coverage during their retirement.

"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 an "out-of-network provider".

"Post Service Claim"

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

"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.

"Preservice Claim"

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.

"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.

"Qualified Spouse"

The person to whom you (the Participant) are legally married on the date retiree benefits, including any Retirement Self-Payment Credit benefits are applied by this Plan, provided that the marriage has lasted for at least one year (twelve months.) If you die before your retiree healthcare benefits under this Plan begin, your surviving spouse will be considered a Qualified Spouse if you and she were married at least one year prior to your death.

"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 (osteopath or MD) 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.

"Retiree Self-Payment Credits"

The benefit unit that is utilized to offset the cost of retiree self-payments.

"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 includes all meals, special diets, therapeutic diets, required nourishments, 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.

"Spouse"

Either of two persons who are married to each other. For retirees 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.

"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, injection 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."

"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.

"Traveler"

"Travelers" shall mean eitehr:

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. Or,
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.

"**Treating Physician"**

"Treating Physician" is a physician who is treating you for a primary medical condition (one of more of the medical conditions on which you based your loss of time) on the date the loss of time application is signed and throughout your loss of time period.

"Union"

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

"Urgent Care Claim"

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.

"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

A participant's calendar year family dental allowance limit is always determined by the participants active or retired status with the Plan.

Calendar Year Family Dental Allowance for Active Employees

The Plan pays 80% of the covered dental expenses incurred by you and your eligible dependents up to a maximum benefit of $3,000 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 $3,000 calendar year dental maximum.

Calendar Year Family Dental Allowance for Retirees:

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 the calendar year or $1,000.00.

In each subsequent calendar year, the retiree and any eligible dependent will be limited to a maximum dental benefit of $1,000.00 per family. The Plan pays 80% of the covered dental expenses incurred by you and your eligible dependents up to a maximum benefit of $1,000 per family each calendar year.

Should a retiree receive 420 hours of Employer Health and Benefit Plan contributions in any work quarter, they will be provided active eligibility in the applicable quarter of coverage. When this occurs, the individual and any eligible dependent will no longer be considered a retired participant of the Plan and will be provided with the difference between the annual retiree dental benefit utilized while retired in that calendar year and that of the annual maximum permissible for active participants. Conversely, when the active participant regains retiree coverage under the Plan, their dental allowance and that of any eligible dependent will be limited to the lesser of the unused active participant dental allowance for that calendar year or $1,000.00.

Claims for Dental Services for all Participants:

Dental services must be rendered in accordance with accepted standards of dental or orthodontic practice and must be received while a person is eligible to receive Dental Benefits from the Plan.

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:

- for full or partial dentures when the impression is taken for the appliances.
- for root canal therapy when the tooth is opened; and
- 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:

- Oral exam and cleaning.
- X-rays.
- Space maintainers, fluoride, and sealants for children.
- Fillings.
- Oral surgery including extractions.
- Crowns.
- Endodontic treatment (root canal therapy).
- Periodontal treatment.
- Prosthetics such as bridges and dentures.
- Implants.
- Emergency palliative treatment.
- Anesthetics and analgesics.

Note 1: Payment for dental services does not accumulate toward the participants annual out-of-pocket expense limit.

Dental Care Covered Under the Medical Provisions of This Plan

Dental services provided for the routine care, treatment, or replacement of teeth or structures (e.g., root canals, fillings, crowns, bridges, dental prophylaxis, fluoride treatment, and extensive dental restoration) or structures directly supporting the teeth are generally excluded from coverage under the Plan's medical provisions, except under the limited circumstances outlined below and only when properly documented as medically necessary.

- Treatment related to inflammation and infection.

- Dental repair of teeth due to injury.
- Exams for orofacial medical problems.
- Extraction of wisdom teeth, under certain conditions.
- Extraction of multiple teeth at one time.
- Certain periodontal surgery procedures.
- Consultation for and excisional biopsy of oral lesions.
- Consultation and treatment for temporomandibular joint problems.
- Infection that is beyond the tooth apex and not treatable by entry through the tooth.
- Pathology that involves soft or hard tissue.
- Procedures to correct dysfunction.
- Emergency trauma procedures.
- Appliances for mandibular repositioning and/or sleep apnea.
- Congenital defects.

To make the case that the malady is a medical issue, not simply a dental one, and that it should be eligible for reimbursement under the medical provisions of the Plan, you and/or your provider must document the following:

- The primary presenting situation
- Any secondary, supporting diagnosis.
- The ICD-10 codes and CPT codes for the treatment that is planned.
- Surgical pre-authorization
- Medical Necessity, in the form of a letter of medical necessity
- Support from your Primary Care Physician, in the form of a supporting letter of medical necessity
- The surgery location
- If the treatment is accident related. If so, the nature of the accident.

Note: In the Letter of Medical Necessity you or your provider must outline your case for surgery. Make certain that ICD-10 codes are properly used in this letter and that any other contributing medical factors are thoroughly explained in this document.

Additionally, a signed letter from your primary care physician supporting the recommended treatment and attesting to the fact that the procedures are necessary and will address the underlying problem is required.

Health Reimbursement Arrangement Credit Benefit (HRA) & Your Dental Bills

Participants can utilize their Health Reimbursement Arrangement Credit Benefit toward any unpaid dental balance that remains **AFTER** the Fund has adjudicated the dental claim.

Warning: Prepaying for dental services with your HRA debit card is prohibited. Further, unless you are absolutely certain of your specific co-insurance payment do not use your debit card at the time of service to make payment. If you do the latter, you are reminded that all rules, and provisions as they relate to the proper and timely substantiation of a HRA debit card payments and purchases are in effect. Despite the Funds numerous warnings on this very subject, this remains the primary reason that participants permanently lose their debit card privileges.

Medical Services Provided by a Dentist

Medically necessary medical services that could be performed by a physician (M.D. or D.O.) but are performed by a dentist are covered if performance of those services is within the scope of the dentist's license, according to state law. These services may include, but are not limited to, the following:

- Dental examinations to detect infection prior to certain surgical procedures.
- Diagnostic x-rays in connection with services covered under the medical plan.
- Treatment of oral infections in connection with services covered under the medical plan.

Orthodontia

There is no separate orthodontia benefit under this Plan, rather payments for orthodontia treatments are applied against any available family dental allowance for the calendar year in which services were rendered. Moreover, the Plan maintains a maximum lifetime orthodontia limit per covered active participant of $3,000.00. Provided that they have not fully and previously exhausted their lifetime orthodontia benefit while covered as an active participant of this Plan, a retiree requiring orthodontia work will be permitted to utilize, but not exceed, the lessor of the difference between any active lifetime orthodontia allowances not used as an active participant, and the remaining amount of their retiree dental allowance for that calendar year in which orthodontia claims were incurred.

Pre-authorization

If surgery is involved, make certain your dental or physician's office calls for pre-authorization when the surgery is initially scheduled. Surgeries not pre-certified will not be covered.

DEPENDENTS

Coverage for only those individuals who meet this Plan's definition of dependent will start on the latter of the same date that the employee or retiree coverage began or on the first day of the month after the required documentation needed to establish proof that these individuals meet the Plan's definition of "dependent" has been deemed satisfactory, **AND** you properly enrolled them into the Plan.

Dependent 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 show 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, fail to respond within the stated time-period, that do not provide all requested supporting documentation or complete the form properly and/or repeatedly ignore Fund correspondence on this matter, 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. This also means that any claims incurred during this period of non-coverage will remain the responsibility of the patient.

Reinstatement of coverage, if any, will be determined by the Plan. If reinstatement is granted, coverage will begin on the day following the day the Plan determines that the participant met his or her dependent eligibility verification requirement. Be advised that the Plan will not back date a participant's eligibility for a failure to adhere to this provision. This means that payments for any and all claims incurred during a period of non-coverage will remain with the participant.

Note: If the Plan does not grant reinstatement, the participants may avail themselves of their right to appeal to the Board of Trustees. Please reference the section of this book titled "Appeals."

Warning: *As stated previously within this document each employee is responsible to timely provide to the Plan accurate and complete information needed to administer your family's benefits, including, but not limited to:*

- *Other health Benefit coverage and other insurance Benefits you or any eligible dependent may have in addition to your coverage with this Plan.*
- *Changes in you or your dependents marital status.*
- *Changes in dependent status. (Births, Adoptions, Separations, Divorce, Death)*
- *Changes in your dependents contact information.*

Once again, failure to do so can result in the loss of coverage to you and your family. Further, if this Plan erroneously pays a claim or claims because the employee failed to adhere to the rules of the Plan, coverage for you and all covered dependents will be terminated. 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.

DIALYSIS

Benefits provided under this Plan for treatment received in connection with any type of dialysis include outpatient dialysis, inpatient dialysis (hemodialysis) and home dialysis (peritoneal dialysis) and are subject to the following provisions:

- Charges for hemodialysis and peritoneal dialysis charges, including but not limited to the cost of administration, drugs, and supply will be paid as a single charge (not unbundled.);

- The Reasonable and Allowed Amount for this benefit will be the lesser of (a) 175% of the rate published by Medicare for the dialysis base rate for the applicable calendar year, (b) the PPO allowable amount, or (c) the WellRithms allowed amount.

DIETICIAN

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

Concurrent Review for all outpatient counseling after the seventeenth (17th) visit / treatment.

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.*

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 Arrangement 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 the use of any Health Reimbursement Arrangement Credit Benefit to offset any incurred debts for the reason that these debts were incurred by non-covered participants of the Plan.

Note #2: If you enrolled your spouse's biological children and subsequently divorce your spouse, that child or children will no longer be covered by this 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.)

Durable Medical Equipment Coverage

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 mattresses overlays.
- Traction equipment
- Walkers
- Wheelchairs (up to $500 maximum allowance for the purchase or rental of a wheelchair or scooter)

Durable Medical Equipment Replacement

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. The patient's condition has significantly changed so as to make the original equipment inappropriate in the judgment of the physician.

Warnings:

1. *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 permission from the Plan will be responsible to remunerate to the Plan the full purchase price of said equipment.*
2. *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

Unless otherwise specified within this document, eligibility under the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan is in comprised of two different components:

1. An hourly component and,
2. 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 these eligibility requirements will result in you and any qualified dependent 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
- Retired and receiving a monthly Early, Regular, Normal or Disability pension payment from the Local Union No. 697 I.B.E.W. and Electrical Industry Pension Fund; 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.

Benefit Periods of Coverage – The 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

Note: There exists no middle column because we wanted 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.

Important - The Collective Bargaining Agreement requires every signatory employer to pay you on a weekly basis. However, that document does not stipulate how that employer is to report contributions for unit work performed within a month that does not end exactly at the close of their pay period.

Therefore, if your employer or employers report hours for unit work performed within the last week of a calendar quarter as work performed in the subsequent quarter, those hours will be accumulated along with any other hours reported for the subsequent calendar work quarter and tallied to determine eligibility within that quarters affiliated quarter of coverage.

Benefit Periods of Coverage - <u>The Hourly Requirements</u>

Initial Eligibility

Apprentices, Indiana Plan participants, journeypersons, non-bargained employees identified within a participation agreement and owners and owners-in-fact 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.

- **<u>Fast-Tracked Eligibility</u>**. 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:

  - 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
  - Do not owe money to the Plan,

  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 324 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 324 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 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 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:

i. Specify their intent to provide coverage for the employee within 30 days from the date employment started, and

ii. 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 420 hours were received by the Plan. The initial period of

coverage will be for the remainder of that quarter of coverage and the successive quarter.

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 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 - Initial Eligibility for Retirees that are not Eligible for Medicare Benefits

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.

b. 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.

c. In the fifteen (15) years directly prior to retirement and excluding any period in which you may have been receiving COBRA benefits from this Plan, you will have had to be covered under this Plan for a minimum of forty (40) full calendar year quarters.

d. 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.

e. You must not owe any monies to the Lake County Indiana NECA – I.B.E.W Health and Benefit Plan.

f. Cannot receive COBRA benefits directly prior to gaining retirement coverage under this Plan.

Retiree - Initial Eligibility for Retirees that are Eligible for Medicare Benefits

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:

- 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.
- In the fifteen (15) years directly prior to retirement and excluding any period in which you may have been receiving COBRA benefits from this Plan, you will have had to be covered under this Plan for a minimum of forty (40) full calendar year quarters.
- 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.
- You cannot receive COBRA benefits directly prior to gaining retirement coverage under this Plan.
- Must be enrolled in Medicare Parts A and B at the time of first being eligible to receive Medicare benefits. This 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.

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.

Retiree Continued Coverage: Once retiree coverage starts, a retiree must maintain continuous coverage for themself and their dependents by making any monthly self-pay no later than 4:30 P.M. on the last business day prior to the upcoming calendar month of coverage. 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. If coverage lapses, it will remain a permanent lapse.

Retiree to Active Journeyperson: Retired individuals who have 420 hours of Health and Benefit Fund contributions made on their behalf within a work quarter, will be no

longer be considered a retired participant under this Plan and will be afforded the same coverage that is provided to active employees and their families under this Plan in the corresponding quarter of coverage.

Should a retired participant regain active eligibility status under this Plan:

1. The retiree's self-payment, if any, will not be assessed during the quarter or quarters of coverage in which they enjoy active eligibility status. And,
2. The retired participants' right to receive coverage under any retiree provision of this Plan will cease and subsequently be held in abeyance until termination of active eligibility status.

Note: Participants are advised that while receiving active coverage under this Plan, all rules, policies, and provisions for active (non-retiree) coverage under this Plan are in effect. This would include, but is not limited to, those rules, policies and provisions that speak to continued eligibility for journeypersons, automatic HRA deductions to maintain active coverage status, and the Retiree Self-Payment Credit benefit. Consequently, the Plan is informing all retirees that are thinking about or are actively working to reread and relearn the rules, provisions, and policies as they relate to active coverage under this Plan.

Reminder: Reread the section above and reread and relearn your benefit Plan. Not doing so may cost you both money and time.

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.

Failure to Meet the Enrollment Requirements of the Plan

Failure to meet the enrollment requirements of the Plan will result in either:

- A delayed initial eligibility start date, or
- A delayed continuation of coverage date, or
- The immediate cessation of eligibility.

Participants are reminded that claims incurred during any period of non-coverage will remain the participants responsibility.

Owing Money to the Plan

If you owe money to the Plan, eligibility for benefits under this Plan will terminate for you and any dependent in accordance to this Plan's rules and guidelines and all applicable Federal laws. Coverage will be reinstated upon full remuneration of said obligation AND provided the participant has satisfied all other initial and/or continued eligibility provisions of the Plan.

However, in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, the cancellation or discontinuance of coverage for the participant and any dependent will occur in accordance to the fraud provisions of this Plan.

Reinstatement of Eligibility

If your coverage terminates, it cannot be reinstated if you have any unsatisfied debt to the Plan and until you meet the Plan's reinstatement requirements as stipulated within this provision. Further, and 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: If a participant has not been covered under this Plan for twelve (12) consecutive months, they must re-enroll themselves into the Plan by reverifying and if necessary, updating their personal and dependent information on file with the Plan. This would include submitting any missing supporting documentation as needed and/or requested by the Plan. **Remember**, one of the two facets needed for you and your dependents to be covered under the Plan is enrollment, as such, the Plan highly recommends that you read and understand the "Enrollment" section of this document.

Warning: *Missing, incomplete or the untimely completion and/or untimely submission of an updated enrollment form and/or of any 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 for reinstatement 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 reinstatement of you and/or any eligible dependent coverage will remain the sole responsibility of the participant.

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 – 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.

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.

Retiree: Should a retiree lose their eligibility under this Plan; coverage will not be reinstated.

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 sixty days to manually submit unpaid medical expenses that were incurred during the time of coverage under this Plan for reimbursement. After that sixty-day period, any monies left within your HRA will be forfeited.

Termination of Apprentice 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 the chance 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.

Warning: *Unless otherwise noted, self-payments are always due in accordance with the dates and times listed within the section of this document titled "Self-Payments". The chart below has been provided to you as a reminder:*

Insufficient Work Hours Received for Calendar 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

Termination of Journeypersons and Employees Eligibility - 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: Reread the other warning. Moreover, in addition to the self-payment due date being listed as stated previously, they are often placed on the Fund website, listed in the Funds newsletter, and placed on your shortage of hours' notice.

Termination of Retiree Eligibility - Coverage for retired participants will terminate upon:

- At age 65, or at such a time that you are entitled to receive Medicare benefits and you fail to enroll timely in Medicare Part A and B and/or failed to timely provide the Plan with proof of said enrollment. Failure to do both will result in not being covered under this Plan during retirement.
- 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 a failure to provide requested documentation needed to properly administer that individuals' benefits.
- Upon death.

EMERGENCY ROOM FACILITY CHARGES

Knowing where to go for medical care can save you lots of time and money – not to mention, gets 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, the Plan provides 24/7 access to medical professionals through its **Telemedicine / Telehealth benefit provider identified on the reverse side of your medical identification card**. The Telehealth/Telemedicine medical professional that assists you will be able to help you identify whether you are dealing with a situation that requires emergency room care, a situation that can be treated at an urgent care center, or whether you are dealing with a situation that can wait until a scheduled appointment with a physician can be made.

Nevertheless, if you believe that you or a covered dependent's 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

- If a reasonable and prudent person would consider the situation to involve a serious impairment to bodily function or serious dysfunction to a bodily organ or body part without immediate emergency medical attention that one could only receive within an emergency room,

Then immediately call "911" or go to your nearest emergency room.

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 facility's 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.

EMPLOYEE

Each employee is required to properly enroll themselves in the Plan. Enrollment is the process by which employees register for and sign themselves and any eligible family members up as participants in the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Fund. For details as to how to enroll yourself and any eligible family members, please reference the section of this document titles "Enrollment," and "Dependents."

Employee 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 employees to verify their eligibility status within the Plan.

This verification process is the Plan's method of making certain that your personal information and all supporting documentation are on file. This process is mutually beneficial as similar to you, the Fund wants to ensure that your access to the benefits described within this document are not delayed or denied, that your claims are paid

fast and efficiently, and that any prior or concurrent authorizations are handled quickly without any impediment.

Failure to Respond or Respond Timely: Employees that do not respond to the Plans verification requests or fail to respond correctly and completely and within the stated time-period, and/or do not provide all requested supporting documentation, 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. This also means that any claims incurred during this period of non-coverage will remain the responsibility of the patient.

Reinstatement of coverage, if any, will be determined by the Plan. If reinstatement is granted, coverage will begin on the day following the day the Plan determines that the participant met his or her dependent eligibility verification requirement. Be advised that the Plan will not back date a participant's eligibility for a failure to adhere to this provision. This means that payments for any and all claims incurred during a period of non-coverage will remain with the participant.

Note: If the Plan does not grant reinstatement, the participants may avail themselves of their right to appeal to the Board of Trustees. Please reference the section of this book titled "Appeals."

Warning: *Because of its importance the Plan is reiterating what has been previously stated within this document as it relates to each employee responsibility to timely provide to the Plan accurate and complete information needed to administer you and/or your family's benefits, including, but not limited to:*

- *Other health Benefit coverage and other insurance Benefits you or any eligible dependent may have in addition to your coverage with this Plan.*
- *Changes in you or your dependents marital status.*
- *Changes in dependent status. (Births, Adoptions, Separations, Divorce, Death)*
- *Changes in your dependents contact information.*

Once again, failure to do so can result in the loss of coverage to you and your family. Further, if this Plan erroneously pays a claim or claims because the employee failed to adhere to the rules of the Plan, coverage for you and all covered dependents will be terminated. 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.

END STAGE RENAL DISEASE (ESRD)

Participants that are diagnosed with kidney failure who are on dialysis or have a kidney transplant are advised that this Plan requires: that they:

- Notify and work with the Plan's Case Management provider. **Important** Notification needs to occur upon initial diagnosis of the disease. (Please see the section of this document titled "Case Management" for more information as to how this program works.)

- Enroll in Medicare Part A and B at the first opportunity they are eligible to do so, but no later than the 30th month of treatment. And,

- Notify the Fund Office in writing of their enrollment in Medicare. Participants with end stage renal disease are reminded that the Plan's rules concerning the timely notification of other insurance remain in effect as do the rules that relate to the failure to disclose that or disclose that in a timely manner.

The importance of the thirtieth (30th) month and enrolling in Medicare Part A and Part B

Participants are advised that upon the cessation of the thirtieth (30th) month of treatment, this Plan ceases to be the primary insurer for you. Consequently, if you failed to enroll into Medicare or failed to enroll in both Medicare Part A and Part B at the same time you will be responsible to make payment for the treatments you receive prior to Medicare eligibility but after the thirtieth (30th) month of treatment.

Regarding the former, if you are diagnosed with end stage renal disease (ESRD), the first chance to enroll in Medicare begins in the month you begin treatment for kidney failure (dialysis or transplant). Moreover, transplant recipients who want Medicare to cover transplant and immunosuppressant medication after surgery will need to sign up for Medicare during their first year of treatment.

Additionally, if you are Medicare approved, the start date of Medicare coverage is determined by the type of treatment you are receiving. Listed directly below is a general guide as to how Medicare determines your coverage start date. This chart is provided as a courtesy and should not be relied upon as being definitive or current. Consequently, participants are advised to consult with the Center of Medicare Services to obtain the start date of their coverage under Medicare.

TREATMENT OPTION	DATE MEDICARE BECOMES EFFECTIVE
In Center Hemodialysis	The first day of your fourth month of dialysis
Home Dialysis	The first day of the first month you start home dialysis

Transplant	The month you are admitted to a Medicare-approved hospital for a transplant or up to two months before admittance if pre-transplant healthcare and testing are begun.

ENROLLMENT

One of the two facets needed for you and your dependents to be covered under the Plan, is enrollment. (The other is the requirement set forth within this Plan's "Eligibility" provision.)

In order for an employee to be enrolled, they must complete in its entirety the Plans enrollment form and provide certain documentation as identified directly below. The documentation to substantiate a dependent can be found within the sections of this document titled "Birth," "Children," and "Marriage."

Required Documentation for an Employee

1. A fully completed enrollment form.
2. A copy of the employee's birth certificate / passport
3. A copy of the employee's Social Security card.
4. A fully completed and executed ERTS form.
5. Or any other information required by the Fund Office.

Participants are reminded to also complete the Funds ERTS form and beneficiary form in their entirety. Regarding the former, if you work outside of the jurisdiction of the IBEW Local 697 and you have not completed the ERTS form, benefit contributions may not come back to this Plan or come back timely. As to the latter, if no beneficiary form is on file or on file and incomplete, then upon the covered participants untimely demise, the life insurance proceeds will be paid out in accordance with that specific benefit provision.

Note: 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. Ignoring these requests or not completing in their entirety the requested forms or not timely providing any and all requested information is at your own peril.

Changes in Participant Status. Each employee is responsible to timely provide to the Plan accurate and complete information needed to administer your family's benefits, including, but not limited to:

- 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)
- Separation of spouses
- 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")

Warning: *Re-read the section of this topic titled "Changes in Participant Status" again. You as the employee are the party that the Plan holds responsible to keep it informed, and informed timely as to any changes in your dependents status that could affect the Plan's ability to correctly administer your family's benefits. Such items would include but are not limited to the following:*

- *Other health Benefit coverage and other insurance Benefits you or any eligible dependent may have in addition to your coverage with this Plan.*
- *Changes in you or your dependents marital status.*
- *Changes in dependent status. (Births, Adoptions, Separations, Divorce, Death)*
- *Changes in your dependents contact information.*

Failure to keep the Plan informed in a timely manner can result in the loss of coverage to you and your family. Further, if this Plan erroneously pays a claim or claims because the employee failed to adhere to the rules of the Plan, coverage for you and all covered dependents will be terminated. 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.

EXCLUSIONS AND PLAN LIMITATIONS

No payment will be made for and/or no consideration will be given for:

- **Abortions**
- **Acupuncture treatments** during any period in which a participant was prescribed an opioid.
- **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. COBRA – While covered under the COBRA provisions of this Plan,
d. Death during surgery.
e. Death resulting from a mental or physical illness.
f. Drug overdose or use of intoxicants unless taken under the advice of a physician.
g. Felonious conduct.
h. Internal conflicts, insurrection, or rebellion of any country.
i. Operating any vehicle under the influence of drugs or alcohol.
j. Sickness, disease, or bacterial infection, unless the latter was due to an accidental cut, wound, or due to botulism or ptomaine poisoning.
k. Suicide, attempted suicide, or intentionally self-inflicted injury.
l. Travel, including but not limited to, getting in or out of a vehicle used for aerial navigation if the person is:
    i. Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.
    ii. Performing, learning to perform, or instructing others to perform as a pilot or crew member of any kind.
    iii. 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.
- **Adverse outcomes**, **expenses, issues, problems, or situations** that were created by a participant or provider as a result of not acting in accordance with Plan policies, provisions, or rules, or due to a participant's nonobservance of, or dereliction to learn and understand the rules, policies, and provisions of this Plan.
- **Air conditioners**
- **Alcohol** abuse treatments in a partial day program or an in-patient program without prior approval / pre-certification.
- **Alcohol** abuse treatments in an out-patient setting of seventeen days or greater without prior approval / pre-certification.

- **Alternative medical treatments or programs** intended to provide personal fulfillment or harmony.
- **Anatomical gift** expenses or fees or organ transplants expenses or fees that are not expressly permitted under this Plan.
- **Anesthesia** services 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.
- **Any errors** as defined by this document
- **Any invalid charges**
- **Any medical technology or therapy** that aims to produce a therapeutic effect through the manipulation of gene expression or through altering the biological properties of living cells including the replacement, deletion, or insertion of genetic material.
- **Any unbundled charges**
- **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.**
- **Assistance and/or the training of a newborn or a child** in breast or bottle feeding.
- **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.
- **Assumptions.** The Plan pays claims and administrates claims and eligibility in accordance with the rules, policies and provisions outlined within this document. Assuming, presupposing, imagining, or believing how this Plan works neither makes a claim payable, nor an individual covered under the Plan.
- **Automatic Health Reimbursement Arrangement** account self-payment deduction reversals.
- **Autopsies.**
- **Babysitters.**
- **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 surgery** that **has not been pre-approved** or pre-certified by the Plan's review organization.
- **Batteries** for hearing aids or for other non-imbedded medical devices.
- **Billing issues and errors** arising out of any participant's failure to monitor and review for correctness this Plan's explanation of benefits, or another insurers explanation of benefits for correctness. This would include allowing erroneous payments to be made by this Plan, because the participant and/or their guardian did not adhere to the Coordination of Benefit provision of this Plan.
- **Billing mistakes**, of any sort, that a medical, dental, vision, or pharmaceutical provider creates or any third-party causes, and the correction thereof by this Plan.
- **Biofeedback** counseling, treatments, or testing.
- **Bio identical hormone replacement therapy** that contains elements that are not approved for the purposes that they prescribed.
- **Birthing centers** that are not 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**.
- **Bodily injury, disease or illness** resulting from or by any act of operating any vehicle, piece of machinery or armament while under the influence of drugs or alcohol.
- **Breastfeeding counseling, instruction or support** claims for newborns or children.
- **Breast pump expenses** above the allowable limit.
- **Breast pump purchased** prior to the birth of a child.
- **Breast pump replacement parts.**
- **Calling providers or collection agencies** to address matters that are not directly attributed to or caused by this Plan. This would include, but is not limited to matters, issues or situations caused by:

a. A provider's poor hiring practices.
b. A provider's poor training or lack of training of their employees.
c. A provider's employee lack of understanding of their employers' systems.
d. A provider's employee lack of understanding of the healthcare industry in which they have chosen to work. This would include but is not limited to standard insurance practices concerning the proper submission of claims or the timely receipt of pre-certifications.
e. Any coding failures by the provider.
f. Any errant submissions of claims to the incorrect paying entity.
g. The failure of the participant to timely notify and submit the proper documentation needed to properly adjudicate claims and administer the Plan. This would include but is not limited to anything to do with a participant not properly notifying the Plan about other insurance coverage, marital status, and dependent status.
h. Miscommunications by a participant to a provider or another participant.

Note: Participants are reminded that while many of these items are out of their control, all of the aforementioned matters are out of the control of this Plan. Consequently, participants must address the problem with the party or parties responsible for creating them.

- **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, far sightedness, 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 of participants while not covered under this Plan.**

j. 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.**

k. For **procedures, services, supplies, or treatments** which are **not medically necessary.**

l. For **procedures, services, supplies, or treatments** that **require prior approval, pre-certification, or concurrent review but in which prior approval, and/or precertification was not obtained.**

m. For **procedures, services, supplies, treatments** for or **related to** a dependent's **pregnancy, including, but not limited to miscarriages, births, fertility and/or infertility treatments, check-ups, and coaching.**

n. For services and goods associated with a provider's medical error, negligence and/or malpractice.

o. For **services** and **goods not covered by the Plan.**

p. For **services beyond the scope of a practitioner's license.**

q. 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.

r. For **services incurred after coverage ends.**

s. For **services incurred prior to the proper enrollment** of a dependent in the Plan.

t. For **services incurred within a hospital emergency room** for non-emergency sicknesses or conditions.

u. For **services not medically necessary** or not recommended, ordered, or approved by a doctor.

v. 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.**

w. 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.

x. For **services resulting from or occurring as a result of felonious conduct** committed by the patient or his family member(s).

y. For **services that fall under the federal False Claims Act.**

z. For **services which are chiefly for instruction, education, or training.**

aa. 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.

bb. 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.**

cc. **Incurred by a person who is not covered under the Plan.**

dd. **That exceed the Plans maximum allowed amounts, Reasonable and Allowed Amounts or usual, customary, and reasonable amounts.**

ee. **That have been waived.**

ff. **That you or a dependent are not legally required to pay.**

gg. **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 apprentice electrician or journeyperson electrician.
- **Choices, decisions, and actions of a participant that are incongruent to the rules, provisions and policies listed within this document**, as well as any adverse outcomes. Consequently, it is in every participant's best interest to read, learn and understand the rules and provisions contained within this document.
- **Claims of apprentices** that failed to meet the eligibility provisions of this Plan.
- **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.
- **Claims** submitted after three-hundred and sixty-five (365) days from the date of service.

- **Claims** that are lost, undelivered, or incorrectly addressed and are not received. Also see "Issuance of claims."
- **Claims** that utilize incorrect or inappropriate coding. Also see "Issuance of incorrect claims and coding failures," "Calling providers," "Billing mistakes," and "Coding failures of other parties."
- **Claims** of an employee or their dependent that failed to adhere to both the enrollment or eligibility rules and provisions of this Plan.
- **Claims** that are the responsibility of another party due to a court-imposed order or other document.
- **COBRA periods of coverage are not permitted to be used in the calculation of earning coverage in retirement.**
- **Coding failures of other parties.** If a claim contains A) outdated or incorrect medical code, B) insufficient information and/or C) erroneous information it will be rejected. Should this occur, your recourse for any adverse outcomes is with the issuing entity, not with this Plan.
- **Comfort support animals or sessions or treatments with comfort support animals.**
- **Commodes.**
- **Common law** partners.
- **Compounded hormone replacement therapy** that contains elements that <u>are not</u> 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.
- **Correction** of billing mistakes, claim errors, submission errors, and the after affects that are caused by any party other than this Plan.
- **Correction of Health Reimbursement Arrangement (HRA) submissions resulting from** the improper use of the debit card. This would include but is not limited to any circumstance caused by either a provider incorrectly billing the participant with an erroneous balance, or result from a provider demanding payment at the time of service and/or those that refuse to properly bill the Lake County Indiana, NECA – IBEW Health and Benefit 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.**
- **Coverage for apprentices who fail to meet the hourly, AND enrollment AND JATC participation status requirements of this Plan.**

- **Coverage** for participants and any dependent that fail to meet both the hourly and enrollment provisions of this Plan.
- **Craniomandibular treatments**, unless proven to be medically necessary.
- **Cryonics or cryonic suspension** of any kind.
- **Custodial care.**
- **Debit Card reactivation** if the participant chooses not to attend any coach and correct meetings, misses a coach and correct meeting for any reason, or causes their debit card to be deactivated again AFTER attending a coach and correct meeting.
- **Deductibles are not payable as secondary under the Coordination of Benefits provisions of this Plan.**
- **Dependent children's pregnancies.**
- **Dependents not properly enrolled in the Plan.**
- **Dependents that do not meet the eligibility requirements of this Plan.**
- **Detoxification in a hospital or rehabilitation center unless authorized by the Plan.**
- **Diabetic education.**
- **Diagnosis and/or treatment of conditions or maladies identified as a non-covered benefit within this document.**
- **Diagnostic testing for non-emergency medical conditions** within a participating hospital emergency room will not be covered.
- **Diapers and Diaper services.**
- **Dietician visits** that are not pre-certified / prior approved.
- **Disclination** – Unless otherwise approved by the Fund Manager, the Fund will not utilize its resources in any manner to address matters, problems, or situations that the Plan did not directly cause or to which the erring entity and/or casualty is disinclined, adverse, unwilling, or reluctant to address. This would include any reason, such as, but not limited to, the belief that it would be easier for the Fund to solve or the erroneous understanding that these matters are the Funds responsibility to correct or remedy.
- **Discount cards** for medical, dental, pharmaceutical or visions services.
- **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.**
- **Eligibility** for those that do not meet the eligibility requirements of this Plan.
- **Eligibility** for those that do not meet the enrollment requirements of this Plan.
- **Eligibility** for those that fail to make their self-payment on time or in accordance to the self-payment provisions of the Plan.
- **Eligibility** for those that owe money to the Plan.
- **Employees** that are not properly enrolled in the Plan.
- **Employees and any of their dependents** that do not meet the eligibility requirements of the Plan.
- **Emotional support animals are not covered.**
- **Encounters** for the insertion or removal of contraceptive devices.
- **Epidural** injections without prior authorization.
- **Exceptionalism.** No participant is superior to that of another and no situation, unusual or extraordinary as it may be, is deserving in any way of treatment that differs from the rules, provisions or policies set forth within this document.
- **Exercise devices or equipment.**
- **Exercise programs or physical fitness programs** other than those described within this document.
- **Expenses for treatments or supplies that the Plan has inquired about** and the participant or the participants provider has not responded to within ninety (90) calendar days of the issuance of the inquiry.
- **Expenses in excess** of the Funds allowances as set forth within this document.

- **Expenses in excess** of what is actually owed, including, but not limited to HRA balance billing for co-insurance submissions and transactions.
- **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.
- **Faith Healing**
- **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** during any period in which you were not eligible to receive benefits from this Plan.
- **Fitness club fees** for any covered dependent other than your spouse.
- **Fitness club fees** which 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, and sex or transgender status.
- **Gene therapy treatment or any medical technology or therapy** that aims to produce a therapeutic effect through the manipulation of gene expression or through altering the biological properties of living cells including the replacement, deletion, or insertion of genetic material.
- **Genetic counseling** for or on any genetic test not specifically identified and covered under the Patient Protection and Affordable Care Act (PPACA). (For example, BRCA mutations.)
- **Genetic testing for procreative management** that is not specifically identified and covered under the Patient Protection and Affordable Care Act (PPACA).

- **Genetic testing** that is not for the diagnosis or treatment of an existing medical condition 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 Arrangement Credit Benefit (HRA) account** balances lost and/or forfeited for any reason, including but not limited to fraud, failure to timely notify the Fund Office in writing of your divorce, and/or repeated and improper submissions.
- **Health Reimbursement Arrangement Credit Benefit account (HRA)** credits when receiving loss of time or short-term-disability benefits or when gaining initial eligibility or the reinstatement of eligibility.
- **Health Reimbursement Arrangement (HRA) Credit Benefit account credits** to offset the expense of COBRA with this Plan or any other. (Please see directly below)
- **Health Reimbursement Arrangement Credit Benefit (HRA) account deductions** that are made automatically by the Plan to continue a participant's eligibility are not reversable. Please make sure to read and understand the section of this document titled "Health Reimbursement Arrangement" in its entirety.
- **Health Reimbursement Arrangement Credit Benefit (HRA) account** requests for the repayment of any out-of-pocket expenses incurred after a participant's eligibility has been terminated. This would include, but is not limited to, the expense associated with COBRA coverage, or any out-of-pocket expense incurred while covered under this Plan's COBRA provision. Please make sure to read and understand the section of this document titled "Health Reimbursement Arrangement" in its entirety.
- **Health Reimbursement Arrangement Credit Benefit (HRA) dental and medical submissions and/or transactions** made prior to the Plan adjudicating the claim.
- **Health Reimbursement Arrangement (HRA) Credit Benefit account debit cards** that are used to make prepayments.
- **Health Reimbursement Arrangements Credit Benefit account debit cards** that have been permanently deactivated will not be reactivated.

- **Health Reimbursement Arrangements (HRA) Credit Benefit coach and correct educational meetings** for non-employees.
- **Health Reimbursement Arrangements (HRA) Credit Benefit payments** for expenses incurred while not a covered participant of this Plan or prior to a participant being established.
- **Hearing aid repair**
- **Hearing exams or testing** for the fitting of hearing aids.
- **Hearing exams or testing** for routine exams with a frequency of greater than once every two calendar years.
- **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. Eye care 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:**
    - **Confinements** for the treatment of non-acute illnesses.
    - **Confinements** not related to injury, illness, or surgery.
    - **Confinements, services, or treatments that are non-emergency related** that are received prior to precertification being granted by the Plan.
    - **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.
    - **Dental care** performed in a hospital or hospitalizations for dental care unless prior approval is obtained and is certified by your physician.
    - **Mental or nervous inpatient treatments**, except as stated in the pages of this document.
    - **Separate charges** by a salaried hospital physician or staff.
    - **Take home drugs.**

- **Household help,** including but not limited to homemaker services, sitters, childcare 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 crime, misdemeanor, 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. Committing an act or failing to act when the participant clearly knew or should have known the act or omission was illegal.
  e. Past or present military service**.**
  f. 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.
- **Included Health** services for retirees with Medicare as their primary insurer.
- **Infant formula** other than that which is specialized for children with an inborn error of metabolism.
- **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.**
- **Intent.** The Plan neither pays a claim, grants eligibility, reactivates debit cards, executes upon, makes allowances for, permits for the allocation of Short term Disability payment or loss of time credits, nor provides a favorable determination based on a participant's or another entity's intent.
- **Issuance of claims and issuance of correct claims–**The Health and Benefit Plan does not issue medical and/or dental claims. Accordingly, the Plan cannot correct any erroneous claims or chase down and be responsible for the timely

and correct submission and/or resubmission of a treating medical professional's claim forms.

- **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.
- **Items** intended only to make things more convenient or comfortable including Rx delivery methodologies and systems that do not improve the clinical efficacy of the pharmaceutical being administrated.
- **Jacuzzis**
- **Lap band adjustments** one year or more after the surgery.
- **Lasik surgery**
- **Late self-payments**
- **Life insurance** payments made to any beneficiary of a participant who was covered under the COBRA provision of this Plan at the time of death.
- **Life insurance** payments made to any beneficiary prior to said beneficiary being able to substantiate their identity to the satisfaction of the Plan.
- **Life-partners.**
- **Loss of benefits or eligibility due to a participant's** incorrect understanding of how their employer or employers determine the date that they close out a month and use to calculate their monthly Fringe Benefit contribution obligation as described within the Collective Bargaining Agreement. Employer reporting issues, whether real or perceived, that result in self-payment or loss of eligibility, must be addressed by the issuing employer or employers. The Plan does not move hours from one work quarter period to another unless it made an error in the crediting of such.
- **Loss of benefits or eligibility due to a participant's** lack of timely action, inaction, incorrect action, ignorance, inability, or unwillingness to timely submit correct documentation, payment or incorrectly submitting documentation or insufficient payment by a cut-off date or within the parameters of any Plan provision.
- **Loss of benefits or eligibility due to Plan communications** that are misdirected, returned, or undelivered, due to the failure of the participant to update his or her contact information with the Plan.
- **Loss of benefits or eligibility due to responsibilities** that are consigned to the care of another, and that party fails to timely submit correct documentation or payment or incorrectly submits documentation or insufficient payment by the cut-off date or within the parameters of any Plan provision.

- **Loss of time benefits** for any period of disability during which you are not under the regular care of an M.D. or D.O. for the disability which resulted in your inability to work.
- **Loss of time benefits for any period of time during which you were employed or working or obtained erroneously.**
- **Loss of time benefits** for any period of time while covered under the COBRA provisions of this Plan.
- **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, or the instruction on how to conduct maternal and newborn clinical assessments.
- **Matters that are neither in the Plans control nor of the Plan's making**. Such matters would include but are not limited to:
    a. The inability of a provider or the provider's staff to correctly interpret the network affiliation or contractual obligation to which they have agreed to adhere.
    b. The proper application of any discount not negotiated directly by the Plan. This would include any pharmaceutical issued discount card or coupon.
    c. The timely and correct issuance of bills and claims.
    d. The timely and correct reissuance of provider bills that contained erroneous information.
    e. The tracking down of misdirected or incorrectly submitted claims.
    f. The decision of a participant not to utilize a participating provider.
    g. The decision of a provider or participant not to pre-certify a procedure that requires prior authorization by this Plan.
    h. A participant's failure to address or timely address issues or matters.
- **Medical, Mental Health or Dental services and supplies** furnished or provided in or by a federal, state, or local governmental institution, agency or program that is required to provide health services to the incarcerated or to an inmate.
- **Medical technology** that aims to produce a therapeutic effect through the manipulation of gene expression or through altering the biological properties

of living cells including the replacement, deletion, or insertion of genetic material

- **Mental health in-patient treatments or services** that were not pre-certified or prior approved.
- **Mental health outpatient treatments or services** performed after precertification, concurrent review or prior approval are required by this Plan.
- **Midwife** services performed by a non-licensed, nonregistered nurse midwife or a midwife that is a relative.
- **Mime therapy**
- **Mindreading.**
- **Misdirected claims.** The Plan is not responsible for either the failures of an issuing entity to submit a claim to the proper address or for any failure of the U.S. Post Office to deliver said claim in a timely manner.
- **Missed appointments.**
- **Mistakes, errors, or omissions caused by any entity other than this Plan.** If you, your treating medical professional, or another entity created an adverse outcome, your recourse is to be found with those entities.
- **Moving hours by the Fund** from one work quarter to another for the sake of providing eligibility to a participant.
- **Music therapy.**
- **Myofunctional therapy.**
- **Naprapathy** other than those therapies and healing and restorative methodologies, procedures or services as described within this document.
- **Negotiating with Medical Providers –** Unless authorized by the Fund Manager.
- **Negotiating with Medical Providers** after services are rendered.
- **Non-biological children** that are neither adopted, nor your stepchild through marriage, nor someone who is placed with you by a state or federal court as a foster-child.
- **Nursing homes.**
- **Nutritionist services – see "dietician services" above.**
- **Occupation-related** conditions resulting from accidental bodily injury, illness or disease sustained while the person was in the course and scope of their employment and thus is or may be payable in whole or in part under any workers compensation act or any occupational diseases act or any similar law.
- **Occupational therapy in excess of 17 visits without prior approval.**

- **Oocyte cryopreservation.**
- **Opaque requests of any sort.**
- **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.**
- **Paternity Testing**
- **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, but not limited to telephones, TV's, cosmetics, newspapers, magazines, laundry, guest trays, the renting or purchase of movies or paying for access to events delivered through any Media device or service (Sorry K-Pop fans) 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.
- **Phrenology treatments and consultations.**
- **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.
- **Pilgrimages, religious or otherwise, in whole or in part** are not a covered benefit.
- **Pregnancy related expenses for dependent children or for anyone but employees and their dependent spouses.**
- **Prepayments of any kind**, including but not limited to those made utilizing the HRA benefit of this Plan.
- **Preventive tests and services** other than described within this document.

- **Psychological treatments** in an inpatient setting without prior approval / precertification.
- **Psychological treatments in an outpatient setting** after 17 visits 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.**
- **Reinstatement of eligibility and any Retire Self-Payment Credits** if a participant acts fraudulently, or intentionally or unintentionally makes material misrepresentations of fact.
- **Relationship counseling.**
- **Repairing** hearing aids.
- **Rest homes.**
- **Retiree eligibility for coverage on or after they either decline or fail to properly enroll in the Plan's chosen Medicare Advantage Plan D program or failed to make a timely self-payment.**
- **Retiree eligibility reinstatement after coverage has been terminated.**
- **Retiree Self-Payment Credit benefits** being utilized for or toward any retiree medical expense other than off-setting the participants retiree self-payment with the Lake County Indiana, NECA-IBEW Health and Benefit Plan.
- **Reversals of automatic Health Reimbursement Arrangement Credit Benefit** account self-payment deductions.
- **Reversal of the deactivation of a participants Health Reimbursement Arrangement Credit Benefit debit card.**
- **Reversal surgeries,** relating to or resulting from the participants decision to reverse a surgery such as, but not limited, elective sterilizations or vasectomies.
- **Routine exams, tests, physicals, 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.
- **Routine hearing exams or testing** with a frequency of greater than once every two calendar years.
- **Sales tax.**
- **Self-payments for initial eligibility**
- **Self-payments** that arrive after the due date or in amounts less than what is due.
- **Self-payments** that are submitted in amounts greater than what is due. Participants are advised that banking and accounting services are not a covered Benefit under the Plan, and as such, the Plan is not authorized to utilize its limited resources to keep track of that which is your responsibility. Please reread the section of this Document titled "Self-Payment" especially the section that addresses overpayments as the submission of an overpayment could possibly result in the loss of benefits.
- **Service animals** are not covered.
- **Services resulting** from felonious conduct or those that result from attempts to commit or a commission of a misdemeanor.
- **Services, supplies, tests, or drugs** related to the diagnosis or treatment of fertility or infertility.
- **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, and sex or transgender status.
- **Shipping charges.**
- **Short-term disability benefits** for any period of disability during which you are not in the regular care of a M.D. or D.O. for the disability which resulted in the inability to work.
- **Short-term disability benefits for any period during which you were employed or working.**
- **Short-term disability benefits** for any period during which you were or are covered under the COBRA provisions of this Plan.
- **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** after 17 visits or treatments without pre-certification / prior approval.
- **Substance abuse inpatient treatment**s that are not pre-certified, approved or coordinated by the Fund.
- **Substance abuse out-patient treatments greater than** 17 without obtaining pre-certification / prior approval from the Plan.
- **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.
- **Surviving dependent eligibility for any benefit on and after the remarriage date.**
- **Surviving dependent reinstatement of eligibility after coverage has been terminated.**
- **Synagis Injections** that are received prior to precertification.
- **Teladoc services rendered on or after May 1, 2024.**
- **Telephone consultations that are not properly billed as such.**
- **Temporomadibular Disorder (TMD) treatments**
- **Temporomandibular joint (TMJ)** treatments.
- **Therapies or programs** that are primarily supportive in nature, and/or that take place in a theater, a camp, farm, ranch, park, or another outdoor setting 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 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 ligation reversals**
- **Untimely actions** of participants, providers and/or third parties.
- **Vasectomy reversals.**
- **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.**
- **Widow eligibility for any benefit on and after the remarriage date.**
- **Widow reinstatement of eligibility after coverage has been terminated.**
- **Wilderness therapy** of any sort and for any reason including, but not limited to, alcoholism, bulimia, depression, drug addiction, mental health issues, physical rehabilitation, or substance abuse.
- **Whirlpool baths**
- **Worker Compensation / Occupational Disease expenses are not covered under the Plan.**

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 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 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 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 benefit program to help you make exercise a part of you and your covered spouse's life, as well as to help you pay for it.

Eligibility for Reimbursement

To be eligible for the Plan's benefit stipend, you must be an employee or spouse and:

A. Be a member of a health club, fitness center or 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. Make a minimum of at least eight (8) visits per month to that facility.

Level of the Stipend Benefit

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

Claims will be paid in one of the following three manners:

1. Monthly, via direct deposit; or,
2. Once a quarter, via direct deposit; or,
3. Once a year by direct deposit.

Note: The Plan strongly recommends that participants wishing to take advantage of this benefit do so by submitting those reimbursement requests monthly or quarterly. By doing so, participants receive timely reimbursements as well as avoid any possibility of not being reimbursed should their claims arrive after the timely filing period. Again, the timely filing period is anytime within three-hundred and sixty-five days from the month after the visits were made.

Fitness Stipend 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:

A. 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
B. That the Health and Benefit Plan will not be issuing 1099 forms.

How to Claim a Stipend.

Fitness Club Stipend reimbursement benefit requests will be administrated in accordance with the provisions listed within the section of this document titled "Claim Procedures." As a reminder that provision states that in order for the Plan to consider providing a benefit, a claim, and in this case, your Fitness Club Stipend reimbursement request must be filed with the Fund Office within three-hundred and sixty-five days from the month after the visits were made. If submitted annually, this means that all unclaimed reimbursement requests for the prior calendar year must be received by the Plan no later than the last business day of January of the following year in order to be considered for payment.

Note: Claimants wishing reimbursements for visits that exceed three-hundred and sixty-five days must submit an appeal. Please see the section of this documents titled "Appeals."

Ineligible or Non-reimbursable Expenses

The Plan recognizes that activities such as, but not limited to:

- Archery
- Axe throwing.
- Basketball
- Bicycling clubs
- Boot camps.
- Chiropractic services
- Dance classes.
- Diet instruction/coaching.
- Euro-cising.
- Golf

- Hiking
- Hunting
- Martial arts/karate
- Mime classes.
- Iron-man Challenge Race Club fees.
- Paddle Ball
- Pickle Ball
- Pilates classes
- Personal fitness instruction
- Platform Tennis
- Racquetball
- Rock Climbing
- Rowing
- Running Clubs
- Tennis
- Sculling/rowing
- Sports leagues
- Swim clubs.
- Swimming lessons
- Squash
- Wellness Program instruction
- Yoga

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.

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 or unintentionally 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

- Unintentionally or intentionally permits the Plan to make payment on any claim in which the Plan is not responsible to pay or pay as the primary insurance carrier.
- Withholds, omits, conceals, or fails to disclose any information in connection with enrollment.
- Withholds, omits, conceals, or fails to disclose any information in connection with an accident, or injury, including, but not limited to those that resulted from felonious conduct or those that result from attempts to commit or a commission of a misdemeanor.
- Withholds, omits, conceals, or fails to disclose any information in connection with this Plan's Short-term Disability benefit and Loss of Tims benefit, including but not limited to the timely notification of their return to work.

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, including the loss of any and all Retiree Self-Payment Credits, 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 enumeration of any Plan losses, including, but not limited to, all legal expenses and administrative expenses associated with the fraudulent act.

Further, the participant may be subject to civil penalties; criminal prosecution under federal and/or state criminal statutes; 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 with 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

See **Included Health**.

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 CREDIT BENEFIT

The health reimbursement arrangement (HRA) credit benefit is an **employer-funded** Benefit which provides reimbursement to employees and participants for qualified medical, dental, vision and Rx expenses. The amount of this Benefit is determined by the Board of Trustees and is subject to periodic modification.

With regard to this Benefit, Employees and participants are informed as follows:

- ❖ Employees and participants do not have individual accounts.
- ❖ This Benefit is not portable.
- ❖ If eligibility under the Plan is lost this benefit is also lost.
- ❖ Funds cannot be withdrawn to prepay medical expenses. Meaning; the expense must be incurred before reimbursement can be requested (Read this Plan's Fraud provision, especially the sixth-noted point.); and,

❖ Reimbursement may be possible through the use of the HRA debit card.

Warning: As it relates to the HRA debit card feature of this benefit, participants are warned that:

- While the Fund's HRA benefit allows for the use of the debit card for those transactions that can be automatically substantiated, it is nevertheless the participants responsibility to monitor their usage to make certain that each transaction that requires substantiation gets verified timely and appropriately. In most cases the latter is accomplished by the timely submission of the Plans explanation of benefits, or in the case of an optical or pharmaceutical claims, the timely submission of the appropriate documentation.

- Usage of the debit card feature of this benefit is not a right, but rather a privilege. Said privilege will be permanently taken away should if the participant infringes upon the terms of its proper use.

- It is the Internal Revenue Service (IRS) that dictates how this benefit is to be administered. The Plan is required to administer this benefit in accordance to the Internal Revenue Codes. No exceptions.

- Pursuant to IRS provisions, and unless noted otherwise by this Plan, all claims must be adjudicated by the Plan PRIOR to the utilization of this benefit. Failure to adhere to this provision may lead to the permanent deactivation of the participants HRA debit card privileges.

- If you lack the discipline to utilize the HRA debit card properly and in accordance with both IRS and the Plan's provisions, and:

    - You are not 1000% sure that the amount you are being charged would be the ***correct*** balance that is owed **AFTER** the Plan has processed the claim and any deductible or network discounts have been applied.

    - You are not 1000% sure that:

        - The provider will submit or timely submit to the Plan a claim that indicates that the claim was already paid so that an explanation of benefits is issued so that you can use that to substantiate the improper usage of the debit card.

        - That you will reimburse the Plan within the required sixty (60) days the exact amount that the Plan paid or would have paid as a non-HRA claim.

- You are not 1000% sure that the service, medical goods, or treatments being paid for or purchased are **automatically substantiated** pursuant to the Internal Revenue Code.

- You are not 1000% certain that you know how to timely monitor and substantiate your card usage within the CREATE claims system.

- You are not 1000% sure that you always ask for AND receive all receipts and have filed them away.

- You are not 1000% certain if the amount you are contemplating paying or already paid is correct, or,

then do not use your HRA debit card. Instead, pay for the service, treatment, or medical goods by using some other method of payment. Then wait for the explanation of benefits to be issued and submit your HRA claim request.

- That the Plan's Coach and Correct provision is a once in a lifetime benefit. After the employee exercises their right under this provision or does not attend any of the coach and correct meetings within the allotted time period their card will remain permanently deactivated and remain deactivated for the lifetime of the individual's participation in the Plan.

Account Benefit

The Health Reimbursement Arrangement Credit Benefit account is 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. All participants are reminded that this program is a benefit of the Plan that is provided once certain requirements are met.

Account Funding

The Health Reimbursement Arrangement Credit Benefit is funded solely by employer contributions. Meaning: Neither a journeyperson nor employee's weekly or hourly wage is being deducted for this benefit.

Further, it is not permissible for a journeyperson or an employee to fund this benefit directly.

The methodology utilized to determine the amounts that get credited to a participant account can be found within the section of this provision titled "Crediting – How Your Account Gets Credited."

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.

Accumulating HRA Credits

All participants are reminded:

- That like all other benefits of this Plan, the Health Reimbursement Arrangement Credit Benefit is funded solely by employer contributions. Meaning: *Neither a journeyperson nor employee's weekly or hourly wage is being deducted for this benefit.*
- That it is not permissible for a journeyperson or employees to fund this benefit directly.
- That the Health Reimbursement Arrangement Credit Benefit is not a cash program. As such a participant cannot cash out their HRA. All amounts credited remain general Health and Benefit Fund assets except to the extent that they are paid as benefits.
- This is not a vested benefit.
- That accumulated credits are posted by the Fund Office after all participants credits from the corresponding work quarter are deemed correct.
- That the methodology used to calculate this benefit is subject to change, including, but not limited to being temporarily suspended or fully discontinued.

Accumulated credits will be calculated as follows:

A. If establishing initial eligibility for the first time or reestablishing eligibility after having lost coverage under the Plan, any accumulated credits will be based upon ONLY those hours in excess of 450 (or the equivalent as stated within section B) that are contributed in the calendar quarter after two full successive calendar quarters of continuous coverage has been completed. For example. Teresa met her initial eligibility requirement and subsequently became effective to receive benefits on February 1. In accordance with the Plan's eligibility provisions, Teresa would be granted coverage for the remainder of the 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.)

To determine the number of awarded credits, the Plan would tabulate only those hours contributed on Teresa's behalf for work she performed under covered employment in April, May and June. The HRA credits that Teresa will be provided will be granted in the corresponding Quarter of Coverage, which in this example would be in the fourth quarter. Please reference section C of this provision for further information.

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 HRA 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.

Hour threshold needed x Local 697 inside journeypersons rate.

_____ divided by _____

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 accumulated to your HRA account would be 468. Using this example, the formula would look like as follows:

450 x $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 with the following schedule:

Work Quarter in Which 450 Hours or Greater Were Worked	Will be Accumulated 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 there exists an administrative "lag quarter" that separates a work quarter from its corresponding quarter of coverage. Meaning: Contributions in excess of 450 hours within a work quarter do accumulate 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,

Allowable Reimbursable Expenses / Qualified HRA Expenses

Participants are advised that Section 213(d) of the Internal Revenue Code dictates which medical expenses are qualified, and hence, allowed to be paid or reimbursed through an HRA. However, and while an expense may be permissible under Section 213(d) of the Internal Revenue Code, it may not be permissible to be reimbursable or payable under this Plan. This is because Section 213(d) also permits the Trustees to restrict certain expenses or entire categories of expenses.

Under this Plan's HRA Credit Benefit program, covered expenses are defined as the charges that are in excess of the maximum benefits payable under this Plan and only for those charges that were:

A. Incurred after the initial funding of the participants HRA, and

B. Incurred while a covered participant of this Plan.

Such covered expenses would include:

- 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

Note: 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.

Apprentices and Indiana Plan Participants

This Plan's Heath Reimbursement Arrangement (HRA) is not available to apprentices nor Indiana plan participants.

Changes to the HRA Credit Benefit Program

The Trustees have the right to:

- ✓ Modify the rules and provisions surrounding this benefit, including, but not limited to, amending the methodology used to calculate any benefit, changing the amount of the Benefit, or eliminating the debit card feature.
- ✓ Revise the list of covered Health Reimbursement Arrangement Credit Benefit expenses,
- ✓ Pause or even terminate the Health Reimbursement Arrangement Credit Benefit

at any time.

Coach and Correct Program

Those participants that have their HRA debit cards permanently deactivated on or after December 1, 2024, may have their HRA debit cards reactivated provided the employee attends a HRA educational meeting within twelve calendar months from the date the card was deactivated.

Warning: Should an employee attend an educational meeting and subsequently cause their card to be permanently deactivated again, or if the employee decided not to attend any of the HRA educational meetings during the aforementioned period, the employees' card(s) shall remain permanently deactivated and remain deactivated for the lifetime of the individual's participation in the Plan. No exceptions. remainder of the employee.

Warning #2: Unless noted otherwise, said HRA educational meetings will occur after the membership meetings of January, April, July and October.

Warning #3: Only employees can attend a Coach and Correct Program.

Warning #4: Employees may be required to take an exam during or directly after the Coach and Correct meeting. Failure to pass the exam will result in the employees' card remaining permanently deactivated for the lifetime of the individual's participation in the Plan.

Covered HRA Participants

This Plan's HRA Credit Benefit is available to those journeypersons, and employees who have accumulated the benefit at the time an eligible expense was incurred AND who were awarded credits.

Death and/or Disability and Your HRA Account

In the event of your death, the balance in your account can be used by your eligible 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 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 Health and Benefit Funds 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 sixty-day period your HRA card will temporarily be deactivated and will remain deactivated until such time as that documentation is submitted and deemed appropriate. For this reason, the Plan strongly recommend and reminds you:

A. To keep your Health and Benefit Plan's explanation of benefits or if you do not wish to do that then to learn how to access, download, and attach a Health and Benefit Fund explanation of benefits to the Create portal so as to quickly substantiate a purchase.

B. To keep the paper receipts of every debit card purchase you make at a pharmacy and/or a vision provider. And,

C. That the "R" in "HRA" stands for reimbursement. Meaning; other than the services that can be automatically substantiated, 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.

   They can, however, be utilized for the quicker transmission of HRA payments **AFTER** the claims were paid and only for those amounts in excess of the maximum Plan benefit.

Additionally, IRS rules state that debit cards 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. Should this occur, you can still submit your reimbursement request either:

- Electronically, through the Plan's third-party HRA administrator website or,
- Manually, by downloading the HRA Manual Claim Form off of the Health and Benefit Funds website (https://www.ibew697benefits.com/healthcare/) Make sure to complete that form in its entirety and submit that completed form along

with the appropriate documentation to the address listed on the bottom of that HRA form or Fund Office.

Regarding documentation, and for the reason that it is the Internal Revenue Code that dictates how this benefit is to be administered, all medical claims need to be substantiated with the Funds explanation of benefits for the services rendered.

Warning: If you choose to do otherwise, you run the risk of your HRA submission being denied. This would include any invoices, itemized bills or receipts that you submitted that contain the name of the patient, the providers name, the service, or item being paid for, the date of the transaction and the dollar amount.

Debit Card Deactivation / Termination

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 of the card in any way, including prepaying for all or part of an eligible dental, medical or vision expense prior to the Plan adjudicating the claim, or,*

2. *Fail to submit any requested documentation during that sixty (60) day period, or*

3. *Fail to fully reimburse the Fund within sixty (60) days of an improper use of a debit card, or*

4. *Have to reimburse the Plan for incorrect usage or untimely usage of the debit card more than once,*

Your debit card will be temporarily deactivated, and the employee will need to attend a coach and correct meeting in order to have their debit card activated again. Participants who find themselves in this scenario are strongly urged to read the Coach and Correct Program provision of this Plan to see how that works.

Warning: Failure to attend the class and/or pass the exam will result in the employees' card remaining permanently deactivated for the lifetime of the individual's participation in the Plan.

Further:

1. 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.

Debit Card Usage for Prescribed Over-the-Counter Medications

If you use the HRA debit card 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.

Dental Claims & the HRA Credit Benefit

Participants wishing to use the HRA benefit for dental expenses are reminded of the following:

1. That the use of this benefit and/or its debit card to prepay dental expenses is prohibited.

2. That unless you are 100% certain that the amount the dentist is charging as your coinsurance is **correct** AND can timely substantiate that payment with the Funds explanation of benefits, then you should not be utilizing the debit card.

3. That the "R" in "HRA" stands for **reimbursement** and,

4. That it is the Internal Revenue Service (IRS) that dictates how this benefit is to be administered. Meaning; they set the rules.

Regarding point number three, be advised that the Internal Revenue Service's usage of the word reimbursement is deliberate as their intent for these types of tax advantage programs was and is to provide **reimbursement** AFTER payment was made for the qualified expenses that are in excess of the maximum Plan benefit.

The Plan strongly recommends that you read and understand both the Dental Benefit and Health Reimbursement Arrangement Credit Benefit provisions in their entirety so that you do not run afoul of either the Internal Revenue Service's intent, requirements, and rules or those of this Plan.

Lastly, always wait until you receive your explanation of benefits before using your debit card.

Divorce

The Health Reimbursement Arrangement Credit Benefit is not a vested benefit. As such, any credit remains a general asset of the Health and Benefit Plan except to the extent that they are paid as benefits. Consequently, they are neither alienable under any Qualified Domestic Relations Order nor assignable to any other party.

Moreover, the failure to inform the Plan of your divorce at the time it occurred will cause the immediate forfeiture of any HRA credit benefit balance.

Documentation

You need to keep your original receipts and documentation for prescriptions and health related expenses for all transactions (including debit card transactions), so you'll have them if needed to verify a claim.

Be advised that:

- The IRS requires that all transactions are validated, including the debit card transactions and,
- The Plan requires each medical, hospital, and durable medical good reimbursement to be substantiated by a copy of the Health and Benefit Funds explanation of benefits for that service or product.
- If seeking reimbursement for a **pharmaceutical or for vision products** or services, the Plan requires an itemized receipt that clearly delineates the name of the patient, the provider's name, the service, or item(s) being paid for, the date of the transaction and the paid dollar amount.
- If your purchase is 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.

Regarding debit card transactions in which the Plan or its third-party administrator does not have the electronic data needed to validate, you'll be asked to provide the Plan with the proper supporting documentation. You will have sixty (60) calendar days from the date of the debit card transaction and/or submission of an electronic or manual claim to submit the needed supporting documentation. Therefore, and this is **important**, make certain you pay attention to respond promptly to any request for receipts or notice of missing receipts or documentation. Failure to do so can result in:

1. The expense being labeled as 'ineligible,' in which case you would be obligated to reimburse your HRA.
2. The temporary deactivation and/or permanent deactivation of your debit card.
3. The supporting documentation of different and subsequent HRA requests to be applied toward debit card transaction(s) that have yet to be substantiated by the participant.
4. The amount of the unsubstantiated purchase becoming taxable income.

WARNING: *Regarding point #3, should this occur, it very well may result in the reimbursement or payment request with the correct supporting documentation to go unfulfilled. Therefore, participants need to monitor their HRA claim requests and debit card usage to make certain that they remain in compliance with the rules of the Plan and Internal Revenue Service's regulations.*

FSA Store

In order to make using your HRA credit benefit more convenient, easy as well as to reduce **most** confusion about what products is considered HRA eligible, the Plan has provided you access to the FSA Store.

Please note the use of the underlined and bolded word "most" in the prior paragraph. You are reminded that the expenses that this Plan deems payable through this benefit are those that are described within the section of this provision titled "Allowable Reimbursable Expenses / Qualified HRA Expenses." Therefore you are advised that the Plan may require substantiation in the form of a either a prescription, a letter or medical necessity from a treating physician, an explanation of benefits and/or detailed receipt, or all four for any purchase that falls outside of what is listed within the aforementioned section of this Plan HRA provision.

The FSA store can be accessed by either:

A. Clicking the "View Alerts" or "File New HRA Claim" options of the finance section within your "Mycreatehealthcare" portal. Specifically, you will need to click the FSA Store logo that appears on the top right-hand side of the banner on the page you are directed to.

B. Keying into your browser FSAstore.com.

Again, when utilizing the FSA store, most card purchases should be auto approved without you needing to submit further paperwork. However, should you purchase something through that store that the Fund requests substantiation you will be required to provide the proper supporting documentation to the Plan. Failure to provide the Plan with the requested and proper supporting documentation within sixty (60) days of the request, and subsequent failure to reimburse the Fund for the unsubstantiated amount within thirty (30) days after failing to provide proper supporting documentation will result in the permanent deactivation of the debit card and the amount of the unsubstantiated purchase becoming taxable income.

Government Rules

Government rules, specifically, those of the Internal Revenue Service (IRS) determine what medical and dental expenses are qualified and hence reimbursable. The Trustees, at their sole discretion, may refine further which expenses can be reimbursed for employees and participants alike.

Important: The Internal Revenue Service neither permits HRA benefits to be used to prepay for any service or goods, nor does it allow for the payment of any covered benefit, service, or portion thereof that is this Plans obligation to pay. Meaning: expenses that are the obligation of this Plan are excluded and deemed unqualified for reimbursement.

Note: The word "reimbursement" is in the very title of the benefit. That's deliberate for the reason that under Internal Revenue Service codes participants are to be reimbursed for their out-of-pocket expenses for a covered or allowed expenditure as described within this provision.

HRA Website

Participants are encouraged to utilize the third-party administrators secured website whenever they wish to view their HRA balance, upload receipts, file a reimbursement request, 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 expenses or charges paid by any healthcare plan or third-party payer.
- 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.
- Claims without receipts

- COBRA payments
- Commuting expenses of a disabled person
- Cosmetic surgery and procedures
- Cosmetics, hygiene products and similar items
- Dietary supplements
- Double dipping. You cannot be reimbursed in full or in part for any amount for any claim or claims in which the Health & Benefit Plan or another insurance provider has paid on your behalf and also be reimbursed through the HRA program for those same amounts.
- Educational Expenses
- Environmental control devices such as air purifiers and humidifiers
- Exercise equipment.
- Expenses incurred prior to the initial funding of the HRA account.
- 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
- Prepayments of any kind.
- 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.

Losing Your HRA Balances

Participants who cease to be covered under this Plan, and/or have chosen to be covered under the C.O.B.R.A. provisions of this Plan are not permitted:

a. To use any HRA balances for reimbursements of services incurred after they have lost coverage or were covered under the C.O.B.R.A provisions of the Plan
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.*

   Should this occur, participants are advised that future HRA credits can once againaccumulate going forward. As to how that occurs, please reference the section of this provision titled "Accumulating HRA Credits."

2. *The Plan's timely submission of claims policy also applies 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.*

Not A Vested Benefit

Credits within an individual HRA are not vested. All amounts credited remain general Health and Benefit Fund assets except to the extent that they are paid as benefits.

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 previously 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 are covered as a retiree under this Plan, your HRA account credit balance will continue to exist, and you may use it to cover your self-payment premiums or for reimbursements on other HRA covered expenses.

Note: Whenever a retiree obtains active eligibility status under this Plan, they are no longer considered a retiree covered under the retiree benefits of the Plan. As such, retiree self-payments, if any, will not be assessed for the period or periods of active coverage. However, and for the reason that this Plan considers you an active participant, the shortage of hours expense can and will be assessed. Should a participant have a HRA account credit balance greater than the amount needed to cover the participants shortage of hours payment, it will automatically be deducted, unless:

- The Plan receives the participants written notice thirty (30) days or greater that he or she does not want their HRA Credit Benefit automatically deducted because they are no longer be working in retirement at all or to the levels that would maintain continued coverage as an active journeyperson.

Warning #1: *Reread that **note** above again. Participants should refamiliarize themselves with all rules, provisions, and policies that are applicable for covered active participants of the Plan. Especially those that relates to continued eligibility for journeypersons, the Health Reimbursement Account Benefit, the Retiree Self-Payment Credit Benefit, the Self-Payment policy and rules, the Shortage of Hours provisions and the sections of this document that speak to a participant responsibility.*

Warning #2: *If an automatic deduction is made, under no circumstance will that deduction be reversed, and the participants account recredited.*

Self-Payments and/or Shortage of Hours Payments

Participants that owe the Plan a self-payment, a shortage of hours payment or a payment to maintain 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.

If, due to a shortage of hours, you are in danger of losing your eligibility under the Plan and have an HRA benefit balance **in an amount greater** than the quarterly total of your shortage of hours, your HRA benefit balance will be automatically debited to be used to cover that participants shortage of hours balance **in full** for that quarter of coverage.

Participants are advised that said deductions will occur at a time and date as determined by the Plan to be administratively prudent and cost effective as well as on a date early enough to ensure that a participant's shortage of hours payment arrives at or before the due date.

Warning #1 about Self-Payments: *HRA benefit balances will only automatically be deducted upon a shortage of hours scenario and only when a participants HRA benefit balance exceeds that of the quarterly shortage of hours balance payment for that entire quarter. MEANING: There will not be any automatic deductions of HRA benefit balances if there exists insufficient HRA benefit balances to cover the full shortage of hours for that quarter.*

Warning #2 about Self-Payments: *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 last business day of the month preceding the month or period of coverage. Excluding holidays and inclement weather, you should anticipate that it will take a minimum of fourteen calendar days from the time you electronically file to the time the Fund physically receives your payment from the HRA administrator. If there is a Holiday or the chance of inclement weather, make the appropriate allowances by submitting the documentation and a properly completed request earlier than fourteen calendar days. In summary, plan accordingly as payments not received by the due date will result in the termination of your eligibility in the Plan.*

Submission of HRA Claims

Participants are not permitted to reimburse themselves for expenses incurred prior to having an HRA benefit. Similar to all other claims, there is a twelve (12) month limit as to how long a participant has to submit a claim for reimbursement for which the Plan will make a reimbursement. Submissions that are not timely substantiated will

be denied. For more details on this, please reference the section of this provision titled "Timely Submission of Your or Your Dependents HRA Claims."

Timely Submission of Your or Your Dependents 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.

Remember: 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. **Important:** As you are no longer a participant of the Plan, you cannot utilize any HRA credit balance to make a self-payment. Further, you will have sixty (60) calendar 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.

As a reminder, 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.*
4. *Exams for the fitting of hearing aids*

HEARING EXAMS / TESTING BENEFIT

The Plan covers diagnostic exams with an audiologist when a physician, clinical nurse specialist, nurse practitioner, physician's assistant or other eligible provider refers you to determine appropriate medical or surgical treatment of hearing loss or a hearing - related problem.

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 routine 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.

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.

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.

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).

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.

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 people 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, counterintelligence, and other national security activities to authorized Federal officials.

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

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.
2. 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.

3. 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.

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 a qualified physician, nurse practitioner, clinical nurse specialist or physician assistant.

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. However, any infusion drugs must be obtained through the Plans pharmaceutical benefit manager (PBM).

The Plan will pay up to 100 visits per calendar year. However,

- Services of up to four (4) hours by a home health aide shall be considered a visit.
- Any infusion drugs used and/or administered during Home Health Care visits MUST be obtained from the Plan's Rx vendor SavRx.

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:*

- *Chores (including picking up prescriptions and running other errands)*
- *Companionship, or sitter services (including activity planning, escorting the patient to events and so on)*
- *Custodial care,*
- *Homemaker services (including shopping laundry, cleaning, meal preparations and so on.)*
- *Meals delivered to your home,*
- *Transporting patients to grocery stores, pharmacies, banks and so forth.*

Warning #2: A "place of residence" for home health services does not include a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID). Participants of the Plan may receive home health services in any setting in which normal life activities take place other than a hospital, nursing facility, ICF/IID or any setting in which payment is, or could be, made under Medicaid for inpatient services that include room and board.

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 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:
    1. Physician,
    2. R.N.,

3. L.P.N.,
4. 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
5. 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 Pricing: 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 reasonable reimbursement that is fair to the hospital, and 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 accommodation when only a private room is available.

Emergency Room Fees for Conditions that are a Non-Emergency or that Do Not Meet This Plan's Definition of an Emergency.

Services, treatments, and procedures that are rendered for conditions or reasons that do not meet this Plan's definition of an "emergency medical condition" will not be paid by the Plan.

Emergency Treatments Received at a Non-Designated Facility, Hospital or Urgent Care Facility.

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network costsharing amount (such as copayments and coinsurance).

This would include being balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these poststabilization services

Consequently, emergency room services received within a non-designated facility, hospital or urgent care facility will be paid in accordance with 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.

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 are 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 hospitals and related hospital facilities. Level C facility claims will be paid in accordance with the following formula:

   70% of 130% of this Plan's Reasonable and Allowed Amount.

4. 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.
5. 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.

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 with the following formula:

70% of 130% of this Plan's Reasonable and Allowed Amount.

Warning: *This could result in 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 not be paid for by the Plan.*
- *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.*
- *The continued participation of any one hospital, clinic or other provider cannot be guaranteed.*
- *The fact that a physician or provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it medically necessary or guarantee that it is a covered service.*

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.*

INCLUDED HEALTH

The Plan has contracted with Included Health (formally Grand Rounds) a Telemedicine / Telehealth organization that provides the non-Medicare eligible participants of this Plan the with the capability of:

- **Consulting with a certified healthcare provider 24 hours a day/7days a week via the phone, online via a webcam or through their mobile app for common medical conditions** such as, but not limited to: allergies, colds & flu, cold sores, Covid-19 (can prescribe certain FDA-approved antiviral for adults 18+ when deemed appropriate), diarrhea, ear-pain, eye-irritation, fever, foot pain, headaches, heartburn, insect bites, knee pain, lab interpretation, mild injuries, nosebleed, pink eye, rashes, rolled ankle, select mental health needs as described later in this section of this benefit description, sinus problems, sore throat, sports injuries, sprains and strains, upset stomach and more.
- **Receiving second opinions from world-leading experts**. If you're unsure about a diagnosis, or you've been recommended surgery as a form of treatment, Included Health can arrange for you to get a remote second opinion from a leading expert specializing in your area of need.
- **Finding top doctors and specialists within this Plan's PPO network.** If you need a primary care physician or specialist for an in-person visit Included Health can help you find trusted and experienced doctors within the Plan's network and can even set the appointment for you.
- **Getting quick answers to medical questions**.
- **Receiving chat-based coaching and support** on subclinical conditions, such as:

- Stress
- Emotion management
- Sleep issues
- Irritability
- Burnout
- Dissatisfaction at work
- Blocked creativity
- Career challenges
- Stress from finances
- Communication difficulties
- Relationships & conflict
- Parenting challenges
- Life transitions
- Breaking habits
- Smoking cessation
- Motivation
- Goal setting

To access these services visit: www.includedhealth.com/IBEW697, download the Included Health Mobile App: (Search "Included Health" in the mobile app store) or call 800-929-0926.

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 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 age Sixty-five (65) or older. The beneficiary or beneficiaries of deceased retirees age 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 with the short-term disability provisions of this Plan, you and the treating 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 the licensed treating physician or physicians 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:

1. During any period of disability resulting from an occupational injury or disease.
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. During any period of disability after this Plan's short-term disability benefits have been exhausted.

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.*
3. *Participants are advised that the reversal of loss of time credits may affect the amount of any required monthly self-pay.*

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 prior to any eligibility being loss. Participants must be able to substantiate that to the Plan. 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.

Warning: Should the withholding, concealing, omitting or the failure of any participant to disclose any information in connection with this Plan's Loss of Time benefit and Short-Term Disability benefit, including but not limited to the timely notification of the participants return to work date result in a benefit being erroneously received, this will be considered an act of fraud against the Plan. This Plan's rules as they relate to fraud will be applied should this occur. Therefore, you are reminded of your obligation to inform the Plan of your return-to-work date PRIOR to your return to work.

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

Assuming you have met the hourly requirements, your spouse 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 the supporting documentation proper outlined within this section.

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,
- A copy of your spouse's birth certificate / passport
- A copy of your spouse's insurance card and letter of credible coverage from their insurance provider.

Warning: *Any bills incurred prior to the Plans enrollment of you and/or any eligible dependent will remain the sole responsibility of the participant.*

Note: If your spouse is covered as a participant, meaning your spouse is being covered as an employee, your spouse's Plan will be considered by this Plan as their primary insurance and as such, 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 permitted by this Plan.

Remember: You as the employee are ultimately responsible to provide to the Plan accurate and complete information needed to administer your spouses and any eligible dependents Health Benefit Plan Benefits under this Plan. This would include, but is not limited to:

- Other health Benefit coverage and other insurance Benefits you or any eligible dependent may have in addition to your coverage with this Plan.
- Changes in you or your dependents marital status.
- Changes in dependent status. (Births, Adoptions, Separations, Divorce, Death)

- Changes in your contact information that would or could affect the Plan's ability to communicate properly with them. 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.

Further, should your spouse have a child or children from a previous marriage or relationship, and should you wish to enroll that child or children, please make certain to read the section of this document titled "Children" that speaks directly to the enrollment of "Stepchildren."

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 with 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."

MEDICARE BENEFITS

Medicare is our country's health insurance program for people aged 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.

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.

Now, 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.

Contacting Social Security Administration about Your Medicare Benefits.

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

Medicare Part A (Hospital Benefits)

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 hospitals and skilled nursing facility care. But special limits do apply to hospice care.

Medicare Part B (Physician/Provider Benefits)

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.

Medicare 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).

Medicare 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 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.**

Medicare 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).

MENTAL AND NERVOUS DISORDERS

Precertification required for all partial day and inpatient stays.

Concurrent review required for all outpatient treatments of greater than seventeen (17) days.

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: S*ervices and/or treatment not pre-certified will not be covered by the Plan.*

MILITARY LEAVE

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 ac-cumulated 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 so 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 includes 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.

ORTHOTIC 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 medically 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

There is no separate orthodontia benefit under this Plan, rather payments for orthodontia treatments are applied against any available family dental allowance for the calendar year in which services were rendered.
Moreover, the Plan maintains a maximum lifetime orthodontia limit per covered active participant of $3,000.00. Should a retiree require orthodontic work and provided they have not previously exhausted the orthodontia benefit as an active participant, they will be provided the lessor of $1,000.00 or up to the remaining amount of their retiree dental allowance for that calendar year.

OTHER INSURANCE

Participants are reminded if they or their family has other insurance, they must inform the Plan of that fact. Please reference the section of this document titled "Coordination of Benefits" for more information as to how and when that should be done.

As it relates to workers compensation, automobile or any other insurer that provides coverage for medical treatments, supplies, sompensation, or expense resulting from any claim that would otherwise be covered under this Plan, you must exhaust that coverage before this Plan will make any payment on said medical treatments, supplies, or expenses.

Note: You cannot be receiving workers' compensation, unemployment benefits or Social Security benefits or any other compensation for lost wages and be receiving this Plan's short-term disability benefits. If the Plan learns that you are receiving other compensation for lost wages 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.

PATRICIPANT OBLIGATIONS AND RESPONSIBILITY

It is the participant's responsibility and obligation to:

1. Read, learn, understand, and follow the requirements, provisions, rules, and guidelines set forth within this document.
2. Read all materials and communications concerning this Plan at the time of issuance.
3. Timely provide to the Plan accurate and complete information needed to administer your Health Benefit Plan, including, but not limited to:
    a. Other health Benefit coverage and other insurance Benefits you or any eligible dependent may have in addition to your coverage with this Plan.
    b. Changes in you or your dependents marital status.
    c. Changes in dependent status. (Births, Adoptions, Separations, Divorce, Death)
    d. Changes in your contact information.
4. 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.
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. Complacency any dispute between the Plan and participant over settlement funds is resolved.
14. Understand that the Health and Benefit Plan:
    a. Is accountable for the administration of the benefits, provisions and rules listed within this document.
    b. Can only adjudicate claims as they are presented.
    c. Is not responsible for claim issuance and cannot make claim issuance corrections of any sort.
    d. Will not incur any expense, including time and/or material, remedying the effects of the decisions, actions, or sadly, lack thereof of any participant, provider or third party that is either illegal or that in which adversely affects the Plan. Or to phrase differently, decisions and/or actions, or lack thereof, that adversely affect the Plan does not bind the Plan to any action to mitigate the effects of that decision nor does it absolve you from any adverse consequence or from being accountable to cure any violation, including the full and immediate remuneration of any expense to the Plan.
15. Understand your health problems and participate, and along with your health care professionals and providers, develop mutually agreed upon treatment goals.
16. Provide, to the extent possible, any and all information that your health care professional needs to provide the proper care.
17. Read, learn, and understand your benefits. It is in every participant's best interest to do so. If you have a question or if you do not understand what you read, **call the Fund Office before proceeding with any action.** The Office number is 219-940-6181.

PARTICIPANT 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:

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 with 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).

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.

Enforce Participants 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 a suit in a state or federal court. In addition, if the participant disagrees with the Plan's decision or lacks 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 will 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.

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.

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.

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.

A 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

A Breakdown of 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 utilize 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.

A Breakdown of 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 on 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 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 with 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 higher out-of-pocket expenses to you and a higher expense to 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 antihypertensive and combination antihypertensive,

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.

With that said, 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.

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 providers and request a reduction in the remaining balance.

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.

Choosing an In-Network Physician 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 with 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.

Warning: *The continued participation of any one physician, hospital, or other provider cannot be guaranteed. Moreover, participants are reminded that a physician or provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it medically necessary or guarantee that it is a covered service.*

Important - 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 demographic 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 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.

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.

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 physician's charge.

PLAN P

Plan P contributions are used to calculate a participants Retiree Self-Payment (RSP) Credit benefit, if any. Please reference the section of this book titled "Retiree Self-Payment Credit Benefit" for more information as to how that benefit works.

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 PERFORMED WITHIN A PARTICIPATING LEVEL A AND LEVEL B FACILITY BUT RENDERED BY NON-PARTICIPATING: *ANESTHESIOLOGISTS,* *EMERGENCY ROOM PHYSICIANS* *PATHOLOGISTS* *RADIOLOGISTS*	 90% 90% 90% 90%

CHARGES FOR NON-EMERGENCY SERVICES RENDERED BY NON-PARTICIPATING:	
ANESTHESIOLOGISTS,	70%
EMERGENCY ROOM PHYSICIANS	70%
PATHOLOGISTS	70%
RADIOLOGISTS	70%
CHARGES FOR EMERGENCY SERVICES RENDERED BY NON-PARTICIPATING PROVIDER &: PERFORMED WITHIN A NON-PARTICIPATING FACILITY	
ANESTHESIOLOGISTS	
*EMERGENCY ROOM PHYSICIANS***	90%
PATHOLOGISTS	90%
RADIOLOGISTS	90%
	90%
CHARGES FOR NON-EMERGENCY SERVICES PERFORMED WITHIN A NON-PARTICIPATING FACILITY BUT RENDERED BY NON-PARTICIPATING:	
ANESTHESIOLOGISTS	70%
*EMERGENCY ROOM PHYSICIANS***	70%
PATHOLOGISTS	70%
RADIOLOGISTS	70%

All of the percentages listed above are percentages of the Plan's Reasonable and Allowed Amount.

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.

With that said, when you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in this Plan's network.

PRECERTIFICATION / PRIOR AUTHORIZATION REQUIREMENT

This Plan's precertification / prior authorization requirement is the:

- Process for authorizing the non-emergency use of facilities, certain diagnostic testing, and other health services before care is provided. And,
- The process in which you and your provider can determine whether or not the Plan covers and to what extent that Plan covers a requested procedure.

Participants are informed that this program is not designed to be the practice of medicine or to be a substitute for medical judgment of the attending Physician or another health care provider. Rather, the Plan relies upon and utilizes the information provided to determine whether the proposed care:

- Is medically necessary,
- Is the appropriate treatment.
- Is of the appropriate length of hospitalization
- Is of the appropriate length of for that treatment

- Is a covered benefit under the Plan.
- If admission is appropriate

Important:

A. You are required to obtain prior authorization for certain benefits under the Plan before the services are rendered or the supplies received.

B. Generally, the treating physician will assist you in obtaining the precertification / prior authorization for whatever procedure you seek to obtain and/or agreed to have performed.

C. Some providers will even spearhead the effort.

D. However, you are ultimately responsible for making certain that the precertification / prior approval has been obtained prior to receiving the requested services.

E. This also means that you are responsible for making certain that either you or the treating physician provides the Plan or the Plan's review organization with all pertinent information needed to justify the request. Such information would include, but is not limited to the patients' medical charts, results of diagnostic testing, and any notes from consultations with other physicians or specialists.

F. Precertification is required for all inpatient care and any inpatient or out-patient surgeries. 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.

Approval

If your pre-certification / prior approval submission is approved, you will be covered to the limits of the Plan.

Appeal of the Denial

If the submission is denied, it is the patient's responsibility to follow up with their treating physician and that physicians' responsibility to advise the patient on whether their assessment of the medical necessity of the treatment, service, or supply, conforms with, or is defensible under the Plan's definition of medical necessity or medical appropriateness. Or, phrased differently, why there is a discrepancy between what was requested and what was certified / approved, or not approved.

If you or the treating physician disagrees with the denial, it is your responsibility, and/or that of your treating physician to take the necessary steps to appeal the denial.

Should your submission for pre-certification / prior approval be denied, you may appeal said determination. Please reference the section of this book titled "Appeals."

Not every medical procedure requires precertification / prior authorization by the Plan. There are, however, several services that the Plan requires to be pre-certified / prior authorized. They are as follows:

- Alcohol Dependency – All Inpatient treatments
- Alcohol Dependency – Outpatient treatments greater than 17 please see concurrent review.
- Ambulatory Surgery
- Bariatric / Gastric Bypass
- Birthing Centers
- Brachytherapy
- Cardiac rehabilitation
- Cardiac nuclear scans
- Cataract Surgery
- Chemical Dependency
- Chemotherapy
- Corrective and/or cosmetic surgery
- Dental work performed in a hospital setting.
- Detoxification
- Diabetic Management
- Dialysis
- Dietician/Nutritionist counseling greater than 17 please see concurrent review
- Durable medical equipment in amounts greater than $1,000.00.
- Epidural injections/nerve blockers
- Gastric Bypass
- Genetic testing for conditions other than exempted under the PPACA.
- Home health care
- Hospice of greater than 180 days
- Hospital admissions of any length of stay or of any type
- Hysteroscopy's
- Injectable treatments of $1000 or greater, that are administered in Office.

- Infant formula that is specialized for children with an inborn error of metabolism.
- Infusion therapy if not able to be obtained through this Plans pharmaceutical/drug program.
- Inpatient care
- Inpatient mental health
- Inpatient rehabilitation
- Inpatient substance abuse rehabilitation
- Inpatient surgery
- Mastectomies
- Mental Health (Inpatient)
- Mental Health (Outpatient) treatments greater than 17 please see concurrent review.
- Nasal Surgery
- Occupational therapy treatments greater than 17
- Orthotics greater than $1,000.00.
- Orthotripsy
- Outpatient mental health treatments greater than 17 please see concurrent review.
- Outpatient substance abuse treatments greater than 17 please see concurrent review.
- Outpatient surgery
- Pharmacogenetics
- Physical therapy treatments greater than 17
- Podiatric surgeries
- Private duty nursing
- Prosthetics
- Pulmonary rehabilitation
- Physical therapy
- Radiation therapy
- Reconstructive and corrective surgery
- Rehabilitation therapy
- Respiration therapy
- Sclerotherapy

- Skilled nursing benefits
- Specialty drugs must be pre-certified with the Plans PBM and/or Specialty Drug PBM
- Speech therapy treatments greater than 17 please see concurrent review
- Sterilization Procedures
- Substance Abuse – All Inpatient
- Substance Abuse – Outpatient treatments greater than 17 please see concurrent review.
- Surgeries of any type
- Synagis injections
- Transplants
- Trigger point injections.
- Vein therapy

Participants and providers alike are informed that:

1. Precertification / Prior Authorization and/or Concurrent Review 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 that a second opinion be obtained 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.

Denials

If a particular course of treatment or medical service is not pre-certified or prior approved, it means either:

1. A claim for those services / treatments will be denied regardless of whether the service or supply is otherwise covered by the Plan. Consequently, you may be responsible for the full cost of the service or supply.
2. The Plan does not consider that course of treatment as medically necessary and/or appropriate based upon the information provided by you or your treating professional. Consequently, you may be responsible for the full cost of the service, treatment, or supply.

The decision to consent to treatment or care or receive supplies not approved by or covered by this Plan, and the subsequent responsibility to pay for those services, treatments, supplies, or care, remains solely with that of the patient.

How to Pre-certify or Obtain Prior Authorizations

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 certain tests 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, medical 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 the 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.

Why does this Plan require precertification or prior authorization on certain procedures and not others?

The Plan requires precertification / prior-authorization or concurrent review 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-pocket costs by understanding what is covered by the Plan.

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 medical 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

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 not be subject to the annual deductible.
- Physician charges will be paid in accordance with the network affiliation of the medical professional rendering treatment. Consequently:

  g. 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.

  h. If the physician professional rendering service is a participating provider, then the Plan will pay 90% of the Reasonable and Allowed Amount.

  i. 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 pay 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:

  j. 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.

  k. 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).

  l. 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 to 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:

m. 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.

n. 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 pay at 90% of the Reasonable and Allowed Amount.

o. 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 be paid 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.

Warning: *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 for any reason, 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.*

Working within Jurisdictions without reciprocity AND/OR not updating your ERTS election.

If you work outside the jurisdiction of the IBEW Local 697 and/or work in covered employment under the Jurisdiction of another IBEW Local Union that either does not participate within the IBEW National Reciprocity Agreement, or does, but fails to adhere to its rules and policies in a timely manner, your eligibility in this Plan will terminate on the earlier of:

1. The first day of the month in which your accumulated work hours and contributions received by the IBEW Local 697 do not meet the eligibility requirements established by the Board of Trustees. Or
2. The first day of the month on which any self-payments do not meet the eligibility requirements established by the Board of Trustees.

Warning: *When you are "cleared" to perform work within another IBEW Local's jurisdiction, you are kindly reminded that:*

- *Said clearance is provided by that Local and not by the Benefit Funds of IBEW Local 697 or the IBEW Local 697.*
- *The other Local does not notify either the IBEW Local 697 or the Benefit Fund of the IBEW Local 697 that you are working within their jurisdiction. Therefore,*
- *The Health and Benefit Fund does not know where you are working, who you are working for and whether or not said work was performed within the jurisdiction of the IBEW Local 697, until such time that contributions are received through the Local NECA chapter or through the IBEW Electronic Reciprocity Transfer System (ERTS). Further,*
- *The Health and Benefit Fund is responsible for the administration of those contributions at the point that they are received by this Fund. In other words, if another Local Union Benefit Office did not reciprocate or reciprocate timely your contributions back to this Plan, you need to speak to them. The IBEW Local 697 Health and Benefit Fund is neither in control of nor has any influence over the administration of another Local's benefit program and this Local is not signatory of the other Local's collective bargaining agreement (CBA) that you worked under.*

However, and for the reasons:

- *That you chose to work in their jurisdiction.*
- *That prior to you performing covered work within another IBEW Local's jurisdiction you made certain that your ERTS election is current and aligned with your desire to have the employer contributions reciprocated back to your home Local.*

- *That the other Local's benefit office is not acting accordance with your ERTS election to have the employer contributions made on your behalf reciprocated back to your home Local.*

You are in the "driver's seat" and need to notify that Local Union's benefit office that they have failed to adhere to the National Reciprocity Agreement and your ERTS election.

In the situation where the employer failed to make your contributions or submit them timely, you are reminded that as an IBEW member you have the responsibility to notify that Local's Union about any infraction in the terms of the CBA between that Local Union and their signatory employer.

If you failed to update your ERTS election, and as a result you lose eligibility with this Plan, your eligibility will be reinstated in accordance to the reinstatement eligibility provisions of the Plan.

Remember, employer contributions will be reciprocated in accordance with your ERTS election on file when those contributions were earned. It is your responsibility to keep your ERTS election current. If your election is different than that of your intent, the desired outcome will be as well. Should this occur, you are reminded that this Benefit Fund or that of another Local followed your instructions that were on file at the time the contributions were earned. Neither of the aforementioned entities is responsible for any negative repercussions that occur as a result of your intent not being congruent to your actions, or lack thereof.

REFERENCED 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 basis of this Plan's determination of a reasonable and fair amount of 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 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.

RETIREE FIRST

In order to assist the Medicare eligible participants of this Plan the Plan has contracted with Retiree First.

The Fund recognizes that finding your way through Medicare associated retiree healthcare benefits can be daunting. Annual changes and confusing language often muddy understanding and frequently, yet unintentionally mask available options and resources.

RetireeFirst is a world class service dedicated to helping the Medicare eligible participants navigate the Plan's chosen Medicare Advantage program. The advocates at RetireeFirst are dedicated to serving, addressing, and helping the Plan's Medicare eligible participants understand their benefits and connect them to programs that will improve their health and wellbeing.

Whether you need formulary, tier and co-pay assistance, or support with claims filing, or help with updating your personal information, obtaining ID card replacements, or anything else, RetireeFirst will help you address those matters and concerns in a manner that is as stress free as possible.

To contact a RetireeFirst Advocate, either call 800-716-0774 or 856-780-6218 or email them at members@retireefirst.com.

Warning: This benefit is only available to the Medicare eligible retirees of the Plan.

RETIREMENT SELF-PAYMENT CREDITS (RSP)

Retiree Self-Payment Credits (RSP) is a benefit whose sole purpose is to offset the required retiree healthcare self-payments to the Local 697 Health and Benefit Plan. The key word in the aforementioned sentence is the word "benefit". **All benefits are made in the form of a credit for retiree coverage under the Local 697 Health and Benefit Plan. Meaning:**

- No direct payment will be paid to you or your spouse.
- No benefits will be paid if you do not qualify for the retiree coverage or if you decline coverage or lose retiree coverage through the Local 697 Health and Benefit Plan.

Accruing / Earning Retiree Self-Payment Credits

An individual begins to accrue Retiree Self-Payment Credits, when they perform unit work under a Collective Bargaining Agreement (CBA) that requires an employer to make Plan P contributions on the participants behalf.

Credits are earned and accrue as follows:

1. For the Period Before January 1, 2002

   If an individual was a participant of the Local 697, I.B.E.W., Electrical Industry Pension Fund (hereinafter Pension Plan) the number of credits provided under this section will equal the number of Pension Plan credits that individual earned as of January 1, 2002.

   If an individual was not a participant of the Pension Plan, a credit under this section will be granted for each full calendar year an individual was covered under the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Plan prior to January 1, 2002.

2. For the Period on or After January 1, 2002

   Retiree Self-Payment Credits are granted based on the following schedule:

Hours of Work in Covered Employment per Calendar Year	RSP Credit
Less than 200 Hours	No Credit
200 Hours to 399 Hours	Three-tenths (3/10)
400 Hours to 599 Hours	Four-tenths (4/10)
600 Hours to 799 Hours	Five-tenths (5/10)

800 Hours to 999 Hours	Six-tenths (6/10)
1,000 Hours to 1,199 Hours	Seven-tenths (7/10)
1,200 Hours to 1,399 Hours	Eight-tenths (8/10)
1,400 Hours to 1,599 Hours	Nine-tenths (9/10)
1,600 Hours or More	One Full Credit

Note: An individual is only entitled to earn one full Credit under this section in any Calendar Year.

(For the purpose of the following sections, participant refers to an individual with Retiree Self-payment Credits (RSP)

Active Members Who Were Participants in the Pension Plan on May 28, 2001, will be provided with the following RSP Credits

Individuals who were a participant in the Local 697 Pension Plan and the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Plan on May 28, 2001, will be provided RSP credits equal to their number of years of Pension credits.

Active Members Who Were Not Participants in the Pension Plan on May 28, 2001, to July 31st, 2022 will have their RSP Credits calculated in accordance with the following provision

You did (or will) become a Participant under this section on January 1 after you had/have at least 1,000 Hours of Plan P contributions during a period of twelve (12) consecutive months. The 1,000 Hours of Plan P contributions must be on or after January 1, 2000. If you do not meet the 1000 hours requirements during a calendar year, your initial 12-month qualifying period, your next 1,000-Hour qualifying period begins on January 1st that occurs during that initial 12-month qualifying period.

Accruing / Earning Retiree Self-Payment Credits in Retirement

No retiree Self-Payment Credit can be earned during any period in which the participant is also receiving said benefit. However, in the event that a retiree obtains active eligibility status, the employer contributions made on that individual's behalf during any quarter of active eligibility coverage, shall be actuarially calculated to determine if any increase to the number of years of self-payment credits earned to date is due.

Benefit Calculations

Your monthly Retiree Self-Payment Credit will be based on you:

A. Meeting the retiree eligibility requirements of the Health and Benefit Plan.

B. Your age
C. Your earned RSP Credits (your Years of Service).
D. Your Retirement date, and,
E. Whether or not you incurred a RSP Credit freeze and/or a RSP Permanent Break in Service.

Remember: Your monthly Retiree Self-Payment Credit may be periodically changed. As such, please refer to the Plan P tab at the IBEW697benefits.org website or contact the Fund Office at 219-940-6181 for the current schedule of the Retiree Self-Payment Credits.

Break In Service

Please reference the section of this Benefit titled **RSP Credit Freeze**.

COBRA and Retiree Self-Payment Credits

If you have elected for coverage under this or any other Plan's COBRA provisions it means that you have lost eligibility for retiree coverage under this Plan.

Warning:

All participants are advised that their eligibility to receive RSP credit benefits cease when they lose retiree eligibility under this Plan. Please refer to the section of this provision titled "Termination from the Retiree Self-Payment Benefit Program" for more information.

Warning #2:

Kudos to you for thinking of it. But no. The Plan does not permit RSP credits to be utilized in any other manner other than that which is permitted under this Plan. As such, Participants cannot utilize Plan P credits to offset the expense of COBRA, or the expense of any other insurance program, retiree expense, or ……..for anything else.

Credit for Non-Work Hours

On or after January 1, 2002, a participant may receive a Retiree Self-Payment Credit for hours of work pursuant to the following situations:

Apprentice Training School Attendance and RSP Credits

An apprentice shall be credited with hours of work in Covered Employment when he/she attends the Local 697, I.B.E.W. Electrical Industry Apprenticeship Training School during the regular workday of a regular work week. For this purpose, each hour of attendance shall be considered as an hour of work in Covered Employment

provided however that no hours of actual work in Covered Employment are reported for the same such hours.

Under no circumstance will an apprentice be provided with more than two (2) full non-work Plan P Credits during their lifetime. Such periods would include, but is not limited to, Plan P Credits based upon Pension Credits granted under the Local 697, I.B.E.W., Electrical Industry Pension Fund for periods prior to January 1, 2001, classroom time, short-term disability, workers compensation, military leave or for periods granted under FMLA provisions.

Disability

- An employee shall be credited with 40 hours or less of work in covered employment for each week or partial week they are receiving Short Term Disability benefits from the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan for temporary or total disability or receiving Workmen's Compensation benefits.
- No more than two (2) full non-work Retiree Self-Payment Credits will be allowed during that participants lifetime for periods in which they are receiving FMLA, Loss-of-Time, Military, Short-Term Disability, Worker Compensation Benefits or for classroom time while an apprentice within the Local 697 JATC program. Periods non-work periods during your lifetime. This includes any RSP Credit granted prior to January 1, 2001, based on Pension Credits earned under Local 697, I.B.E.W., and Electrical Industry Pension Fund.

Family Medical Leave Act (FMLA) and your RSP Credits

The Family Medical Leave Act (FMLA) requires certain employers (but not all) to grant unpaid leave. In general, affected employers must grant you 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 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.

Any leave of absence granted by an Employer that qualifies under FMLA shall result in those hours being credited towards RSP Credits to the extent those hours would have been credited but for such absence (or, where that cannot be determined, eight hours of Service per day of absence) to a maximum of 501 hours over a 12-week period

for any FLMA leave. The hours so credited shall be applied to the Plan Year in which such absence begins, if doing so prevents the Employee from incurring a ONE-YEAR BREAK in that Plan Year; otherwise, they shall be applied to the next Plan Year. The Trustees may require, as a condition for granting such credit, that the Employee establish in a timely fashion and to the satisfaction of the Trustees that the Employee is entitled to such credit. This subsection shall apply only to absences that begin after December 31, 2001.

No more than two (2) full non-work Retiree Self-Payment (RSP) Credits will be allowed for all non-work periods during your lifetime. This includes any Retiree Self-Payment (RSP) Credit granted prior to January 1, 2001, based on Pension Credits granted under a similar provision of Local 697, I.B.E.W., and Electrical Industry Pension Fund.

Military Service and your RSP Credits

Participants who experience a leave of absence due to "qualified military service" after December 31, 2000, can receive up to a maximum period of five (5) years (unless a longer period is required under federal law). You will be credited with RSP Credits based on your average Hours of Service for all completed calendar months in the year that you entered the military, up to a maximum of 1,600 per Calendar Year. If you did not work during some months in the current year, the Hours for all completed calendar months for the preceding year will be used to calculate the average RSP Credit to be granted.

RSP Credits will only be granted if you make yourself available for Covered Employment as follows:

- Up to 30 days of service: Report the next scheduled workday after safe travel and 8 hours of rest.
- 31-180 days of service: Apply within 14 days after completion of service.
- 181+ days of service: Apply within 90 days after completion of service.
- Your reemployment rights will be terminated, and therefore no RSP Credits will be granted, if you are:

    1. Separated from uniformed service with a dishonorable or bad-conduct discharge; or
    2. Separated from uniformed service other than honorable conditions as characterized by the regulations of the uniformed service; or

3. A Commissioned Officer dismissed by sentence of a general Court Marshall; in commutation of a sentence of a general Court Marshall or, in time of war by order of the President; or
4. A Commissioned Officer dropped from the roles due to absence without authority for at least three (3) months; separation by reason of a sentence to confinement adjudicated by a Court Marshall; or a sentence to confinement in a federal or state penitentiary or correctional institution.

Eligibility for Benefits

You will be eligible to receive Retiree Self-Payment Credit benefits if:

- You were covered as an active member under the Lake County Indiana NECA – I.B.E.W. Health and Benefit Plan on the day prior to the commencement of your Pension. And,
- You are eligible for and at time of initial retirement, you elect retiree coverage through the Local 697 Health and Benefit Fund. Remember, the eligibility requirements for retiree coverage under the Health and Benefit Plan require that the participant be covered under that Plan for a minimum of forty (40) full calendar year quarters in the fifteen (15) years directly prior to retirement, **excluding** any period in which the participant may have been receiving COBRA benefits from the Health and Benefit Plan. And,
- Contributions are being made or have been made on your behalf as a result of performing work covered under an IBEW Local 697 Collective Bargaining Agreement or worked under a Participation Agreement that mandated Plan P contributions. And,
- RSP Credits exist and were not lost due to any break in service.
- Other than receiving a Social Security Disability Award, if you retire prior to age sixty-two (62), you must have at least twenty 20 RSP Credits. If you retire prior to age sixty-two (62) and do not have twenty (20) RSP Credits, any Plan P credits will be provided to offset the expense of coverage under this Plan upon obtaining age sixty-two (62).

  Should you retire prior to age sixty-two (62) but without twenty (20) RSP Credits, AND subsequently be awarded a Social Security Disability award, any earned RSP Credits, excluding any lost through a break in service, will be backdated and applied to offset the retiree self-payment expenses incurred in the months following the Social Security Award date or the month in which the participant became eligible for retiree coverage under this Plan, whichever is the latter.

Not Earning Retiree Self-Payment (RSP) Credits

You will not earn any Retiree Self-Payment Credits:

A. In any calendar year in which you fail to complete at least 200 Hours of Service under Covered Employment that requires Plan P contributions. Or,

B. During any quarter of coverage periods in which you are receiving a Retiree Self-Payment Credit benefit. (Please see the section of this provision titled "Accruing / Earning Retiree Self-Payment Credits in Retirement.")

Reciprocity and Retiree Self-Payment Credits.

Whether establishing RSP credit for the first time or receiving RSP credit as a matter of continuous employment and/or through reciprocity, the sum difference between the received reciprocated hourly contributions that are less than the current Local 697 Plan P hourly contribution rate in effect at the time the contribution was earned, but nevertheless greater than the Health and Benefit Plan's hourly contribution rate in effect at the time (or those that are specifically set forth within a collectively bargained agreement or participation agreement,) will be used to calculate the equivalent hours of work performed and hence the RSP credit earned, if any.

The following formula will be used to calculate the equivalent number of hours, and hence RSP Credits.

Dollar amount over the hourly IBEW Local 697 Health & Benefit rate in effect at the time the work was performed x the number of hours worked.

DIVIDED BY

The Plan P hourly rate in effect at the time the work was performed.

For example, if you worked 475 hours within another IBEW Local's jurisdiction, and that Local's Health and Benefit hourly rate was $9.62 per hour, and the IBEW Local 697 Health and Benefit Plans hourly rate was $10.22, and the hourly Plan P contribution rate is $1.50 per hour, you would not earn any RSP Credit for the reason that the received contributions were not greater than the $10.22, let alone the equivalent of the sum total of the hourly IBEW Local 697 Plan P rate plus the hourly Local 697 Health and Benefit rate. ($11.72)

Conversely, if the hourly rate within the other IBEW Local mentioned in the aforementioned example was $11.00, you would earn 3/10th of a RSP Credit. Here is how that was calculated:

475 Reciprocated Hours x $0.70 ($11.00 - $10.22 = $0.78) / 1.50 = 247 hours

247 hours = Three tenths (3/10th) of a RSP Credit

RSP Credit Freeze

If you fail to earn a total of 200 hours of RSP Credit during a period of three (3) consecutive Calendar Years, you will be deemed to have left Covered Employment on the first day of the three consecutive years. At which point you will experience an RSP **Credit Freeze**. Meaning the RSP Credits the participant earned before the accrual break will be frozen at the rate in effect at the beginning of the 3-year period that determined the accrual break.

Should the participant return to covered employment in which Plan P contributions are contractually obligated to be made on their behalf, the RSP Credits earned after the participants accrual break will be those that are in effect at the time the credits were earned. Should the RSP credit amount be increased, the credits the participant earned after their accrual break will be eligible for the higher benefit amount. And vis-a-versa. Meaning; should the benefit amount be lowered; the participant would be eligible for the lower amount. Upon the participants retirement, their Retiree Self-Payment (RSP) Credit benefit will be the sum of all Retiree Self-Payment Credits multiplied by the applicable monthly benefit rates. Consequently, an RSP accrual break establishes the monthly benefit rate used to determine a participants RSP monthly benefit.

RSP Credit Permanent Breaks in Service

A **RSP permanent break in service** will occur after a participant incurs five consecutive years in which they were credited with less than 200 hours of service. A RSP permanent break in service results in a:

1. Permanent loss of all RSP credits earned prior to the break. And,
2. Your participation within this Plans RSP Credit Benefit program ceases.

However, if an active employee vacates from covered employment for any of the hereinafter enumerated reasons:

A. A Temporary Total Disability (as the term is defined under the Indiana Workers Compensation Act); or

B. A position as a full-time employee with the I.B.E.W. Local 697 Union; or

C. A position as a full-time employee with the I.B.E.W. International Union; or

D. A position as a full-time electrical inspector prior to receiving any Retiree Self-Payment Credit benefit; BUT.

That employee returns to covered employment and earns a RSP Credit within FIVE CONSECUTIVE YEARS OR LESS from the commencement date of their separation,

then their RSP Credit for all years shall be the credit rate in effect in the year of their Pension application.

RSP Credit Reinstatement of Participation

If you lose your status as a Participant, you will again become a Participant by completing 1,000 Hours of Service during a 12-consecutive-month period.

When accomplished, you will be reinstated to Participant status retroactive to the first day you return to work.

Warning: *All participants are advised that under no circumstance will hours utilized to calculate a participant's reinstatement be also applied or counted toward any additional RSP credit for the calendar year in which they were reinstated.*

Warning #2: *Under no circumstances will previously lost RSP Credits be reinstated to any individual. This would include but is not limited to any individual who experiences a break in service, owes this Plan any money or commits an act of fraud against the Plan.*

Note: The monthly benefit rate for Participants who left Covered Employment before January 1, 2001, and did not reestablish participation before January 1, 2002, will be $0 for all accrued Plan P Credits earned before January 1, 2001.

RSP Credit Survivor Benefits

After a Participant's death if their spouse is a "Qualified Spouse" and continues as a Participant in the Lake County Indiana NECA / I.B.E.W. Health and Benefit Plan the deceased Participant's Retiree Self-Payment Credit will accrue to the spouse.

The rules for payment of the RSP Survivor Benefit are as follows:

1. The spouse must be a "Qualified Spouse."

   To be considered a Qualified Spouse the spouse must have been legally married to the Participant on the date their RSP Credit benefit began. Benefits are only payable to the spouse if they are still a Qualified Spouse when the Participant dies. If the Participant dies before their RSP Credit benefits begin, the surviving spouse will be considered a Qualified Spouse if they and the Participant were married at least one year prior to the Participant's death.

2. The RSP Credit benefit for a surviving Qualified Spouse upon the demise of an active Participant.

   After the death of an active (non-retired) participant, the calculation of any Retiree Self-Payment Credit is based upon the age the qualified spouse. Should the qualified spouse be under the age of 55, the credit granted shall be the rate in effect for a participant at the age of 55 or the rate in effect for a 55-year-old

participant at the time in which credits were frozen. If the spouse has obtained the age of 55 or greater than the Retiree Self-Payment Credit will be that for a participant of the same age or the same age at the time credits were frozen.

Termination from the Retiree Self-Payment Benefit Program

Your participation in this program and eligibility to continue to receive or eligibility to receive future Retiree Self-Payment Credit benefit will permanently cease upon:

- Any lapse in eligibility for retiree coverage under the Plan.
- At any time that an active or retired participant commits an act of fraud against the Plan.
- At any time a retired participant makes a misrepresentation to the Plan, or to anyone else who subsequently seeks remuneration for services rendered to you or your dependent that results in the Plan making an erroneous payment.

Using Excess Hours for Additional Retiree Self-Payment Credits

In any given calendar year after January 1, 2002, any participant who has received over 1,600 hours in Plan P contributions, will have the hours in excess of 1600 applied to any Calendar Year(s) after December 31, 2001, in which that participant worked in covered employment at least 200, but less than 1600 hours.

Excess Hours will not be applied to Calendar Years before January 1, 2001, nor will they be applied to Calendar Years during which you had fewer than 200 Hours or years in which you returned to work and were receiving retiree coverage under this Plan.

RETIREMENT

Regardless of any earned future quarters of coverage, when a participant retires under this Plan, they are no longer considered an employed and active participant of this Plan. As such, they will be entitled to only those benefits that are described directly below and/or to the applicable provisions and exceptions as described within this document.

Benefits for Covered Retirees who <u>are eligible for</u> Medicare Benefits

Retired participants who have met the eligibility requirements of the Plan and are eligible for Medicare benefits will be placed into a Medicare Advantage Plan with Part D coverage. In addition to those benefits, these participants will also be provided with the following benefits through the Plan:

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 $1,000.00. Each subsequent calendar year they will be limited to a maximum dental benefit of $1,000 per family.

2. Retired participants will be provided with the same vision benefits as an active participant EXCEPT they may opt for a pair of safety glasses in lieu of regular frames once every twenty-four (24) months. And,
3. In addition to the Part D pharmaceutical benefits provided through the Medicare Advantage Plan, retired participants will also be provided supplemental pharmaceutical coverage through SavRx.

However, these participants will not be entitled to the following benefits through this Plan:

- Retirees will not be entitled to any Short-Term Disability and Loss of Time benefits.
- Retirees and any eligible dependents will not be entitled to the Plan's Telemedicine / Telehealth Benefit.
- Retirees and any eligible dependents will not be entitled to the Plan's Included Health Benefit.
- Retirees and eligible spouses will not be entitled to the Plan's Fitness Club Reimbursement benefit.
- Retirees of and over the age of sixty-five (65) will not be entitled to Life Insurance Benefits from this Plan. Rather, a taxable death benefit will be provided to only those retirees receiving a monthly Pension benefit from the Pension Plan of the Local 697 I.B.E.W. & Electrical Industry Pension Plan.

Warning: *The Plan's Medicare Advantage Plan with Part D coverage is subject to change, as such, please refer to the Plan's website and/or all communications so that you remain properly informed of any and all benefit changes and/or improvements.*

Further, retirees and their eligible dependents are reminded that all provisions within this document, including, but not limited to coordination of benefits, eligibility, enrollment, exclusions, fraud, and self-payments, will remain in effect.

Benefits for Covered Retirees who <u>are not eligible</u> for Medicare Benefits (Under the age of sixty-five (65), and not eligible for Medicare Benefits)

Are the same as the benefits that are provided to active members, except as 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 $1,000.00. Each subsequent calendar year they will be limited to a maximum dental benefit of $1,000 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.

Remember: Retirees and their eligible dependents are reminded that all provisions within this document, including, but not limited to coordination of benefits, eligibility, enrollment, exclusions, fraud, and self-payments, are in effect.

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.

In an effort to assist the participants of the Plan in this endeavor, the Fund has contracted with Included Health. Included Health can arrange for you to get a remote second opinion from a leading expert specializing in your area of need. This service is of no cost to you. For more information, please reference the benefit titled "Included Health" within this document.

Should you elect not to utilize this Plan's Included Health 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 request 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.

SELF-PAYMENTS

If you experienced a deficit in hours; meaning you have fewer than the quarterly hourly requirement necessary to maintain eligibility during a quarter of coverage, you can maintain your eligibility by making self-payments in accordance with the following rules:

Amount and Due Date of All Self-Payments

All self-payments must be made for the full amount AND unless otherwise stipulated, received by the Fund Office no later than the dates and times listed within the chart directly below:

Quarter of Coverage	Self-Payment Due Date (Unless Otherwise Stated)
January, February, March	12:00 P.M. on the last business day of the month of December that precedes the quarter of coverage
April, May June	4:30 P.M. on the last business day of the month of March that precedes the quarter of coverage.
July, August, September	4:30 P.M. on the last business day of the month of June that precedes the quarter of coverage.
October, November, December	4:30 P.M. on the last business day of the month of September that precedes the quarter of coverage.

How to Calculate an Hours Deficit

As eligibility for coverage under this Plan is based on hours worked within a work quarter, determining if a deficit has occurred is easy. Simply take the number of hours required to maintain eligibility in the corresponding quarter of coverage (420 for journeypersons and 324 for Apprentices, Boot Camp and Indiana Plan participants) and subtract the number of hours you worked under covered employment during the work quarter. If the number you get is zero or greater, then you have a deficit and can elect to make a self-payment. If the number is a negative, you do not have a deficit.

If you are unclear as to where you can find a record of the hours in which you worked, you can check your worklog, or your paychecks from that work quarter. Keep in mind that the Collective Bargaining Agreement (CBA) does not determine when an

employer cuts off any given month for the reporting of an employee's hours. In rare instances this has negatively affected a few employees, leaving them short of the required number of hours needed for initial or continued eligibility under the Plan. Therefore, each employee is urged to not only read the CBA but to always inquire and ascertain for themselves the reporting practices of their employers in order to properly calculate any deficit in hours.

Late Self-Payments

Late payments will not be accepted. If you fail to make your self-payment on time, your eligibility will terminate on the last day of the coverage quarter for which you were previously eligible due to hours or self-payments.

Limits on the Number of Full Self-Payment You Can Make

You can make **full** self-payments for up to a maximum of four consecutive work quarters (12 months). If you return to covered employment during a 12-month self-payment period AND re-establish eligibility by working the required number of hours for your classification, you will be entitled to a new 12-month self-pay period if you have a subsequent period of underemployment.

Limit on the Number of Partial Self-Payments You Can Make

There is currently no limit on the number of consecutive **partial** self-payments you can make.

Self-Payment in Amounts Less than That Which is Owed –

Unless otherwise permitted, all self-payments must be made in full **AND** be received by the Fund Office by the due dates set forth in the chart directly below. (Note – the chart below is identical to the chart listed above, between point #1 and point #2. This chart can also be found within in the section of this document titled "Shortage of Hours.")

Quarter of Coverage	Self-Payment Due Date (Unless Otherwise Stated)
January, February, March	12:00 P.M. on the last business day of the month of December that precedes the quarter of coverage

April, May June	4:30 P.M. on the last business day of the month of March that precedes the quarter of coverage.
July, August, September	4:30 P.M. on the last business day of the month of June that precedes the quarter of coverage.
October, November, December	4:30 P.M. on the last business day of the month of September that precedes the quarter of coverage.

Note: If unclear as to the time and date in which a self-payment is due, please call the Fund Office at 219-940-6181.

Self-Payment Start Date for Retirees

Effective, January 1, 2023, and upon meeting the eligibility requirements of this Plan, a retired participants first self-payment will be assessed for the month following the last month of the calendar of coverage that was earned while employed.

Self-Payment Requirement for All Retirees Covered by the Plan

The Plan requires retiree self-payments, if any, to be deducted automatically, each month, from the participants choice of either their bank account or from their monthly Local 697 IBEW & Electrical Industry Pension Fund monthly benefit. No exceptions.

Shortage of Hours and Your HRA Benefit

If, due to a shortage of hours, an active participant of the Plan is in danger of losing their eligibility under the Plan and the participant has an HRA benefit balance **in an amount greater** than the quarterly total of the shortage of hours, the participants HRA benefit balance will be automatically debited to cover that shortage of hours for that quarter of coverage.

Note: The date that the account is debited is determined solely by the Plan and can and will change from quarter to quarter.

Note #2: Automatic deductions are mandated by the Board of Trustees for all non-retired participants of the Plan. If you do not wish for an automatic deduction to occur, you may avail yourself of your right to make an appeal to the Board. Please see the section of this document titled "Appeals".

Should the participants HRA benefit balance **be less than** what is needed to cover in full their shortage of hours payment, no automatic deduction will occur. Meaning: The Plan will **neither** make any automatic deductions of HRA benefit balances if there exists insufficient HRA benefit balances to cover the full shortage of hours payment for that quarter, **nor** will it institute, make or procure any partial deductions on behalf participants for any reasons, including, but not limited to:

- A participant's neglect in providing sufficient time for the HRA third party administrator to issue a physical check and/or,
- For the U.S. Postal Service to deliver said payment on or before the due date, or,
- For any purported unsuccessful electronic request attempts.

Note #3: Participants are reminded and strongly encouraged to read the section of this document titled "Health Reimbursement Arrangement".

Self-Payment Amounts

Your self-payment amount must be equal to the number of hours you are short of the requirement multiplied by the current Health and Benefit Plan contribution rate. Payment is to be always in the exact amount as communicated by the Fund.

Warning: **Underpayments:** *If an underpayment occurs, the payment will be returned. Unless the participant reissues a full payment and does so in a timely manner so that the Fund Office receives his or her full payment by the specified due date, the participants coverage will terminate, and they will be offered COBRA.*

Warning #2: Overpayments: *Don't make them. Simple. Just don't do it. There is absolutely no reason to make an overpayment. This would include a participants desire to deal with clean, round numbers. The Plan likes those too; however, it does not like, nor will incur the added costs associated with dealing with that overpayment. Such costs would include but is not limited to, recording that overpayment, issuing a refund check, writing a letter explaining what occurred, mailing that letter and refund check to the participant, and subsequently tracking that refund check payment to make sure it is negotiated.*

Warning #3: *The Plan is only responsible for that which it controls. As such, concessions, or allowances for late payments for any reason other than a Plan error will not be provided.*

Where Do You Find the Number of Hours You Worked During Any Quarter?

You check your work log and/or paychecks from that quarter.

As a reminder, your employer pays your benefits in accordance to that which is mandated within the Collective Bargaining Agreement. That document is silent as to

how a month's end is to be determined for purposes of reporting the contributions that are earned in any month. Obviously, this could affect the number of hours a employer reports for you in a given month and possibly leave you short of the required number of hours you need for continuous eligibility or for that matter, initial eligibility. Consequently, each employee is urged to ascertain from their employer their accounting department's reporting cycle so as to be able to calculate any hour deficit.

SHORT-TERM DISABILITY BENEFITS

Only eligible active members or a covered employee of a contributing employer, who is not covered under the COBRA provisions of the becomes unable to work due to a non-job-related accidental injury or illness, is eligible to receive this benefit. Retirees will not be entitled to any 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 (based upon the straight time rate and a forty (40) hour week excluding any overtime) up to a maximum of $700.00 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 an 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 in its entirety 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 until the date that is disclosed.

   Warning: *All forms must disclose a return-to-work date. If no date is given, no benefit will be provided*.

   Warning #2: *The Plan will only provide this benefit in accordance with the terms of this provision. Therefore, read thoroughly all the provisions of this Plan especially those that speak to the timely submission of properly completed forms.*

2. You 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.

Participants are responsible for:

- Keeping the Plan updated on their disability status the moment said status changes.
- Notifying the Plan of changes in their banking information
- Knowing their benefit period.
- Acting in accordance to Plan provisions to make sure that they do not have a lapse in benefit payments.
- The gathering all required or requested information,
- Obtaining the appropriate signatures, and,
- The timely submission of all of the above to the Plan.

Reminder: Know when your benefit period ends and give special attention to the provisions of this Plan that speak to deadlines for submissions and the proper completion of forms. Additionally, the Fund generally does not send out reminder notices concerning the expiration of the benefit period. Any reminder beyond this one will be at the discretion of the Fund and are provided as a courtesy.

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 a 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. You and the treating physician must complete it in its entirety and submit to the Plan its Short-Term-Disability Form.
6. (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 of this Plans Short-Term Disability Benefit

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:
    a. Were covered under the COBRA provisions of this Plan.
    b. Were receiving Social Security retirement or disability benefits.
    c. Were receiving unemployment compensation.

d. Were receiving 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 fully and properly completed Short-Term Disability Form is not received within
7. 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 Short-Term Disability Benefits for Continuous Coverage During Periods of Twenty-Six (26) Weeks or Less

Individuals who find themselves disabled beyond the date established by their treating physician but before receiving twenty-six weeks of short-term disability benefits, may apply for an extension of benefits by completing the Plan's Statement of Continuance of Disability Form. 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 properly completed a **Statement of Continuance of Disability Form** and delivered it to the Fund Office within fourteen calendar days of the previously established disability benefit period on the original or prior forms.

Reminder: It is the participants responsibility to make certain that the Fund Office is in receipt of a properly completed **statement of continuance of disability form** within fourteen calendar days of the disability benefit period previously established by their treating physician.

Warning: *If you fail to have a properly completed* ***statement of continuance of disability form*** *at the Fund Office within fourteen calendar days of the disability benefit period previously established by their treating physician, your disability will no longer be deemed continuous. Any statement of continuance of disability form received by the Fund Office after fourteen calendar days will be denied for the reason that the Plan will treat said injury or illness as different and unrelated to the prior. Consequently, a Short-Term Disability Benefit Form must*

be completed in its entirety and all requests will be treated as a new disability. Accordingly, initial eligibility rules, including waiting periods, will be applied.

Extension of Short-Term Disability Benefit Beyond Twenty-Six (26) Weeks

Individuals who find themselves totally disabled beyond the date established by their treating physician but before 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.

Reminder: It is the participants responsibility to make certain that the Fund Office is in receipt of a properly completed Short-Term Disability Form within fourteen calendar days of the disability benefit period previously established by their treating physician.

Failure to Provide Timely Notification of Your Return to Work

Warning: Should the withholding, concealing, omitting or the failure of any participant to disclose any information in connection with this Plan's Loss of Time benefit and Short-Term Disability benefit, including but not limited to the timely notification of the participants return to work date result in a benefit being erroneously received, this will be considered an act of fraud against the Plan. Participants are advised that all rules, including, but not limited to the immediate termination of their and any eligible dependents coverage under the Plan, will be applied should this occur. Therefore, all participants are reminded of their obligation to inform the Plan of your return-to-work date PRIOR to your return to work.

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 weekly benefit amount will be fifty percent (50%) of the members weekly salary (excluding overtime) up to a maximum of $700 a week.

The Plan will determine that amount based upon the following factors:

- The classification of the participant at the time of injury.
- The straight time rate in effect at the time for that classification at the time of injury.
- A forty (40) hour work week.
- The unemployment compensation rates for the State of Indiana.

Warning: Under no circumstances will the amount of the Funds payment exceed fifty percent (50%) of the employees' weekly salary (excluding any overtime) or $700.00 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

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

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 compensation for lost wages and be receiving this Plan's short-term disability benefits. If the Plan learns that you are receiving other compensation for any lost wages 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.*

SHORTAGE OF HOURS

A shortage of hours occurs when a participant fails to work within a calendar work quarter the required number of hours needed to continue their and their family's eligibility for benefits in the corresponding quarter of coverage. Please see the chart below:

Work Quarter	Quarterly Requirement for Apprentices	Quarterly Requirement for Journeypersons	Will Provided Eligibility for Quarter of Coverage
January, February, March	324	420	July, August, September
April, May June	324	420	October, November, December
July, August, September	324	420	January, February, March
October, November, December	324	420	April, May June

Note: The Collective Bargaining Agreement requires every signatory employer to pay you on a weekly basis. However, that document does not stipulate how that employer is to report contributions for unit work performed within a month that does not end exactly at the close of their pay period.

Therefore, if your employer or employers report hours for unit work performed within the last week of a calendar quarter as work performed in the subsequent quarter, those hours will be accumulated along with any other hours reported for the subsequent calendar work quarter and tallied to determine eligibility within that quarters affiliated quarter of coverage.

Note #2: Under no circumstances other than Fund error or an employer correction, will the Plan adjust, modify, or move the hours reported by an employer from one work quarter to another work quarter in order to reduce the amount of a participant's shortage of hours.

What to do if you experience a Shortage of Hours: You must reference the section of this document titled "Self-Payments" to learn about that option. The latter allows you to continue you and your family's eligibility under this Plan by making a payment for the monetary difference between the cost of the required hours needed to continue your eligibility for the quarter of coverage in question and the monetary equivalent of the total amount of employer or employers' contributions made on your behalf in the corresponding work quarter.

Should you decide to make a self-payment, you are reminded that the full amount of your self-payment must be received by the Fund Office no later than the times and dates set forth within the chart below:

Quarter of Coverage	Unless Stated Otherwise, Your Self-Payment is Due No Latter Than
January, February, March	12:00 P.M. on the last business day of the month of December that precedes the quarter of coverage
April, May June	4:30 P.M. on the last business day of the month of March that precedes the quarter of coverage.
July, August, September	4:30 P.M. on the last business day of the month of June that precedes the quarter of coverage.
October, November, December	4:30 P.M. on the last business day of the month of September that precedes the quarter of coverage.

If you do not elect to make a self-payment, you and your family's eligibility under the Plan will be terminated. Should this occur, you can avail yourself of your right to continue your eligibility and that of any eligible dependent, under this Plan's COBRA provision. Please reference the sections of this document that speak to COBRA as well as termination of eligibility.

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.

There is extremely strong evidence that mental health counseling combined with pharmacotherapy is most effective in the treatment of tobacco addiction.

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 those periods of time in which the participant was complying in a calendar year toward the total out-patient mental health treatments allowable prior to this Plan's concurrent review provision comes into effect.*

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

Concurrent Review is required for all outpatient therapy treatments after the seventeenth (17th) visit / treatment. Out-patient Treatments or therapy beyond seventeen (17) visits or sessions that do not receive approval prior to that visit, treatment or session occurring will not be covered.

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)

Note: The Plan pays for habilitative speech therapy for children over the age (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.)

STERILIZATION PROCEDURES

Voluntary vasectomies, and tubal ligations, for employees and their spouses only.

Precertification is required before the Plan can make payment for this benefit.

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).

SUBJECT MEDICAL BILL ADMINISTRATION

From time to time, and at the sole discretion of the Fund Office, the Plan may utilize the services of a contracted Subject Medical Bill Administrator (Currently WellRithms) to assist with the negotiation and resolution of the payment of a claim.

Should a participant's claim be assigned to the Subject Medical Bill Administrator the participant is required to fully cooperate with the policies and procedures of the Subject Medical Bill Administrator. Such cooperation would include but is not limited to the assignment of the claim in question, the completion and timely submission of a participation agreement and HIPAA authorization, and the timely notification of any communications, including collection notices, or balance billings between the provider and the participant to the Subject Medical Bill Administrator.

The Plan participant will receive communication from Subject Medical Bill Administrator explaining the process.

The Procedures and Protocols of the Subject Medical Bill Administrator in processing or negotiating any such claim are attached hereto, made a part hereof and incorporated into this Summary Plan Description.

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.

When the Plan pays benefits, and/or makes loss of time contributions, (hereinafter referred to as expenditures); and you and any eligible dependents have a cause of action against any third party(s), which you or said dependent fail to bring in a timely manner, the Plan may at its discretion bring suit against said third parties to protect their expenditures. In such an event, you or any eligible dependent must fully cooperate with the Plan, which said cooperation includes, but is not limited to, providing information and documentation, appear in court, and otherwise cooperate in any legal proceedings stemming from said expenditures made by the Plan.

The Plan shall have the same rights as you or eligible dependent to recover expenditures from ANY SOURCE as that term is defined above.

If the Plan proceeds on your behalf or that of any eligible dependents to collect expenditure, any amount received with first go to satisfy said expenditure, any additional sums if recovered, will go to reimburse the Plan for any and all costs or expenses incurred in pursuit of the expenditure. NEITHER YOU NOR ANY ELIGIBLE DEPENDENT will be entitled to any portion of the proceeds collected by the Plan.

Nothing within this Plan precludes you or any eligible dependent from pursuing any legal right you may have against any third party.

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 required for all partial day and inpatient stays.

Concurrent Review required for all outpatient treatments of greater than seventeen (17) days.

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

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. Be pre-certified by the Plan or its review organization.
3. Detoxification treatments must be pre-certified.

Level A facility charges will be paid at 100% of the negotiated rate.

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 payable at 70% of 130% of the Plan's Reasonable and Allowed Amount (RAA).

Warning:

- *Services and/or treatment not pre-certified will not be covered by the Plan.*
- *Services and/or treatments that do not meet the concurrent review provisions of the Plan will not be covered.*
- *Group homes, halfway houses, wilderness programs, camps or institutions providing custodial care are not considered residential treatment facilities under this Plan.*
- *All detoxification requires precertification / prior approval.*
- *Similar to all substance abuse addictions, pharmaceutical treatments for smoking cessation will be limited to those products that are not considered over the counter or those that can be purchased without a prescription.*

TELEHEALTH – TELEMEDICINE

This benefit is available to all non-Medicare eligible covered participants.

Services rendered through the Plan's **assigned** Telehealth/Telemedicine benefit is not subject to the Plan's deductible nor out of pocket maximums and are paid at 100% of the Reasonable and Allowed Amount.

Assigned Telehealth – Telemedicine Provider

On and after May 1, 2024, the assigned Telehealth/Telemedicine service provider is **Included Health.** Please refer to the section of this document titled "**Included Health"** for more information as to how this benefit works and how it can help you and any eligible dependent.

Up until May 1, 2024, eligible participants and their covered dependents who require assistance addressing non-emergency medical health conditions can continue to call Teladoc at the number on the reverse side of their medical identification card, through Teladoc's app or via video call.

Warning: Services performed by Teladoc on or after May 1, 2024, are not a covered benefit by the Plan. If a participant mistakenly calls or accesses Teladoc on or after May 1, 2024, they will be responsible to make payment to Teladoc for the full cost of the service.

Non-assigned Telehealth/Telemedicine services

Telehealth/Telemedicine services provided by your physician, or a physician not employed through the Plan's assigned Telemedicine/Telehealth provider, 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.

TOBACCO ADDICTION

Please reference "Substance Abuse."

Note: The Plan treats tobacco addiction similar to any other chemical dependency and/or addiction. As such the rules, provisions and guidelines under this Plan's substance abuse provisions will govern what this Plan will cover.

TRANSPLANTS

To receive the transplant benefit, the participant must:

1. Obtain prior approval.
2. Coordinate the treatment with the Plan's case management provider; and
3. Have the transplant performed at a center of excellence as designated by the Plan or its third party-administrator. A center of excellence is a hospital or facility that has been specifically approved and designated by the Plan or its third-party administrator to perform these procedures and to whom the Plan has obtained a case or event rate agreement prior to services being rendered.

In order to receive benefits,

4. Prior approval is required.
5. Treatment must be coordinated with the Plan's case management provider; and
6. All transplants must be performed at a center of excellence as designated by the Plan or its third party-administrator. A center of excellence is a hospital or facility that has been specifically approved and designated by the Plan or its third-party administrator to perform these procedures and to whom the Plan has obtained a case or event rate agreement prior to services being rendered.

Warning #1: The Plan will cover only those transplants that it determines to be non-experimental and non-investigational.

Warning #2: Benefits will only be paid if the services for the transplant are provided by or arranged by the Designated Provider chosen by the Plan or its designated third-party administrator. Consequently, either you, your physician or surgeon must notify the third-party administrator of the possible need for a transplant as soon as it is known.

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

Donor benefits:

If the transplant involves a living donor, covered expenses include the medical services required to remove the organ or tissue from the donor's body, preserving it, and transporting it to the site where the transplant is performed. Donor benefits are also payable for these services if the person covered under this Plan is a live organ or tissue donor to a recipient who is not covered under this Plan. In such case, no payment will be made under this Plan for the recipient.

Whether the covered person is the recipient or donor, the maximum benefit payable by the Plan is $10,000.00 for all donor-related costs per transplant procedure.

Limitations of Donor benefits:

The aforementioned donor benefit is only payable if the expenses are not covered by another source, including, but not limited to, another healthcare plan. Further, payment will be made up to the $10,000 allowance and in accordance with the in-network and out-of-network provisions of this Plan.

Additionally, the Plan does not cover:

- Travel expenses, lodging, meals or other accommodations for donors or guests.
- Donor search fees.
- The purchase of an organ or tissue.

Recipient:

Participating provider charges will be subject to the deductible, and annual out-of-pocket maximums and payable at 90% of the Plan's contracted rate with the center of excellence or designated provider.

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)

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 the International Brotherhood of Electrical Workers (IBEW) 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.*

Travelers from Other Locals Working Within the Jurisdiction of Local 697

Members of other Locals working within the jurisdiction of the International Brotherhood of Electrical Workers Local 697 will have the employer contributions made on their behalf into the Lake County Indiana, NECA – I.B.E.W. Health and Benefit Fund reciprocated back to the Health and Welfare Plans at Local on file within the ERTS system.

Should an employee have no Local listed within the ERTS system, for whatever reason, this Plan will keep the contributions until such time that the employee makes his or her election **AND** that Local has accepted them into their Fund or Plan. Under no circumstances will any employer contributions be given in part or in full to the employee. Further, the failure of the employee or the employees home Local to properly enroll the employee into the ERTS system will neither result in the employee and any dependents becoming eligible for benefits under this Plan, nor necessitate this Plan to provide any interest earnings on said contributions to the home Local Plan once established. Further, this Plan will not be responsible for loss of coverage and benefits based upon the failure of either the employee or their home Local to properly set them up into the ERTS system.

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 for any reason, 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.*

Working within Jurisdictions without reciprocity AND/OR not updating your ERTS election.

If you work outside the jurisdiction of the IBEW Local 697 to work in covered employment under the jurisdiction of another IBEW Local Union that either does not participate within the IBEW National Reciprocity Agreement, or does, but fails to adhere to its rules and policies or reciprocate in a timely manner, your eligibility in this Plan will terminate on the earlier of:

1. The first day of the month in which your accumulated work hours received by the IBEW Local 697 Health and Benefit Fund do not meet the eligibility requirements established by the Board of Trustees. Or
2. The first day of the month in which your self-payments do not meet the eligibility requirements established by the Board of Trustees.

Warning: *When you are "cleared" to perform work within another IBEW Local's jurisdiction, you are kindly reminded that:*

- *Said clearance is provided by that Local and not by the Benefit Funds of IBEW Local 697 or the IBEW Local l697.*
- *The other Local does not notify either the IBEW Local 697 or the Benefit Fund of the IBEW Local 697 that you are working within their jurisdiction. Therefore,*
- *The Health and Benefit Fund does not know where you are working, who you are working for and whether or not said work was performed within the jurisdiction of the IBEW Local 697, until such time that contributions are received through the Local NECA chapter or through the IBEW Electronic Reciprocity Transfer System (ERTS). Further,*
- *The Health and Benefit Fund is responsible for the administration of those contributions at the point that they are received by this Fund. In other words, if another Local Union Benefit Office did not reciprocate or reciprocate timely your contributions back to this Plan, you need to speak to them. The IBEW Local 697 Health and Benefit Fund is neither in control of nor has any influence over the administration of another Local's benefit program nor its Local Union Office. The latter of which is because this Local is*

not signatory to the other Local's collective bargaining agreement (CBA) that you worked under.

However, and for the reasons:

- *That you chose to work in their jurisdiction.*
- *That prior to you performing covered work within another IBEW Local's jurisdiction you made certain that your ERTS election is current and aligned with your desire to have the employer contributions reciprocated back to your home Local.*
- *That the other Local's benefit office is not acting accordance with your ERTS election to have the employer contributions made on your behalf reciprocated back to your home Local.*

You are in the proverbial "driver's seat" and need to notify that Local Union's benefit office that they have failed to adhere to the National Reciprocity Agreement and your ERTS election.

In the situation where the employer failed to make your contributions or submit them timely, you are reminded that as an IBEW member you have the responsibility to notify that Local's Union about any infraction in the terms of the CBA between that Local Union and their signatory employer.

Now, if you failed to update your ERTS election, and as a result you lose eligibility with this Plan, your eligibility will be reinstated in accordance to the reinstatement eligibility provisions of the Plan.

Remember, employer contributions will be reciprocated in accordance with your ERTS election on file when those contributions were earned. It is your responsibility to keep your ERTS election current. If your election is different than that of your intent, the desired outcome will be as well. Should this occur, you are reminded that this Benefit Fund or that of another Local followed your instructions that were on file at the time the contributions were earned. Neither of the aforementioned entities is accountable for any negative repercussions that occur as a result of your intent not being congruent to your actions, or lack thereof.

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 point's 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).

UTILIZATION MANAGEMENT

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.

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.

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.

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.

Active Participant Vision Benefit Schedule

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.

Retiree Vision Coverage

Benefits and Provisions for Retired Participants and their Eligible Dependents are the same as the benefits that are provided to active members, except Retired participants may opt for a pair of safety glasses in lieu of regular frames once every twenty-four (24) months.

WORK RELATED INJURY, ILLNESS OR DISEASE – WORKERS 'S COMPENSATION

If Injured on the Job

Be advised that each employer has their own protocol to follow when it comes to work-related injuries and illnesses. Therefore, it is highly recommended whenever going to a new employer that you request, read, and understand that employer's accident, incident, and work-related illness protocols. Clarification surrounding any questions or concerns you may have about those rules and requirements should be brought to your direct supervisor.

No matter how minor, you have the responsibility to report all work-related injuries

and illnesses to your supervisor. Make sure that you follow your employers' protocols and know if the employer requires such incidences to be reported at the time of occurrence or when symptoms first appear or as soon as practical.

Further, you should expect and be ready to complete or assist in completing any required employee-related incident documentation provided by the employer.

Warning: Not following your employers' protocols could possibly weaken your Workers' Compensation Case.

Warning #2: Not filing a work-related injury or illness with your employer's Workers Compensation Case Insurance provider does not obligate this Plan to making payment for any related claims.

Warning #3: Intentional or unintentional material misrepresentations of fact is considered fraud under this Plan. Remember, it is a participant's responsibility to provide accurate information and to make correct and truthful statements, including information and statements regarding injury or illnesses incurred during employment or caused by work. Therefore, participants are strongly advised to review the Fraud provision within this document.

Possible Work-Related Injuries and the Health & Benefit Plan

In the event that this Plan makes any written inquiry to you or a medical healthcare professional from whom you are receiving treatment, in an attempt to identify whether any medical treatment or supply is the result of a work related injury, illness or disease, and no response to said inquiry is forthcoming within ninety (90) calendar days from issuance, the Plan will assume that the treatments were the result of a work related injury, illness or disease, and no payment will be made.

Note: 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.

Settling a Workman's Compensation Case

There are two ways to settle a Workman's Compensation case in the state of Indiana. The first option is a settlement under Section 15 of the Indiana Workman's Compensation Act (more specifically Indiana Code 22-3-2-15). Under Section 15 Compromise Agreement if a dispute exists between employer and employee the parties can resolve the dispute with the employer paying a certain agreed upon lump sum amount. When a comp case settles in this manner there is no specificity regarding the breakout of the settlement. In other words, there is not a set amount for the disability, medical expense or permanent partial impairment, if any. Also, of import regarding this type of settlement option is that the employee cannot reopen his claim against the employer. The second type of settlement and the more common settlement is an agreement between the employer and employee where everything is broken out. This type of settlement is commonly known as a form 1043 Agreement. Under a 1043 Agreement settlement the settlement is broken down into the amount paid for temporary total disability (lost time from work), medical payments broken out with specificity in terms of the gross amount of the medical paid, the providers and dates of services which lets the parties agree or compensable, and the agreed percentage of permanent partial impairment, if any. In other words, the amount of the settlement is broken down into those three component parts.

For the purposes of the Health and Benefit Plan obviously a Form 1043 Agreement spells out the amount of compensable medical such that the Health and Benefit Plan can then swing back in and pick up any medical before or after the settlement which is determined not compensable. It also sets out what lost time from work is compensable potentially triggering a loss of time benefit honoring to the participant. In the event of a Section 15 compromise the Health and Benefit Plan has no way of knowing which bills are compensable and which are not which may result in future bills for body type treatment being rejected, or similarly a loss of time claim being denied as accident related.

It is Always Desirable for the Health and Benefit Plan Participant to Settle the Claim Under a Form 1043 Agreement.

Please do not lose sight of the fact that the Workman's Compensation claims may be tried before the Industrial Board. If that is done the Industrial Board Member or in certain cases the full Industrial Board will make a quasi-judicial finding as to the temporary total disability, medical expense and permanent partial impairment which is conclusively binding on the Health and Benefit Plan.

ADDENDUM

To the Summary Plan Description/Plan Document for the
LOCAL 697 I.B.E.W Health and Benefit Plan
Effective January 1, 2024
Re: Subject Medical Bill Administration

I. **Shield Advocacy.** It is the Plan's position that a Provider should not balance bill a Plan Participant for amounts in excess of the Maximum Allowable Charge. However, balance billing for such amounts can occur. The Plan has partnered with WellRithms, Inc. to act as the Subject Medical Bill Administrator ("SMBA") as such term is defined herein for certain claims that are assigned to the SMBA by the Plan Administrator, or its designee. These claims are referred to as Shield Claims ("Shield Claims"). For Shield Claims, the SMBA is appointed to act in a limited co-fiduciary role and has ultimate discretionary authority to resolve a balance bill on behalf of a Plan Participant.

If a claim is assigned to the SMBA for Shield Services, the Plan Participant will receive communication from the SMBA explaining the process. The SMBA can be reached at Membersupport@WellRithms.com or call (971) 213-4209.

II. Responsibilities for the Plan Administrator and Subject Medical Bill Administrator. The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be the Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, or is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator.

Notwithstanding any provision of this Plan Document to the contrary, the Plan Sponsor has authority to and hereby does assign limited co-fiduciary authority to WellRithms, Inc. ("Subject Medical Bill Administrator" ("SMBA"). The fiduciary authority allocated to the SMBA is limited to claims that are assigned to the SMBA by the Plan Administrator and accepted by the SMBA ("Assigned Claims"). This limited fiduciary authority involves the repricing of Assigned Claims pursuant to the terms of the Plan Document. The SMBA has ultimate authority to review and reprice Assigned Claims for payment based on their Sustainable Claims Pricing ("SCP") methodology. For Assigned Claims that are appealed under the Plan's Claims Procedure, the SMBA has the limited co-fiduciary authority by the Plan Administrator to respond to all such appeals of Adverse Benefit Determinations. The SMBA will review and respond to all such claims in accordance with the applicable Plan provisions.

III. Notwithstanding the foregoing, the Plan Administrator may use its discretionary authority to select claims which will be assigned to the SMBA ("Assigned Claims"). All Assigned Claims are subject to the terms and limitations set forth in this Plan Document. Please refer to the Plan Administration provision as set forth herein.

IV. You may revoke an authorized representative designation at any time, and you may only authorize one person at a time.

For all Assigned Claims submitted to the SMBA, either directly by the Plan or through the Claims Administrator, the SMBA will be solely responsible for responding to first and/or second level appeals of any Adverse Benefit Determination(s) that are received by the SMBA. The SMBA will review and respond to all such claims in accordance with the applicable Plan provisions.

Audit of Certain Charges. The Plan Administrator has the authority to refer any claim to a designee of its choosing for the purpose of performing a Billing Review. This review may be used to identify Errors, Excess Charges, Unbundling, medically unlikely edits, or any other matter that may impact claims adjudication. It is within the Plan Administrator's sole discretion to review and adopt the recommendations of its designee as its own. Specifically, the Plan Administrator shall not, on a line-item basis (CPT, HRC, HCPCS, etc.) allow a greater reimbursement than billed charges. In addition, revenue codes requiring CPT or HCPCS will be denied when the code is not present on a UB-04 or itemized bill. The Plan Administrator is entitled to rely on all other terms and conditions of this Plan Document, as well as all other nationally recognized billing and coding edits when performing a bill review.

V. The term "Reasonable and Customary Charge" 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 Customary Charge based upon charges made for similar services. Determination of the Reasonable and Customary Charge 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 any 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 the maximum amount that can be billed by the rendering provider, the Reasonable and Allowed Amount shall mean the lesser or 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.

Notwithstanding anything to the contrary, for Shield Servies specifically, the SMBA has the ultimate discretionary authority to determine the Reasonable and Allowed Amount/Reasonable and Allowable Amount even if such amounts do not satisfy the 'lesser of' test described above.

VI. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Member as the sole beneficiary. This Assignment of Benefits definition includes the condition and limitations as further outlined in this Plan Document.

VII. **Balance Bill.** A medical provider's invoice for Covered Charges which were found to be in excess of the Maximum Allowable Charge.

Errors. Charges based on billing mistakes, improprieties or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard; it is in the Plan Administrator's, or its designees, sole discretion to determine what constitutes an error under the terms of this Plan.

Excess Charge(s). A charge or portion thereof billed for care and/or treatment of an Illness or Injury that is not payable under the terms of the Plan because it exceeds the Maximum Allowable Charge or is determined by the Plan Administrator to be based on Invalid Charges or errors in accordance with the terms of this Plan Document. Also, charges for a service or supply furnished by a Direct Contract Provider in excess of the applicable negotiated rate.

Invalid Charge(s). Charges (a) that are found to be based on Errors (as defined in this Document), Unbundling, Misidentification or Unclear Description; (b) charges for fees or services determined not to have been Medically Necessary or reasonable; (c) charges found by the Plan Administrator to be in excess of the Maximum Allowable Charge, or (d) charges that are otherwise determined by the Plan Administrator to be invalid or impermissible based on any applicable law, regulation, rule or professional standard.

Subject Medical Bill Administrator ("SMBA"). WellRithms, Inc. is the Subject

Medical Bill Administrator, and has limited co-fiduciary authority in the review and repricing of certain Assigned Claims.

Sustainable Claims Pricing ("SCP"). A method of repricing utilized by WellRithms, Inc. for claims, grounded in English common law principles of quantum meruit, which takes into consideration reasonable industry standards and local market realities.

Unbundling. Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) the Healthcare Common Procedure Coding System (HCPCS), and/or the National Correct Coding Initiative (NCCI) codes used by CMS. Charges include routine medical and/or surgical supplies that are included in the general cost of the procedure, nursing care and/or services that are performed within the scope of daily duties; surgery, procedures(s), and/or supplies that are included in a surgical procedure room rate; and C-codes that are packages and have no separate reimbursement surgery/procedures and supplies, and C-codes. The Plan has the sole discretion to determine whether a charge is an Unbundled Charge.

WellRithms, Inc. The Subject Medical Bill Administrator ("SMBA").

WellRithms Shield Services ("Shield Services"). The services provided by WellRithms, Inc. for Assigned Claims.

VIII. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity, or fees under review for Maximum Allowable Charge or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this Plan.

The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Member as the sole beneficiary. This Assignment of Benefits definition includes the condition and limitations as further outlined in this Plan Document.

Billing Review. The term Billing Review will mean a review of billing documentation and related medical records undertaken to uncover any, Clinical Edits as necessary and sufficient to allow the Board of Trustees to reasonably assess the accuracy and validity of billed charges submitted in connection with a Claim and to make determinations as to whether any such charges exceed the Allowable Charge.

Clinical Edits. The term Clinical Edits means ***Errors, Excess Charge(s), Invalid Charge(s), Medically Unlikely Edits (MUE), Unbundled Charges, Unbundling*** collectively.

Errors. The term Errors means charges based on billing mistakes, improprieties, or

illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible, or improper based on any applicable law, regulation, rule, or professional standard. It is in the Board of Trustees' sole discretion to determine what constitutes an Error under the terms of this Plan.

Excess Charge(s). The term Excess Charge(s) means a charge or portion thereof billed for care and treatment of an Illness or Injury that is not payable under the Plan because it exceeds the Allowable Charge or is determined by the Board of Trustees to be based on Invalid Charges in accordance with the terms of this Plan Document.

Invalid Charge(s). The term Invalid Charge(s) means a charge (a) that is found to be based on Errors (as defined in this Document), Unbundled Charges, Unbundling, misidentification, and/or unclear description; (b) charges for fees or services determined not to have been Medically Necessary or reasonable; (c) charges found by the Board of Trustees to be in excess of the Allowable Charge, or (d) charges that are otherwise determined by the Board of Trustees on to be invalid or impermissible based on any applicable law, regulation, rule, or professional standard.

Medically Unlikely Edits (MUE). The term Medically Unlikley Edits (MUE) means charges related to incorrect coding based on Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), HCPCS/CPT code descriptions, CPT coding instructions, the nature of the service/procedure, and any other applicable coding guidelines or recommendations.

Unbundled Charge(s). The term Unbundle Charge(s) means charges for medical equipment and supplies that are included in a facility charge; charges for, routine medical and/or surgical supplies that are included in the general cost of the procedure, nursing care and/or services that are performed within the scope of daily duties; surgery, procedure(s), and/or supplies that are included in a the surgical/procedure room rate; and C-codes that are packages and have no separate reimbursement surgery/procedures and supplies. The Board of Trustees has the sole discretion to determine whether a charge is an Unbundled Charge.

Unbundling. The term Unbundling means charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) the Healthcare Common Procedure Coding System (HCPCS), and/or the National Correct Coding Initiative (NCCI) codes used by CMS. Charges include routine medical and/or surgical supplies that are included in the general cost of the procedure, nursing care and/or services that are performed within the scope of daily duties; surgery, procedures(s), and/or supplies that are included in a surgical procedure room rate; and C-codes that are packages and have no separate reimbursement surgery/procedures

and supplies. The Board of Trustees has the sole discretion to determine whether a given line item on a claim is considered Unbundling.

IX. Billing Review.

The Board of Trustees has the authority to refer any claim to a designee of its choosing for the purpose of performing a Billing Review. This review may be used to identify Errors, Excess Charges, Unbundling, Medically Unlikely Edits (MUE), or any other matter that may impact claims adjudication. It is within the Board of Trustees' sole discretion to review and adopt the recommendations of its designee as its own.

Specifically, the Board of Trustees shall not, on a line-item basis (CPT, HRC, HCPCS, etc.) allow a greater reimbursement than billed charges. In addition, revenue codes requiring CPT or HCPCS will be denied when the code is not present on a UB-04 or itemized bill. The Board of Trustees is entitled to rely on all other terms and conditions of this Plan Document, as well as all other nationally recognized and coding edits when performing a Billing Review.

X. *GENERAL LIMITATION AND EXCLUSIONS*

1. Any Errors as defined by this Plan Document.

2. Any Invalid Charge(s) as defined by this Plan Document.

3. Any Unbundled Charges based on this Plan Document.

4. Any Medically Unlikely Edits (MUE) as defined by this Plan Document.

XI. *CLAIMS AND APPEALS PROCEDURES*

In certain instances, the Board of Trustees or its designee, may require a provider to submit the following items for the Plan to adjudicate the claim:

- A copy of the itemized bill.
- Medical records.
- Implant invoices.
- Any other information that may be useful to assist the Plan in adjudicating the claim.