INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL UNION NO. 126

HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

2021

This Plan is not a Grandfathered Plan under the Patient Protection and Affordable Care Act

YOUR BENEFIT PROVIDERS

Medical and Hospitalization

Independence Administrators (Active and Non-Medicare Eligible Disabled and Retirees)
Customer Service: 1-844-864-4352
Website: www.myibxtpabenefits.com

AmeriHealth Administrators (Medicare Eligible Disabled and Retirees)
Customer Service: 1-844-352-1706
Website: www.myahabenefits.com

Teladoc
1-800-835-2362
Website: www.teladoc.com

Amplifon
1-866-442-5527
Website: www.amplifonusa.com/ibew126

Eyelation
1-888-308-4703
Website: weborder.eyelation.com

Compusys - HRA
General Questions 1-877-282-8665
Balance Inquiries 1-888-257-0225

Dental
Delta Dental of Pennsylvania
Group Number: PA 3052
Customer Service: 1-800-932-0783
Web Site: www.deltadentalins.com

Vision
Vision Benefits of America (VBA)
Group Number: 4748
Customer Service: 1-800-432-4966
Web Site: www.visionbenefits.com

Prescription Drugs
Sav-Rx
Group Number: IBEWLU126
Member Services: 1-866-233-4239
Mail Order Program: 1-800-228-3108
Web Site: www.savrx.com

Mental Health/Substance Abuse

ALL TREATMENT MUST BE PRE-CERTIFIED BY CALLING: 1-800-778-2119 Independence Administrators (Active Participants and Non-Medicare Eligible Retirees) or AmeriHealth Administrators (Medicare Eligible Retired Participants) at the numbers above.

Weekly Disability Income (WDI)

Guardian – Plan ID 484168
Members Services: 1-800-268-2525
Web Site: www.guardiananytime.com

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Dear Participant:

This booklet summarizes the benefits, rights and obligations that you, as a Participant, have under the Plan of Benefits of the International Brotherhood of Electrical Workers Local Union No. 126 Health and Welfare Fund (the "Plan" or "Fund"). Your Health and Welfare benefits are a valuable asset. Please take the time to read this Booklet and familiarize yourself with the benefits, eligibility rules, limitations and exclusions, and the important information provided in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Only the entire Board of Trustees is authorized to interpret the Plan's governing documents. No employer or the Union, nor any representative of any employer or the Union, acting in that capacity, is authorized to interpret the Plan's governing documents. No employer or the Union, nor any representative of any employer or the Union, acting in that capacity, can act as an agent for the Board of Trustees. Accordingly, WE RECOMMEND THAT YOU DIRECT ALL QUESTIONS ABOUT THE PLAN AND THIS BOOKLET TO THE FUND OFFICE.

This booklet summarizes the provisions of the Plan in effect as of January 1, 2021. You and your family should read this entire booklet. The Plan may be amended in the future by the Trustees and the Trustees have the right to modify or eliminate benefits. Notice of amendments to the Plan will be provided to you. If you have any questions about amendments to the Plan made by the Board of Trustees after the publication of this booklet, write or call the Fund Office.

The Trustees of your Plan are committed to providing you and your family with not only a comprehensive benefit program, but also an administrative office, which is available to assist and serve you as a Participant of the Plan. If you have any questions regarding eligibility for benefits, please call the Plan Administrator at (**610) 489-1185**. If you have any questions regarding benefits available under the Plan, or the claims processing procedure, please contact Independence Administrators (Active Participants and Retired or Disabled Participants not eligible for Medicare) or AmeriHealth Administrators (Retired or Disabled Participants eligible for Medicare) who are the Contract Claims Administrators at customerservice@ahatpa.com or by calling the toll free number on your Plan ID card.

Please do not hesitate to contact the Union Office whenever necessary.

Sincerely and Fraternally,

THE BOARD OF TRUSTEES

Section I- ***ELIGIBILITY REQUIREMENTS***

Who May be Eligible Under the Plan?

The Plan provides coverage to many different classes of participants: active participants, including apprentices, and their eligible family members, disabled participants and their eligible family members, retired participants and their eligible family members, COBRA participants and extended COBRA participants. There are different requirements for maintaining eligibility under the terms of the Plan for different classes of people, and in some cases, the benefits to which you and your family members are entitled are different.

Although the Trustees intend to continue coverage for each class as described in this summary, they must reserve the right to amend or terminate coverage at any time in accordance with applicable law.

It is important that the Fund Office has a complete and accurate record of the essential information about you and your family regardless of your classification. You must formally notify the Fund Office of the following and provide the specified information:

- You, your spouse's and your eligible dependents' social security numbers
- Addition or change in spouse's health coverage (copy of coordination of benefits form required)
- Adoption or anticipation of adoption (evidence of legal proceedings)
- Birth of a child (copy of birth certificate required)
- Change of address
- Change of beneficiary (copy of a signed beneficiary form required)
- Death of participant or family member (original death certificate required)
- Disability of participant or family member (copy of Social Security disability award)
- Divorce (copy of divorce decree required). If you do not timely notify the Fund Office of your divorce, you will be responsible for all claims incurred relating to your ex-spouse, or if applicable, former Dependents, after the date of the divorce.
- Separation. You must notify the Fund Office if you are legally separated from your spouse and/or separated and living apart from your spouse for at least six months (including a divorce from bed and board).
- Eligibility for Medicare/Medicaid of a participant or family member (copy of Medicare/Medicaid card required)
- Eligibility for other health insurance (copy of coordination of benefit form required)
- Marriage (copy of marriage certificate required)

- Military Orders (copy of Military Orders required)

You are required to contact the Fund Office immediately if any of this information changes so that your benefits, and those of your family, are properly administered. Eligibility determinations are made solely by the Fund Office.

Spouses and dependents who are at least age 18 and who are disqualified from enrolling in their own employer's health plan due to being covered under the Fund, shall no longer be eligible for medical and prescription drug coverage under the Fund.

Who is an Active Participant?

An Active Participant is defined as:

- An individual who is working or actively seeking work in the area of and under the trade jurisdiction of Local Union No. 126 and on whose behalf contributions are required to be made to the Fund pursuant to a collective bargaining agreement due to work in covered employment;
- An individual who is employed by the Union, this Fund, the Local Union No. 126 Retirement Trust Fund or the Local Union No. 126 Occupational Safety, Health and Education Trust Fund;
- An individual on whose behalf contributions are required to be made to the Fund pursuant to a participation agreement.

  Please note that management employees are only eligible to participate as an Active Participant if they are paying (either on their own or through their employer) the required contributions for the Fund under the applicable collective bargaining agreement with such employer and such employee was a member (in good standing) of the Local Union No. 126 immediately prior to moving into a management position.

  An Active Participant includes individuals who continue to participate in the Plan by applying their accumulated dollar bank towards the purchase of Plan coverage. You will *not* be considered an Active Participant and you will not be eligible for coverage if you are not actively working for a contributing employer in a position for which contributions to the Fund are required, or if you are not currently working in such a position, you either fail to register for work under the referral procedure established by the Union and the Association or you refuse available work within the jurisdiction of the Union.

If you are an Active Participant who is eligible for coverage and you are unable to work because of either an occupational or non-occupational disability, you will be credited for eligibility purposes with a sufficient number of Hours of work for each week of the disability up to a maximum of 26 weeks in any 52 week period in order to maintain eligibility. All credits and benefits shall be based on a 7 day week, and the number of Hours credited shall not exceed the minimum number of hours required under the Plan to maintain eligibility.

Except as provided the COBRA section of this booklet, an individual is not eligible to participate in the benefits provided by the Fund if the individual is a sole proprietor, partner, or joint venturer or any other type of self-employed person, even though that individual was previously a Participant.

Who is a Family Member?

A family member is defined as an individual who is:

- Your spouse, provided you are not legally separated from your spouse and/or separated and living apart from your spouse for at least six months (including a divorce from bed and board) The term "spouse" shall mean your legally recognized marital partner and refers only to a person of the opposite sex. The Fund Office will require documentation proving a legal marital relationship. A divorce decree terminates the eligibility of a covered spouse or applicable covered dependent(s), regardless of any appeals therefrom.
- Your biological child, stepchild, adopted child or child placed with you in anticipation of adoption who is under 26 years of age.

  The phrase "child placed with you in anticipation of adoption" refers to a child who you intend to adopt, whether or not the adoption has become final, and who has not attained the age of twenty-six (26) as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have been commenced.
- Your child who is mentally or physically incapable of earning his or her own living and providing his or her own support and who attains the age of 26, provided you submit proof of the child's incapacity no later than January 31st each year and as otherwise required by the Trustees. All children who are to receive benefits in accordance with a Qualified Medical Child Support Order (QMCSO). Even if a QMCSO is contested by you, the Plan will provide benefits to the child until the Plan Administrator is provided with satisfactory written evidence that the Court Order is no longer in effect or until your coverage has terminated, whichever is sooner. The provision of benefits in accordance with a

Qualified Medical Child Support Order shall comply with the requirements of ERISA, and in all other respects, the child will be subject to the requirements set forth above.

Anyone eligible for coverage under this Plan as a Participant is not considered to be a family member.

An individual who qualifies as a dependent under the Trust Fund Agreement may elect, in writing, not to be treated as a Dependent. In the event of such election, the individual will not be allowed to revoke such election and be treated as a Dependent until the later to occur of the next Coverage Quarter beginning after the first anniversary after such election, or the first calendar quarter after the revocation of such election.

A family member shall also include your legally recognized same-sex marital partner, who shall, for purposes of this Summary Plan Description, also be referred to you as your "spouse."

Credit for Working

In general, you will be given credit for working for each Hour for which a contribution is made on your behalf to the Fund. You will be given credit for working only upon the actual receipt by the Fund of contributions required to be contributed by a contributing employer on your behalf. (Please note that special provisions apply to newly organized employees, which are described below.)

In the event that you have not been given credit in a Work Quarter because an employer has not paid the required contributions to the Fund but you maintain your eligibility in the corresponding Coverage Quarter by use of your Dollar Bank, then if the Fund subsequently collects the employer's contribution for that Work Quarter and credits that sum to your Dollar Bank, the Trustees may, in their sole discretion, reimburse the payments you made and/or credit your Dollar Bank with the dollars deducted, if applicable.

Requirement for Initial Eligibility

Each Active Participant who is working or actively seeking work in the area of and under the trade jurisdiction of Local Union No. 126 and on whose behalf contributions are required to be made to the Fund pursuant to a collective bargaining agreement due to work in covered employment (each of whom is considered to be "variable hour employee" under the Patient Protection and Affordable Care Act) not covered by the Plan will become eligible under the Plan on the first day of the Coverage Quarter after having

been given credit for working at least 350 Hours at the Local 126 contribution rate for a Contributing Employer for the pay periods ending in the three month Work Quarter.

If you work 350 hours in the Work Quarter (at the Local 126 contribution rate):	You are eligible for benefits in the following Benefit Quarter:
Jan-Feb-March	**June-July-Aug**
April-May-June	**Sept-Oct-Nov**
July-Aug-Sept	**Dec-Jan-Feb**
Oct-Nov-Dec	**March-April-May**

Please note that only Hours worked within the Local Union No. 126's jurisdiction will count toward your initial eligibility.

Employees of the Union, this Fund, the Local Union No. 126 Retirement Plan or the Local Union No. 126 Occupational Safety, Health and Education Trust Fund (and who is considered to be "full time employee" under the Patient Protection and Affordable Care Act) will become an Active Covered Person under the Plan on the earlier of: (1) the first day of the Coverage Quarter next following a one month orientation period beginning on the employee's date of hire or (2) 90 days after such one month orientation period.

Special Note as to Initial Eligibility for Benefits for Participants from Newly Organized Employers

An individual who is employed by an Employer at the time the Employer first enters into an agreement with the Union which provides for contributions to the Plan on behalf of that individual shall be covered under the Fund on the first day of covered employment with such Contributing Employer. The newly organized employee's initial coverage period will continue until the end of the Coverage Quarter corresponding to the Work Quarter during which he is first employed in covered employment. For example, a newly organized employee whose employer first enters into an agreement with the Union during the January Work Quarter is covered through the May Coverage Quarter (i.e., covered until July 31st), and will be eligible for coverage during the August Coverage Quarter if he works 350 Hours during the April Work Quarter. Once established, the Fund will reduce the participant's dollar bank on a quarterly basis until the Fund is fully reimbursed for the cost of the employee's initial coverage period.

Initial Eligibility through Self-Payment of Contributions

Any Active Participant who, because of the unavailability of work within the jurisdiction of the union has been given credit for working at least 200 Hours but less than 350 Hours for a contributing employer for the Work Quarter, may, for the purpose of establishing his eligibility during the corresponding Coverage Quarter, self-pay into the Fund an amount equal to the difference between:

a) the amount contributed by contributing employers on his/her behalf for the Work Quarter, and
b) an amount equal to the local contribution rate multiplied by 350.

Requirement for Continued Eligibility

You must work at least 350 Hours at the Local 126 contribution rate in Covered Employment during each Work Quarter in order to maintain eligibility in the corresponding Benefit Quarter.

Continued Eligibility through Self-Payment of Contributions

Any Active Participant who, because of the unavailability to work within the jurisdiction of the union, has been given credit for working less than 350 Hours for a contributing employer for the Work Quarter, may, for the purpose of maintaining, but not establishing, his eligibility during the corresponding Coverage Quarter, self-pay into the Fund an amount equal to the difference between:

a) the amount contributed by contributing employers on his/her behalf for the Work Quarter, and
b) an amount equal to the local contribution rate multiplied by 350.

An individual may maintain his/her eligibility under this section for no more than 6 consecutive Coverage Quarters.

Once you have earned eligibility under this plan, other than by self-paying, and then have a qualifying event as described under COBRA, he may, as an alternative to these self-pay provisions, continue his/her coverage on the same basis through COBRA.

Eligibility for Disabled and Retired Participants and their Family Members

Prior to August 1, 2014, any individual who has become permanently disabled or has retired, and who was a Participant in the Fund for 10 Working Quarters during the 5 calendar years immediately preceding the permanent disability or retirement, will remain eligible to participate in the Plan, subject to payment of such monthly contributions as the

Trustees may from time to time determine for health coverage.

Effective August 1, 2014, any individual who has become permanently disabled or has retired, and who was a Participant in the Fund for 60 Working Quarters, provided that 10 of such Working Quarters were during the 5 calendar years immediately preceding the Participant's retirement or permanent disability, will remain eligible to participate in the Plan, subject to payment of such monthly contributions as the Trustees may from time to time determine for health coverage. This paragraph is not applicable to individuals who, as of July 31, 2014, have met the requirements for coverage under the 10/5 Rule in the prior paragraph.

To be eligible for a death benefit and/or vision benefit and dental benefit, the Retiree or Disabled Participant will be required to pay an additional contribution as set from time to time by the Trustees. A Retiree or disabled Participant is not eligible for Weekly Disability Benefits.

An individual who is eligible for Medicare, but who is not covered under Medicare for any reason, including his own failure to apply or pay the applicable premium, shall have his/her benefits paid as set forth below (see "Medicare").

A Retired Participant may elect to enroll his/her spouse in the Fund at any time, subject to payment of such contributions as the Trustees may from time to time determine for health coverage, and provided that, if and when he/she is so eligible, the spouse is enrolled in Medicare. Following a Retired Participant's death, an enrolled spouse may continue participating in the Fund provided he/she was covered under the Fund at the time of the Retired Participant's death, makes timely payments of any required contributions, is enrolled in Medicare at the time of the Retired Participant's death, and does not re-marry.

Medicare

You are a Medicare Primary Participant (*i.e.*, eligible for Medicare as your primary coverage) if: (1) you are a Retired Participant age 65 or older, (2) you are a Family Member of a Retired Participant and you are age 65 or older, or (3) you are a Family Member and you are under age 65 and in receipt of a Social Security Disability Award for twenty-four (24) months. A Medicare Primary Participant is eligible to, and must, enroll in Medicare.

Medicare provides benefits as follows:

- **Part A –** inpatient hospital services, post-hospital extended care services, home health services and hospice care. Medicare Part A is free.
- **Part B –** doctors' services, outpatient hospital and a number of other health care services. Medicare Part B is voluntary and requires monthly premium payments.

*If you are A Medicare Primary Participant, this Plan will act as a secondary plan for your medical benefits so **you should enroll in both Medicare Parts A and B when you become eligible**. If either you or your spouse is a Medicare Primary Participant, whether or not you enroll, this Plan will pay as if you or your spouse are enrolled in Medicare Parts A and B. This will result in substantial out of pocket expense for you if you do not enroll. Stated simply, you will be responsible for Medicare's portion of your and your spouse's health care costs. As a result, you should contact Medicare by calling 1-800-MEDICARE prior to becoming eligible for Medicare.*

- **Part D –** prescription drugs.

You will be enrolled in Medicare Part D automatically by the Fund Office when you become eligible. For more information about retiree prescription drug coverage under this Plan, please see the Prescription Drug section of this SPD.

Cumulative Accounts (Dollar Banks)

The Plan allows Participants to accumulate dollars in certain situations for later use, such as when you are out-of-work or you are credited with less than 350 Hours (at the Local 126 contribution rate) in a Work Quarter. These Cumulative Accounts are also known as Dollar Banks. If you have been given credit for working more than 400 Hours (at the Local 126 contribution rate) in any Work Quarter, your Dollar Bank will be credited with the dollar value of those excess hours. The dollar amount credited to your Dollar Bank is limited to 3,000 Hours multiplied by the current Local 126 contribution rate.

If you have been given credit for working less than 350 Hours (at the Local 126 contribution rate) in a Work Quarter, you will remain eligible for coverage in the corresponding Coverage Quarter provided you have a sufficient number of dollars credited to your Dollar Bank so as to make up the difference between the amount actually contributed on account of the hours worked during the Work Quarter and a total of 350 Hours times the current Local 126 contribution rate. The Dollar Bank is charged with and decreased by the amount so used.

Disabled Participants and Retired Participants having a Dollar Bank may elect coverage of different benefits (and, if they make no election, are automatically covered for medical, prescription drug, life insurance, vision and dental benefits) for successive Coverage Quarters so long as the dollar value of the Dollar Bank is sufficient to pay for that coverage. Once a retired and/or disabled participant becomes eligible for Medicare, remaining Dollar Bank can only be used for supplemental coverage to Medicare.

Dependents of deceased Participants having a Dollar Bank are automatically covered for medical, prescription drug, vision and dental benefits for successive Coverage Quarters so long as the dollar value of the Dollar Bank is sufficient to pay for that coverage. Once the spouse of a deceased Retired Participant who is not eligible for Medicare at the time of the Retired Participant's death becomes eligible for Medicare, any remaining Dollar Bank can only be used for supplemental coverage to Medicare, and the spouse's coverage under the Fund shall cease once the Dollar Bank is exhausted.

If the amount in your Dollar Bank is not sufficient to satisfy the required payment, you may, for the purpose of maintaining eligibility, pay into the Fund:

a. For active participants, an amount equal to *350 Hours at the Local 126 contribution rate less* any amount actually contributed on account of the Hours worked during the Work Quarter and less any balance in your Dollar Bank.

b. For Disabled Participants, Retired Participants and Dependents of deceased Participants the required payment to maintain eligibility for the benefits elected less any balance in your Dollar Bank.

In the event that a Participant, disabled Participant, retired Participant, or family member of a deceased Participant does not make such a payment, the balance in the Dollar Bank shall be forfeited.

A Dollar Bank must be used for each consecutive Coverage Quarter provided there is a balance in the Dollar Bank.

Notwithstanding any other provision in the Plan or in this booklet, if a Participant who has a Dollar Bank is a member of a bargaining unit, the employer for which (a "Withdrawing Employer") ceases to make contributions to this Fund due to the bargaining unit members' failure to agree to an increase in the contribution rate or for any other reason, that Participant will forfeit the balance in his Dollar Bank, effective as of the last Working Quarter in which the Participant is employed for such Withdrawing Employer and for which contributions are made to this Fund (the "Withdrawal Quarter"). In the event the Participant is given credit for Hours worked within twelve (12) months of the end of the Withdrawal Quarter, the Dollar Bank Balance will be restored to such Participant's Dollar Bank.

A Participant may not use the contributions credited to his Dollar Bank to continue coverage if the Participant is or was eligible to obtain health insurance through employment with any employer that does not contribute to the Fund (either directly or through a Reciprocal Agreement). For each Work Quarter during which a Participant is not eligible to use the contributions credited to his Dollar Bank under this provision, the Participant's Dollar Bank will nonetheless be charged and decreased by 350 Hours. The

Trustees will adopt rules and regulations governing the obligation of a Participant to notify the Fund of such other employment and to require a Participant to provide information concerning other employment. A Participant who has lost coverage as a result of employment with a Withdrawing Employer may use any remaining contributions credited to the Participant's Dollar Bank to re-establish coverage as of the next Coverage Quarter if the Participant works at least one (1) hour in the Work Quarter in employment for which contributions to the Fund are due. If the balance in such a Participant's Dollar Bank is not sufficient to make up the difference between the actual contributions credited to the Participant during the Work Quarter and 350 Hours (at the Local 126 contribution rate), the Participant may pay into the Fund an amount equal to the difference between the actual contributions credited and the balance in the Participant's Dollar Bank and 350 Hours (at the Local 126 contribution rate).

The Dependents of a Participant shall have no interest in or right to utilize the dollars in a Participant's Dollar Bank except as provided above.

Reciprocity Agreements

The Fund participates in the Electrical Industry Health and Welfare Reciprocal Agreement.

A member of IBEW Local Union No. 126 who is employed in the jurisdiction of another IBEW local union which provides for contributions to a trust fund for the purpose of providing health and welfare benefits (a "Temporary Fund") can have the contributions transferred to the Fund.

In order to re-establish or continue eligibility, and to have contributions transferred from a Temporary Fund to the Fund, you **must** register with the IBEW/NECA Electrical Reciprocal Transfer System ("ERTS") and designate this Fund as your "Home Fund". Please contact IBEW Local Union No. 126 to register under ERTS. For further information about reciprocity and ERTS, please contact the Fund Office.

The amount of contributions transferred from the Temporary Fund to the Fund is at the **lesser** of (1) the Fund's (*i.e.,* the Local 126) contribution rate or (2) the Temporary Fund's contribution rate. When you are employed in the jurisdiction of another IBEW local union, the number of Hours required to maintain eligibility depends on the contribution rate of that jurisdiction. For example, if you work in a jurisdiction whose contribution rate is only 50% of the Local 126 contribution rate, you will need to earn 700 Hours in a Work Quarter to maintain eligibility under this Fund while working in that jurisdiction.

Example #1 A participant works in the jurisdiction of a Temporary Fund whose contribution rate is $5.50 per hour. The Fund's contribution rate is $11.00 per hour. The participant works 350 hours in a month. The participant will have transferred to the

Fund the sum of $1,925 (350 hours x $5.50 per hour). In order to maintain eligibility, a participant must work sufficient hours so that the total of $3850 (which is 350 Hours x the Local 126 contribution rate of $11.00 per hour) is transferred to the Fund. In this case, a participant would need to work 700 hours (700 hours x $5.50 per hour equals $3,850).

Example #2 same facts as Example #1 except the Temporary Fund's contribution rate is $12.00 per hour. The participant will have transferred to the Fund the sum of $3850 (350 hours x $11.00 per hour).

In the event that a Participant does not have sufficient funds transferred from a Temporary Fund to the Fund to result in coverage, the Participant can make up the difference by drawing money from his Dollar Bank or paying the difference.

Termination of Benefits

A Participant's eligibility for benefits will automatically end at the earliest of the following dates:

- as of the last day of the month preceding a Coverage Quarter in which the Participant is not eligible for benefits and is not eligible for any other extension of benefits and has COBRA entitlement, but fails to make the required Self-Payment by the date specified in his COBRA Entitlement Notice. For example, you earn sufficient hours during the month of January, February and March to make you eligible for May, June and July. However, you did not have sufficient hours during April, May and June to maintain your eligibility through August, September and October; or,
- the date the Participant ceases to qualify for COBRA or Self-Pay; or,
- the date the Plan is terminated; or,
- the date specified in the written notice from the Trustees to the Employers and the Union stating that the Benefit Programs for any Employer shall terminate on such date.

A Spouse's eligibility for benefits will automatically terminate upon the occurrence of the following:

A spouse is no longer eligible for coverage under the Fund if he/she has been separated and living apart from the participant for more than six (6) months. In the event that a participant and his/her spouse have been separated and living apart for more than six (6) months, the participant is required to notify the Fund Office. Pursuant to rules adopted by the Trustees, in order to determine continued spousal eligibility under this provision, effective January 1, 2016 you must notify the Fund Office by:

- Completing an affidavit that you and your spouse have been separated and living apart for six (6) months, and
- Providing sufficient documentation substantiating that you and your spouse have been separated and living apart for six (6) months. If, at the time you complete your affidavit, you do not have access to, or possession of, such documentation, you must provide it to the Fund Office as soon as practicable after you are able to gain access to, or possession of, such documentation. The Fund Office reserves the right to determine the acceptable forms of documentation.

A Dependent's eligibility for benefits will automatically terminate upon the occurrence of the following:

- when the Participant's eligibility terminates; or,
- when a Dependent ceases to be a "Dependent" as defined herein; or,
- the date the Dependent ceases to qualify for COBRA or,

Your Rights During Military Service

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") governs the rights of employees to the benefits offered by the Plan during and upon returning from military service for the United States or other organizations with U.S. support.

Coverage During Military Leave

If military leave is less than thirty-one (31) days, you are not required to pay for coverage. The Plan will still provide coverage for thirty-one (31) days without charge.

If you are inducted into or enlist in the Armed Forces of the United States (other than Reserve component) or enter upon active duty (other than for the purposes of determining physical fitness and other than for training) in the Armed Forces of the United States, then the Participant shall be credited for eligibility purposes first by drawing down the Participant's Dollar Bank, and when exhausted the Plan shall credit a sufficient number of Hours for each week of such service up to a maximum of 24 months in order to maintain eligibility. All credits and benefits shall be based on a 7 day week, and the number of Hours credited shall not exceed the minimum number of hours required under the Plan to maintain eligibility. Credit will only be provided if you timely return to employment (whether with a contributing employer or by applying for work with the Local Union No. 126 in accordance with its procedures) within the timeframe permitted under USERRA.

If your military service extends over thirty-one (31) days, when the coverage period above ends, you and/or your Family Members may elect to continue health coverage under USERRA. You may elect continued coverage under USERRA by making self-payment (and, to the extent available, using your Dollar Bank) under COBRA-like terms (i.e., you must pay 102% of the full premium). The maximum length of required continuation coverage is the lesser of:

a) twenty-four months beginning on the day that the military service leave commences, or

b) a period ending on the day after the employee fails to return to employment within the time prescribed by USERRA.

Return to Work from Military Leave

If you receive a certificate of satisfactory completion of military service, and you return to work with one of the participating employers within the jurisdiction of the Union (the "Reinstatement Date") within thirty (30) days after you are relieved from service, you and the your Family Members will be provided with coverage for the remainder of the Coverage Quarter in which the Reinstatement Date occurs and you may purchase coverage (using your Dollar Bank if available, otherwise through self-pay) for the immediately succeeding Coverage Quarter at the rates provided for by COBRA.

Section II – MEDICAL BENEFITS

The Schedule of Benefits lists benefits, maximums, and allowances that your Plan provides for each enrolled person. The coinsurance rates shown in this table are based on your Plan's allowance for each service. *Read the section on Network Doctors and Hospitals carefully* to see how you can save money by receiving your care from network providers.

Remember... Your Plan has Patient Care Management requirements for all inpatient admissions. It may also require precertification for certain outpatient procedures. If you do not comply with these provisions, your Plan may reduce the benefits for those services or may not cover them at all. *Read the sections on Patient Care Management carefully.*

Benefits for Medicare Primary Participants
Medical benefits change for Disabled and/or Retired Participants and their dependents when they become eligible for Medicare. The Medical benefits are the same as described in this document except:

(1) benefits will be reduced by any amount paid or any amount that would have been paid under Medicare Parts A & B;
(2) eligible Medicare allowable balances will be paid at 100%, with no deductible (in or out of network). There is no calendar year deductible.

SCHEDULE OF BENEFITS

	If the Covered Person uses a Preferred Provider, the Plan will pay:	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
Annual Maximum	Unlimited	Unlimited
Calendar Year Deductible • Per Person	 $0	 $250 ($750 family limit)
Coinsurance — This table shows the percentage of the Plan allowance your Plan pays for different covered services. *All payments are based on your Plan's allowance* for the service performed. Your Plan begins to pay for eligible expenses, at the rate shown in the table, *after you meet your calendar year deductible (if applicable)*.		
Maximum out of pocket expenses you could pay in a calendar year (includes deductibles, copays, and coinsurance) • Per person • Per family	 $1,750 $3,500	 $2,000 $4,000

Inpatient hospital (other than maternity)	80%	80% after deductible
Inpatient hospital (maternity)	$500 copay then 100%	80% after deductible
Outpatient surgery	80%	80% after deductible
Transplants	80%	80% after deductible
Emergency Room Treatment	$100 copay then 100% (copay waived if admitted) Non-emergency treatment covered at 80%	
Urgent Care Center or "Minute Clinic"	100% (no copay)	80% after deductible
Teladoc	100% (no copay)	N/A
Skilled Nursing	80%	80% after deductible
Physician office visits	$10 copay, then 100%	80% after deductible
Specialist Office Visits	$25 copay, then 100%	80% after deductible
Diagnostic Outpatient Lab & X-ray	80%	80% after deductible
Preadmission Testing	100%	80% after deductible
Second Surgical Opinion	$25 copay, then 100%	80% after deductible
Ambulance	80%	80% after deductible
Therapy Services (cardiac, physical, respiratory)	$25 copay, then 100%	80% after deductible
Durable Medical Equipment and Prosthetic Appliances	80%	80% after deductible
Chiropractic Services (20 visits per calendar year limit)	100% (no copay)	80% after deductible
Home Health Care	80%	80% after deductible
Hospice	100%	80% after deductible
Allergy Testing	80%	80% after deductible
Allergy Shots (no office visit billed)	80%	80% after deductible
Preventive Care (age and gender appropriate and subject to frequency limitations):	100% (no copay)	80% after deductible
Mental Health Inpatient Outpatient	 80% $10 copay, then 100%	 80% after deductible 80% after deductible
Alcohol & Drug Abuse Inpatient Outpatient Substance Abuse Evaluation with a Department of Transportation Approved Substance Abuse Professional (SAP)	 80% $10 copay, then 100% $10 copay, then 100% (limited to once per lifetime)	 80% after deductible 80% after deductible N/A

COVERED MEDICAL CHARGES

Subject to "Exceptions and Exclusions" which follows, covered medical charges include the charges described below that are Medically Necessary and Incurred while covered under the Plan. (A charge is deemed Incurred as of the date of the service, treatment, or purchase giving rise to the charge.)

FACILITY SERVICES

1. Room and Board
   a. Semiprivate Accommodations — Includes special diets and general nursing care.
   b. Private Accommodations — In a Facility having primarily private accommodations, the Covered Person is entitled to either the Facility's most common semiprivate room charge, if any, or an allowance agreed upon by Independence Administrators and the Facility. The difference between the Plan's allowance and the Facility's charge is the Covered Person's responsibility.

      Private accommodations will be covered in full if Medically Necessary.
   c. Special Care Accommodations — Special care accommodations include intensive care, cardiac care, and burn treatment or such other special care accommodations approved by Independence Administrators.

2. Ancillary Services — Includes those services and Supplies that are regularly provided and billed by a Facility, such as:
   a. use of operating, delivery, and treatment rooms and equipment;
   b. administration of blood and blood processing including blood and blood plasma to the extent that it is not donated or otherwise replaced;
   c. oxygen and other gases and their administration;
   d. prescribed drugs and medications that are dispensed for use in the Facility;
   e. anesthesia and the administration of anesthetics when performed by an employee of the Facility;
   f. medical and surgical dressings, Supplies, casts, and splints; and
   g. diagnostic services.

   When counting the number of days of care furnished to an Inpatient, either the day of admission or the day of discharge will be counted, but not both.

   Charges Incurred after a Facility's regular discharge hour are not covered provided the Covered Person has been advised by his attending Professional Provider prior to such discharge that further confinement is not required.

MEDICAL CARE

Medical care and Facility services rendered to an Inpatient by the Doctor in charge of the case for a condition not related to Surgery or pregnancy, except as specifically provided. Such care includes Inpatient intensive medical care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period.

1. Concurrent Care

   Medical care rendered to an Inpatient by a Professional Provider who is not in charge of the case, but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations, or medical care routinely performed in the preoperative or postoperative or prenatal or postnatal periods, or medical visits required by a Facility's rules and regulations.

2. Consultation Services

   Consultation services rendered to an Inpatient by a Professional Provider at the request of the attending Professional Provider. Consultation services do not include staff consultations that are required by a Facility's rules and regulations.

   Benefits are provided for one consultation per consultant during each period of confinement.

REHABILITATION HOSPITAL CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Rehabilitation Hospital.

No benefits are provided for services in a Rehabilitation Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment; or
2. when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SKILLED NURSING FACILITY CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Skilled Nursing Facility as described in the Schedule of Benefits.

Benefits for medical care in a Skilled Nursing Facility are provided for up to two visits during the first week of confinement and one visit a week for each consecutive week of confinement thereafter.

No benefits are provided for services in a Skilled Nursing Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment;

   when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SURGICAL SERVICES

Surgery for the treatment of Illness or Accidental Injury.

Covered Surgery includes sterilization procedures regardless of their Medical Necessity.

If more than one surgical procedure is performed by the same Professional Provider during the same operative session, benefits will be provided for the highest paying procedure plus an allowance of 50% of eligible charges for the additional procedure(s), plus any additional payment beyond the 50% that is deemed appropriate due to the nature or circumstances of the procedure. No additional allowance will be provided for those surgical procedures determined by Independence Administrators to be incidental to or an integral part of another surgical procedure performed during the same operative session.

1. Preoperative and Postoperative Medical Care

   The payment allowance for Surgery includes related preoperative and postoperative care rendered by the surgeon within the timeframe based on the surgical procedure.

2. Maternity Delivery

   The payment for maternity delivery includes prenatal and postpartum care normally provided by a Doctor for the care and management of pregnancy.

3. Surgical Assistance

   Services rendered by an assistant surgeon who actively assists the operating surgeons in the performance of Surgery.

   The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

4. Anesthesia

   Anesthesia and the administration of anesthetics in connection with the performance of covered medical services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon, or attending Professional Provider.

5. Second Surgical Opinion Consultation

   Consultation services rendered by a surgeon or specialist to determine the Medical Necessity of an Elective Surgery. Such services must be performed and billed by a surgeon or specialist who is not in association with the one who initially recommended the Surgery.

   Benefits are provided for one additional consultation, as a third opinion, in cases where the second opinion disagrees with the first recommendation. In such instances, benefits will be provided for a maximum of two consultations, but limited to one consultation per consultant.

6. Transplant Services

   If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

   a. When both the donor and recipient are covered by the Plan, each is entitled to the benefits of the Plan.

   b. When only the recipient is covered by the Plan, both the donor and recipient are entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under the Plan.

   c. When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program available to the recipient. No benefits are provided under the Plan to the non-Covered Person transplant recipient.

   d. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and procurement are covered up to the Covered Person recipient's Plan limit.

PRE-ADMISSION TESTING

Diagnostic tests and studies performed on an Outpatient basis prior to Elective Surgery. Benefits are provided for preadmission testing if:

1. the Covered Person was scheduled for Surgery prior to the testing;
2. the Surgery is not delayed beyond the 14 day period immediately following the testing; and
3. the Surgery to which the testing is related is covered by the Plan.

EMERGENCY ACCIDENT TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of an Emergency Accident, as defined.

EMERGENCY MEDICAL TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of a condition with acute symptoms of sufficient severity that the absence of immediate medical attention could:

1. permanently place the Covered Person's health in jeopardy;
2. cause other serious medical consequences;
3. cause serious impairment to bodily functions; or
4. cause serious and permanent dysfunction of any bodily organ or part.

Should any dispute arise as to whether an emergency condition existed, the determination by Independence Administrators will be final.

HOME VISITS, OFFICE VISITS, AND OTHER OUTPATIENT VISITS

Medical visits and consultation services for the examination, diagnosis, and treatment of a condition not related to Surgery, or pregnancy, except as specifically provided.

1. Well Child Care and Immunizations

   Well child care including routine physical examinations and immunizations. Benefits are provided for these services as prescribed by the American Pediatric Association. Immunizations as recommended by the Department of Health.

   Well Child Care and Immunizations are subject to a maximum described in the Schedule of Benefits.

2. Routine Physical Examinations

   Examinations including a complete medical history.

   Benefits are provided for these services as prescribed by the American Medical Association. Services provided under a Vision Care program are not covered.

   Routine Physical Examinations are subject to the limits described in the Schedule of Benefits.

DIAGNOSTIC SERVICES

The following procedures when ordered by a Professional Provider to determine a definite condition because of specific symptoms:

1. diagnostic X-ray consisting of radiology, ultrasound, and other diagnostic X-ray procedures.
2. diagnostic laboratory and pathology tests;
3. diagnostic medical procedures consisting of EKG, EEG, and other diagnostic medical procedures; and
4. allergy testing consisting of percutaneous, intra-cutaneous, and patch tests.

THERAPY SERVICES

The following Therapy Services:

1. Radiation Therapy, including the cost of radioactive materials;
2. Chemotherapy by intravenous, intra-arterial, or intra-cavity injection infusion or perfusion, subcutaneous and intramuscular routes. Oral chemotherapy, including its administration, is also covered. The cost if listed as approved or indicated for the diagnosis under treatment by one or more of the following: FDA, NCCN, NIH, NCI. Notwithstanding experimental and investigational use of chemotherapy agents is not covered. All chemotherapy is subject to medical necessity review as antineoplastic agents is covered, provided they are administered as described in this paragraph;
3. Dialysis Treatment;
4. Physical Therapy;
5. Cardiac Rehabilitation;
6. Any other therapy services Independence Administrators determines necessary to treat Accidental Injury or Illness.

HOME HEALTH CARE SERVICES

The following services, as described in the Schedule of Benefits, when provided to an essentially homebound Covered Person by a Home Health Care Agency:

1. Skilled Nursing Care; and
2. Therapy Services;
3. Medical Social Work;
4. Nutritional Services
5. Health services furnished by a home health aide;
6. Medical appliances;
7. Medical equipment;
8. Special meals;
9. Diagnostic or therapeutic services, including surgical services furnished;
    a. In an outpatient department of a Hospital;
    b. In a Physician's office; or
    c. At any other licensed health care facility.

Benefits are also provided for certain other medical services when furnished along with a primary service. Such other services include prescription drugs, diagnostic services, Supplies, and other Medically Necessary services.

No benefits are provided for services in connection with:

1. Custodial Care, food, housing, homemaker services, home delivered meals, and supplementary dietary assistance;
2. services provided by a member of the Covered Person's Immediate Family;
3. patient transportation, including Ambulance services;
4. visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional social services;
5. services provided to Covered Persons who are not essentially home bound for medical reasons; or
6. visits solely for the purpose of assessing the Covered Person's condition and determining whether or not the Covered Person requires and qualifies for home health care services.

HOSPICE SERVICES

Hospice benefits, as described in the Schedule of Benefits, are provided when the Covered Person's attending Doctor certifies that the Covered Person has a terminal Illness with a medical prognosis of six months or less to live.

Hospice benefits are provided for the following services when rendered by a Hospice or under arrangements made by a Hospice in accordance with a Hospice care program and approved by Independence Administrators.

1. Medical care by a Doctor affiliated with the Hospice care program;
2. Nursing care by an R.N., or L.P.N., or home health aide;
3. Medical social services;
4. Therapy services except for dialysis treatments;
5. Dietary services;
6. Laboratory services;
7. Prescribed drugs and medicines;
8. Ambulance services when Medically Necessary to transport the Covered Person to and from the nearest Inpatient Hospice Facility;
9. The following medical services, Supplies, and equipment:
    a. oxygen, including the rental of oxygen equipment;
    b. artificial limbs or other prosthetic devices, but not including replacement;
    c. rental of Durable Medical Equipment;
10. Inpatient Hospice care when needed to control pain and other symptoms associated with the terminal Illness, but only if the Covered Person's attending Doctor certifies that it is Medically Necessary for the care to be provided on an Inpatient basis rather than in a home setting or on an Outpatient basis;
11. Inpatient respite care in a Hospice for up to five consecutive days. Benefits for respite care are provided for up to ten days during each benefit period.

Special Exclusions and Limitations

1. The Hospice care program must deliver Hospice care in accordance with a treatment plan approved by and periodically reviewed by Independence Administrators.

2. No Hospice care benefits will be provided for:
    a. Medical care rendered by the Covered Person's private Doctor;
    b. Volunteers who do not regularly charge for services;
    c. Pastoral services;
    d. Homemaker services;
    e. Food or home delivered meals;
    f. Legal or financial services or counseling;
    g. Curative treatment or services;
    h. Bereavement counseling.

PRIVATE DUTY NURSING SERVICES

The following services, as described in the Schedule of Benefits, .when provided by an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) and ordered by a Doctor. **Prior authorization of services is required.**

Home Services

Nursing services that Independence Administrators determines require the skills of an R.N. or L.P.N. No benefits are provided for the services of a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family.

AMBULANCE SERVICES

Ambulance service by an authorized agency or a Facility providing local transportation of a sick or injured Covered Person:

1. from the site of injury or medical emergency to the nearest Facility; or
2. from the first Facility to the nearest Facility that can provide services Medically Necessary for the treatment of the Covered Person's condition, but only if the services necessary to treat the condition are not available at the first Facility.

Benefits are provided for air Ambulance transportation only if Independence Administrators determines that the Covered Person's condition, and the type of service required for the treatment of the Covered Person's condition, and the type of Facility required to treat the Covered Person's condition justify the use of air Ambulance instead of another means of transport.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC APPLIANCES

1. Durable Medical Equipment

   The rental or purchase of Durable Medical Equipment when prescribed by a Doctor and required for therapeutic use.

   a. Rental — Benefits are provided for rental fees up to an amount that equals, but does not exceed, the purchase price of the equipment.

   b. Purchase — Benefits may be provided for the purchase of Durable Medical Equipment at the option of the Plan.

   If a Claim is filed for equipment containing features of an aesthetic nature or features of a medical nature that are not required by the Covered Person's condition or if there exists a reasonable or feasible and medically appropriate alternative piece of equipment that is less costly than the equipment furnished, the benefit provided is based on the charge for the equipment that meets the Covered Person's medical needs. **Payments for the purchase or rental of Durable Medical Equipment in excess of $500 requires preauthorization by Independence Administrators by calling Independence Administrators' Patient Care Management Department at the number listed on your identification (ID) card.**

2. Prosthetic Appliances

   The first purchase and fitting of artificial limbs, eyes, and other prosthetic appliances that replace all or part of an absent or inoperative or malfunctioning body organ but only if required for the replacement of natural parts of the body lost or becoming inoperative while covered by the Plan (excluding dental appliances).

3. Replacement and Modification

   Benefits are provided for the replacement or modification of Durable Medical Equipment, orthotics, and prosthetic appliances when Medically Necessary due to a change in the Covered Person's physical condition. Benefits for the replacement of such items are provided to the extent that the cost of the purchase is less expensive than the modification. In no event will the Plan pay for contact lenses other than the initial pair of contact lenses following cataract surgery.

4. Diabetic Education

5. Orthotics, provided they are an integral part of a leg brace and the cost is included in the orthotist's charges, including the initial purchase, fitting and repair of orthotic appliance that are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or illness.

DENTAL SERVICES ELIGIBLE UNDER MEDICAL PLAN

1. Dental treatment performed within six months following Accidental Injury to sound natural teeth. Accidental Injury does not include injuries that result from biting or chewing.

   Oral Surgery performed for the removal of impacted teeth partially or totally covered by bone.

ROUTINE NEWBORN CARE

Professional visits to examine the newborn while an Inpatient in a Hospital or Birthing Center. Facility charges for ordinary nursery care of the newborn as well as routine newborn circumcisions are also covered.

MENTAL ILLNESS BENEFITS

Treatment of Mental Illness is eligible anywhere when performed by a Professional Provider as follows:

1. Psychiatric Visits
2. Electro-Convulsive Therapy
3. Individual Psychotherapy
4. Group Psychotherapy
5. Psychological Testing

Facility Services for Mental Illness

1. Inpatient Facility Services

   Facility services provided for Inpatient treatment of Mental Illness by a Facility.

2. Partial Hospitalization

   Treatment of Mental Illness in a planned therapeutic program when such services are rendered during the day only or during the night only.

3. Outpatient Mental Illness Services

   Facility services and supplies provided to an Outpatient by a Facility.

SUBSTANCE ABUSE BENEFITS

1. Inpatient Detoxification Services

   Benefits are payable for a detoxification program provided either in a Hospital or in a licensed Substance Abuse Treatment Facility.

   Room and board

   a. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services

   b. Diagnostic X-ray

   c. Psychiatric, psychological, and medical laboratory testing

   d. Drugs, medicine, equipment, and Supplies

2. Inpatient Rehabilitation Services

   Benefits are payable for Inpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

   a. Room and board

   b. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services

   c. Rehabilitation therapy and counseling

   d. Psychiatric, psychological, and medical laboratory testing

   e. Drugs, medicine, equipment, and Supplies

3. Outpatient Rehabilitation Services

   Benefits are payable for Outpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

   a. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services;

   b. rehabilitation therapy and counseling;

   c. psychiatric, psychological, and medical laboratory testing; and

d. drugs, medicine, equipment, and Supplies.

ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS

Benefits are provided for Routine Costs Associated with a Qualifying Clinical Trial under the health benefit plan. The definitions of routine costs, experimental and investigative are defined in the DEFINITIONS section of this booklet. To ensure coverage, the Plan must be notified in advance of the Covered Person's participation in a Qualifying Clinical Trial.

CHILD IMMUNIZATION COVERAGE

Coverage will be provided for those child immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with standards of the Advisory Committee on Immunization Practices of the Center of Disease Control, U.S. Department of Health and Human Services. Benefits will be exempt from deductibles or dollar limits.

ANNUAL GYNECOLOGICAL EXAMINATION AND ROUTINE PAP SMEARS

- Annual gynecological examination, including a pelvic examination and clinical breast examination; and
- Routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

These gynecological examination/pap smear benefits are exempt from any deductible or dollar limit provisions in the contract. However, they may be subject to any copayment or coinsurance amounts applicable to your group health plan.

COLORECTAL CANCER SCREENING COVERAGE

Coverage for colorectal cancer screening may be subject to annual deductibles, coinsurance, and copayment requirements applicable to your group health plan.

Symptomatic individuals;

Colonoscopy
Sigmoidoscopy
Colorectal Screening Tests (any combination thereof a determined by the treating Physician)

Non-symptomatic individuals covered over age 50;

Annual Fecal Occult Blood Test
Sigmoidoscopy – a screening barium enema test once every five years
Colonoscopy once every 10 years
Colon Cancer test at least once every 5 years

Non-symptomatic coverage for individuals at high or increased risk of colorectal cancer under age 50;

Colonoscopy
Any combination of colorectal cancer screening tests.

APPLIED BEHAVIORAL ANALYSIS (ABA) THERAPY

Children and adolescents under age 21 with Autism Spectrum Disorder (ASD) are eligible for medically necessary applied behavioral analysis (ABA) therapy. The benefit for ABA therapy is limited to $30,000 per calendar year (limited to $10,000 in calendar year 2019). Services must be identified in a treatment plan developed by a licensed physician or licensed psychologist. Services must be prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner. Services must be provided by an ASD service provider or a person, entity or group that works under the direction of an ASD service provider.

PAYMENT OF COVERED MEDICAL CHARGES

1. The Calendar Year Deductible is as shown in the Schedule of Benefits. A Covered Person must Incur covered medical charges of at least this amount within a calendar year before any benefits are payable during that year, unless otherwise stated in the Schedule of Benefits.

   Any covered medical charges Incurred by a Covered Person during the last 3 months of a calendar year which are applied towards the Calendar Year Deductible for that year will also be applied towards the Calendar Year Deductible for the next calendar year.

   A Covered Person must satisfy the individual deductible amount only once during a calendar year. However, after the Covered Persons in a family unit have satisfied the family deductible amount during a calendar year, benefits will be payable for covered medical charges incurred for all Covered Persons in a Family Unit for the remainder of that calendar year. Please refer to the Schedule of Benefits for individual and family deductible information.

   If two or more Covered Persons in a Family Unit are injured in the same accident, only one individual deductible amount will be applied for all family members for covered medical charges Incurred as a result of the accident.

2. When a Covered Person is confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, benefits payable will be determined by the condition primarily being treated. Determination will be made by Independence Administrators based on the Covered Person's medical history and will be conclusive.

3. In counting the number of days of medical care furnished to a Covered Person while confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, either the day of admission or the day of discharge will be counted, but not both.
4. No benefits will be payable under the Plan for charges Incurred after the Hospital's regular discharge hour, provided the Covered Person has been advised by his attending Doctor prior to such discharge that further confinement is not required.
5. Pregnancy benefits will be provided under the same conditions and limitations as any other Illness.

   This Plan does not restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than the following:

   a. 48 hours following a normal vaginal delivery or
   b. 96 hours following a caesarean section.

This Plan does not require that a Provider obtain authorization from the Plan for prescribing a length of stay that does not exceed these periods.

THE PREFERRED PROVIDER NETWORK

Your PPO Network Plan is a program, which allows you to maximize your health care benefits by utilizing the PPO Network, which is comprised of Providers that have a contractual arrangement with Independence Administrators and BlueCard PPO providers. These Providers are called "Preferred Providers." You may think of them as "in-network" providers. Preferred Providers are doctors, hospitals and other health care professionals and institutions that are part of the PPO Network, which is designed to provide access to care through a selected managed network of providers. Services by Preferred Providers are delivered through a selected, managed network of providers designed to provide quality care. The PPO Network includes hospitals, primary care physicians and specialists, and a wide range of ancillary providers, including suppliers of Durable Medical Equipment, Hospice and Home Health agencies, Skilled Nursing Facilities, free standing dialysis facilities and Ambulatory Surgical Centers.

When you receive health care through a Provider that is a member of the PPO Network, you incur lower out-of-pocket expenses and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses, and the amount of your expenses could be substantial. You may have to reach a deductible before receiving benefits, and you may be required to file a claim form.

To locate a National BlueCard PPO network provider go to www.IBXTPA.com or call 1-800-810-BLUE (2583). Independence Administrators covers only care that is Medically Necessary. Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in short procedure units and care in a hospital outpatient department.

Some of the services you receive through this Plan must be pre-certified before you receive them, to determine whether they are Medically Necessary. Failure to pre-certify services to be provided by a Non-Preferred Provider, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews the Medical Necessity of certain procedures/admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective. Precertification also helps determine the most appropriate setting for certain services. Innovations in health care enable doctors to provide services, once provided exclusively in an inpatient setting, in many different settings – such as an outpatient department of a hospital or a doctor's office.

When you seek medical treatment that requires Precertification, you are not responsible for obtaining the Precertification if treatment is provided by a Preferred Provider, i.e., a Provider in the PPO Network that has a contractual arrangement with Independence Administrators. In addition, if the Preferred Provider fails to obtain a required Precertification of services, you will not be responsible for any associated financial penalties assessed by the Plan as a result. If the request for Precertification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State your willingness to assume financial liability.

When you seek treatment from a Non-Preferred Provider or a BlueCard Provider, you are responsible for initiating the Precertification process. You or your provider should call the Precertification number listed on the back of your Identification Card, and give your name, facility's name, diagnosis, and procedure or reason for admission. Failure to pre-certify required services will result in a reduction of benefits payable to you.

For more Information regarding precertification please see the Patient Care Management section of this Booklet

REGARDING USE OF NON-PREFERRED PROVIDERS

While the PPO has an extensive network, it may not contain every Provider that you elect to see. To receive the maximum benefits available under this program, you must obtain Covered Services from Preferred Providers that participate in the PPO Network or is a Blue Card PPO Provider.

In addition, your PPO program allows you to obtain Covered Services from Non-Preferred Providers. If you use a Non-Preferred Provider you will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles and Coinsurance. The Non-Preferred Provider may charge you for the balance of the Provider's bill. This is true whether you use a Non-Preferred Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a Provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense

The Trustees reserve the right (in their sole discretion) to waive application of the deductible with respect to an out of network visit and pay any applicable co-payment on

behalf of a Participant and/or eligible family member if payment of the co-payment results in a cost-savings to the Fund as a result of the Participant (or eligible family member) using the out of network physician (e.g., V.A. benefits). Each waiver will be decided on a case by case basis, and waiver of the deductible for a visit does not waive application of the deductible with respect to future visits.

For specific terms regarding Non-Preferred Providers, please refer to the following sections: Definitions; including but not limited to the definition of Covered Expense and Non-Preferred Provider, and the General Provisions section, Payment of Providers.

BLUECARD PPO PROGRAM

OUT-OF-AREA SERVICES

Independence Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of the PPO Network service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard PPO Program and may include negotiated National Account arrangements available between Independence Administrators and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the PPO Network service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Independence Administrators payment practices in both instances are described below.

BlueCard® PPO Program

Under the BlueCard® PPO Program, when you access covered healthcare services within the geographic area served by a Host Blue, Independence Administrators will remain responsible for fulfilling Independence Administrators contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside the PPO Network service area and the claim is processed through the BlueCard PPO Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or

- The negotiated price that the Host Blue makes available to Independence Administrators.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Independence Administrators uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside of the PPO Network Service Area

Please refer to the Covered Expense definition in the **DEFINITIONS** section of this booklet.

PATIENT CARE MANAGEMENT

You MUST CALL the number for Patient Care Management listed on your identification (ID) card to fulfill the requirements of Patient Care Management.

The precertification process reviews the Medical Appropriateness/Medical Necessity of the requested services only. Precertification is not a guarantee of eligibility for the coverage or payment of a Claim. Coverage and payment are dependent upon, among other things, the Covered Person being eligible, i.e., actively enrolled in the health benefits plan when the services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

A. UTILIZATION REVIEW PROCESS

A basic condition of the Plan's benefit plan coverage is that in order for a health care service to be covered or payable, the service must be Medically Appropriate/Medically Necessary. Medically Appropriate/Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient Department. To assist Independence Administrators' delegate in making coverage determinations for requested health care services, Independence Administrators uses established medical policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Covered Person's benefit plan is called utilization review.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by Independence Administrators to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported, or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which has been approved by Independence Administrators' delegate based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed, it is called a precertification review. Reviews occurring during a Hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. Independence Administrators' delegate follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review using medical policies, established guidelines and evidence-based clinical criteria and protocols; however, only a medical director employed by

Independence Administrators or its delegate may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable guidelines and evidence-based clinical criteria and protocols, taking into consideration the Covered Person's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a medical director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and the Covered Person in accordance with applicable law.

Independence Administrators' utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to Independence Administrators' or its delegate's medical directors to discuss coverage of a case. Medical directors and nurses receive salaries. Contracted external physicians and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. Neither Independence Administrators nor its delegates specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

B. CLINICAL CRITERIA, GUIDELINES AND RESOURCES

The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medically Necessary coverage decisions.

Clinical Decision Support Criteria - Clinical Decision Support Criteria is an externally validated and computer-based system used to assist Independence Administrators or its delegate in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of Illness, these criteria assist clinical staff in evaluating the Medical Appropriateness/Medical Necessity of services based on a Covered Person's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in plan determinations for similar medical issues and requests, and reduces practice variation among Independence Administrators' or its delegate's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following: some elective Surgeries - settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery), Inpatient hospitalizations, Inpatient and Outpatient rehabilitation, diagnostic procedures, Home Health Care, Durable Medical Equipment, and Skilled Nursing Facility.

Medical Policies - Independence Administrators and its delegates maintain an internally developed set of policies, which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which Medical Polices are applied include, but are not limited to: Ambulance, Infusion, Speech Therapy, Occupational Therapy, Durable Medical Equipment, and review of potential cosmetic procedures.

Internally Developed Guidelines - A set of guidelines developed with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting medical policies for coverage.

C. *DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA*

Independence Administrators has agreements with state licensed utilization review entities, where required, and a URAC (Utilization Review Accreditation Commission) accredited utilization management program. Independence Administrators has delegated certain utilization review activities, including precertification review, concurrent review, and case management, to entities with an expertise in medical management of certain conditions and services (such as, mental illness/substance abuse), or certain membership populations (such as, neonates/premature infants), or after-hours precertification services. In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with Independence Administrators' approval.

D. PRECERTIFICATION REVIEW

When required, Precertification review evaluates the Medical Necessity, including the appropriateness of the setting, of proposed services for coverage under the Covered Persons benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. For Covered Persons located in the PPO Network service area, Precertification review may be initiated by the Provider or the Covered Person depending on whether the Provider is a PPO Network Provider. For Covered Person's located outside Independence Administrators PPO Network who are accessing BlueCard PPO Providers, the

Covered Person is responsible for initiating or requesting the Provider to initiate the Precertification review. Where Precertification review is required, Independence Administrators' coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Precertification review is required for a procedure but is not obtained.

1. INPATIENT PRE-ADMISSION REVIEW

Inpatient Admissions

In accordance with the criteria and procedures described above, Inpatient admissions, other than an emergency admission, must be pre-certified in accordance with the standards of Independence Administrators as to the Medical Appropriateness/Medical Necessity of the admission. The precertification requirements for emergency admissions are set forth in the "Emergency Admission Review" subsection immediately following below. The Covered Person is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

a. To obtain Precertification, the Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact Independence Administrators prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. Independence Administrators will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Preferred or Non-Preferred level shown in the *Schedule of Benefits* if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this booklet.

b. If a Covered Person elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

c. If Precertification is denied, the Covered Person, the Physician or the Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, or Facility Provider will be so notified.

2. EMERGENCY ADMISSION REVIEW

Emergency Admissions

1. Covered Persons are responsible for notifying Independence Administrators of an emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by Independence Administrators.

2. If the Covered Person elects to remain hospitalized after Independence Administrators and the attending Doctor have determined that an Inpatient level of care is not Medically Appropriate/Medically Necessary, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.

3. CONCURRENT AND RETROSPECTIVE/POST-SERVICE REVIEW, PRENOTIFICATION AND DISCHARGE PLANNING

Concurrent review may be performed while services are being performed. If concurrent review is performed during an Inpatient stay, the expected and current length of stay is evaluated to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent review may not be performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with a Facility does not require such review.

Retrospective/post-service review occurs after services have been provided. This may be for a variety of reasons, including when Independence Administrators has not been notified of a Covered Person's admission until after discharge, or where medical charts are unavailable at the time of a concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, Independence Administrators may determine coverage of certain procedures and other benefits available to Covered Persons through pre-notification as required by the Covered Person's benefit plan and discharge planning.

Pre-notification is advance notification to Independence Administrators of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity

admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons who may benefit from case management programs.

Discharge planning is performed during an Inpatient admission and is used to identify and coordinate a Covered Person's needs and benefit coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge planning involves Independence Administrators' authorization of covered post-Hospital services along with identifying and referring Covered Persons for disease management or case management services.

E. TRANSPLANT SERVICES

Independence Administrators requests notification of transplant services as soon as the need for an organ or tissue transplant is known. Precertification requirements apply to all services listed in the "Services Requiring Precertification," subsection H. below.

F. MATERNITY SERVICES

Independence Administrators requests maternity care notification as soon as the pregnancy is confirmed by a Doctor.

Precertification requirements apply when:

1. a Covered Person is admitted for any condition or procedure other than delivery of the baby;

2. the type of delivery anticipated or place of service changes before admission for delivery;

3. the Covered Person's medical condition requires a stay longer than 48 hours after a vaginal delivery or 96 hours after an approved cesarean section. Independence Administrators must pre-certify additional Inpatient days;

4. the baby is required to stay after the mother is discharged. Independence Administrators must pre-certify additional Inpatient days.

A Covered Person is encouraged to call Independence Administrators if medical problems develop during the pregnancy.

G. OTHER PRECERTIFICATION REQUIREMENTS

Precertification is required by Independence Administrators in advance for Home Health Care, Hospice Care, certain surgical and diagnostic procedures, Inpatient and Partial Hospitalization services for Substance Abuse, Mental Illness and Serious Mental Illness. A complete list of precertification requirements is shown in the "Services Requiring Precertification," subsection H. below. When a Covered Person plans to receive any of these listed procedures, Independence Administrators will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.
Surgical, diagnostic and other procedures, listed in the "Services Requiring Precertification," subsection H. below, that are performed during an emergency, as determined by Independence Administrators, do not require precertification. However, Independence Administrators should be notified within two (2) business days of emergency services for such procedures, or as soon as reasonably possible, as determined by Independence Administrators.

The Covered Person is responsible to have the Provider performing the service contact Independence Administrators to initiate precertification. Independence Administrators will notify the Covered Person, the Doctor and the Facility, if applicable, of the determination.

H. SERVICES REQUIRING PRECERTIFICATION

For a complete list of services requiring Pre-certification, please call the number for Patient Care Management listed on your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change.

For a complete list of services requiring Pre-certification, please call the number for Precertification listed on the back of your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change.

I. CASE MANAGEMENT

Case management serves individuals who have been diagnosed with a complex, catastrophic, or chronic Illness or injury. The objectives of case management are to facilitate access by the patient to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve outcomes of Covered Persons. Case management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic

or chronic Illness and/or injury across various levels and sites of care.

Independence Administrators will provide case management services for those identified Covered Persons that would benefit from:

- Support during the continuum of care;
- Improved self-management skills;
- Improved transition and coordination among multiple Providers and/or levels of care;
- Assistance to maximize the effective use of health plan benefits;
- Reduction of acute exacerbation of a chronic Illness; and,
- Reduction of preventable complications.

Covered Persons may be identified for case management through the precertification process or through claims review. External referrals are also accepted from Covered Persons' Providers or family members. Covered Persons referred to case management are screened and accessed prior to acceptance into the program. Only those Covered Persons likely to benefit from case management are accepted into case management.

A case manager will consult with the patient, the patient's authorized representative, the caregiver and the attending Doctor in order to develop a plan of care for approval by the patient's attending Doctor and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the care giver to offer assistance and support;
- monitoring Inpatient care;
- identifying available resources for appropriate care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The attending Doctor, the patient and the patient's caregiver must all agree to the alternate treatment plan. Once agreement has been reached, Independence Administrators may reimburse necessary expenses in the treatment plan, even if some expenses normally would not be paid by the benefit plan.

Case management is a voluntary service. Covered Persons must provide their consent for enrollment into case management. There is no reduction in benefits if the patient and the patient's family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

EXCEPTIONS AND EXCLUSIONS

Except as specifically provided in this booklet, no benefits will be provided for services, supplies or charges:

1. Which are not Medically Necessary as determined by the Plan for the diagnosis or treatment of illness or injury;
2. which are Experimental/Investigational, except, as approved by the Plan, Routine Costs Associated with a Qualifying Clinical Trial that meets the definition of a Qualifying Clinical Trial under the Plan;
3. Which were Incurred prior to the Covered Person's effective date of coverage;
4. Which are in excess of the Covered Expense, as defined herein;
5. Which were or are Incurred after the date of termination of the Covered Person's coverage;
6. For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;
7. For which a Covered Person would have no legal obligation to pay, or another party has primary responsibility;
8. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
9. Paid or payable by Medicare when Medicare is primary. For purposes of this plan, a service, supply or charge is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;
10. For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation. This exclusion does not apply to any medical benefits incurred with respect to such occupational illness or injury which is caused by an underlying medical condition;
11. To the extent a Covered Person is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Covered Person;
12. For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the state's Motor Vehicle Financial Responsibility Law or similar law;
13. Which are not billed and performed by a Provider as defined under this coverage as a "Professional Provider", "Facility Provider" or "Ancillary Provider" except as

otherwise indicated under the subsections entitled: (a) Therapy Services" (that identifies covered therapy services as provided by licensed therapists) and (b) "Ambulance Services" in the ***Covered Medical Charges*** *section*;

14. Rendered by a member of the Covered Person's Immediate Family;
15. Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university;
16. For ambulance services except as specifically provided under this Plan;
17. For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect. This exclusion does not apply to mastectomy related charges as provided for in this booklet;
18. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
19. For Alternative Therapies/complementary medicine, including but not limited to, acupuncture, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;
20. For marriage counseling;
21. For Custodial Care, domiciliary care or rest cures;
22. For equipment costs related to services performed on high cost technological equipment as defined by the Plan, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the precertification process and/or by the Plan;
23. For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this booklet/certificate. Services not covered include, but are not limited to, apicoectomy (dental root resection), prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated;
24. For dental implants for any reason;
25. For dentures, unless for the initial treatment of an Accidental Injury/trauma;
26. For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;

27. For injury as a result of chewing or biting (neither is considered an Accidental Injury);
28. For palliative or cosmetic foot care including treatment of bunions (except for capsular or bone surgery), toenails (except surgery for ingrown nails), the treatment of subluxations of the foot, care of corns, calluses, fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and other routine podiatry care, unless associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes;
29. For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes. This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
30. For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such Surgery;
31. For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;
32. For treatment of obesity, except for surgical treatment of obesity when the Plan (a) determines the surgery is Medically Necessary; and (b) the surgery is limited to one surgical procedure per lifetime regardless of whether such procedure was covered by the Plan or another Plan. Any new or different obesity surgery, revisions, repeat, or reversal of any previous surgery are not covered. The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure results in technical failure or when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person.
33. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
34. For diagnostic screening examinations, except for mammograms and preventive care as provided in the ***Covered Medical Charges*** *section*;
35. For routine physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment;
36. For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;
37. For immunizations required for employment purposes, or for travel;
38. For care in a nursing home, home for the aged, convalescent home, school, camp, institution for retarded children, Custodial Care in a Skilled Nursing Facility;
39. For counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided;
40. For home blood pressure machines, except for Covered Persons: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, or (c) with end-stage renal disease receiving home dialysis;

41. As described in the "Durable Medical Equipment" section in the ***Covered Medical Charges*** *section* for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by the Covered Person's condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment, whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs;
42. For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits;
43. For prescription drugs, except as may be provided in the Prescription Drug section of this booklet. This exclusion does not apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels as provided for the treatment of diabetes;
44. For contraceptives;
45. For over-the-counter drugs and any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient admission;
46. For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy;
47. For Inpatient Private Duty Nursing services;
48. For any care that extends beyond traditional medical management for pervasive development disorders, attention deficit disorder, learning disabilities, behavioral problems, mental retardation or autism spectrum disorders (except ABA Therapy); or treatment or care to effect environmental or social change;
49. Except with respect to chiropractic services, for maintenance of chronic conditions;
50. For charges Incurred for expenses in excess of Benefit limits as specified in the ***Schedule of Benefits***;
51. For any therapy service provided for: the ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond this Plan's limits, if any, shown on the ***Schedule of Benefits***; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;
52. For Cognitive Rehabilitative Therapy, except when provided integral to other supportive therapies, such as, but not limited to physical therapy in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy).
53. For Speech Therapy ;

54. For self-injectable Prescription Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered self-injectable Prescription Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration. This exclusion does not apply to self-injectable Prescription Drugs that are: (a) mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by Prescription Drug coverage under the Plan or free-standing Prescription Drug Contract issued to the Group by the Plan; or (b) required for treatment of an emergency condition that requires a Self-Injectable Drug.
55. For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;
56. For hearing aids for adults (age 19 or older), including cochlear electromagnetic hearing devices, and hearing examinations or tests for the prescription or fitting of hearing aids. Services and supplies related to these items are not covered;
57. For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
58. For cranial prostheses, including wigs intended to replace hair;
59. For any Surgery performed for the reversal of a sterilization procedure;
60. For abortion services except when abortion is necessary to avert the death of the mother, and in cases when pregnancy is the result of rape or incest;
61. For diagnosis and treatment of autism spectrum disorders that is provided through a school as part of an individualized education program (except for ABA Therapy);
62. For diagnosis and treatment of autism spectrum disorders that is not included in the autism spectrum disorders treatment plan for autism spectrum disorders (except for ABA Therapy);
63. For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;

For any other service or treatment except as provided under this Plan.

WORKING SPOUSE ELIGIBILITY RULE

If your spouse works and his/her employer offers health coverage your spouse must enroll in that coverage when they become eligible. If your spouse is eligible for and doesn't enroll in his/her employer's health coverage, he/she will not be eligible for coverage under this Plan. Please read the Working Spouse Rule below for exceptions.

If your spouse has a claim for benefits, his/her employer's plan is required to pay that claim before this Plan pays the claim. This is described under the Plan's Coordination of Benefits provisions (see below). In order to ensure that benefit claims are properly coordinated, your spouse is required to provide information about his/her employer's health plan annually or more frequently if his/her plan changes.

WORKING SPOUSE RULE

1. This Working Spouse Rule applies when a Participant's spouse has or is eligible for health care coverage (medical and prescription drug) under another health plan.

2. If your spouse works and is eligible for employer provided medical and prescription drug coverage, your spouse is required to enroll in such coverage.

3. If: (i) your spouse fails to enroll in such coverage, (ii) your spouse enrolls in such coverage, but you fail to provide this Plan evidence of such other coverage in which he/she is enrolled, or (iii) you otherwise fail to comply with this Rule, this Plan will not pay any of your spouse's medical, prescription drug, dental or vision benefit claims. If your spouse enrolls in employer provided medical and prescription drug coverage, provides evidence of such other coverage, and you otherwise comply with this Rule, then this Plan will pay benefits for your spouse pursuant to the Coordination of Benefits provision below.

4. If the Plan discovers that you have provided false information under, or fail to comply with, this Rule, then in accordance with the Plan's Erroneous Payment Rule, you shall be required to repay to the Plan: (a) all payments and the value of all benefits paid on behalf of your spouse under the Plan which would not have otherwise been paid had you complied with this Rule, (b) appropriate interest, (c) any and all costs of collection (including attorney's fees), and (d) penalties directed by the Trustees. In addition, under the terms of the Plan, the Trustees may take any reasonable action to recoup such amounts, including, without limitation, deducting from, or offsetting against, any future benefits and/or payments under the Plan.

Please note that although this rule applies to all medical, prescription drug, dental and vision benefit claims under the Plan, your spouse is only required to enroll in his/her employer's medical and prescription drug coverage.

5. **Exceptions.** This rule will not apply if:

    - Your spouse declined employer provided coverage prior to the time that you became eligible for coverage under this Plan, provided your spouse shows proof of the next available opportunity to enroll and enrolls in such employer provided coverage.
    - Your spouse's employer required him/her to pay the full cost of medical or prescription drug coverage for the lowest cost coverage option.
    - Your spouse's employer does not offer medical or prescription drug coverage.
    - Your spouse's employer only offers retiree medical or prescription drug coverage.
    - Your spouse's only other option for employer provided medical and prescription drug coverage is through COBRA.

6. This rule will apply even if the availability of the spouse's employer provided medical and prescription drug coverage:

    - Is offered only through an HMO
    - Is offered through a cafeteria plan
    - Does not provide an employee only coverage option

    Further, this rule also applies even if:
    - Your spouse works part-time, so long as medical and prescription drug coverage is offered.
    - You are a retiree, but your spouse is actively employed.
    - Your spouse's employer offers an incentive not to enroll in its medical and prescription drug coverage.

7. If your spouse is enrolled in employer provided medical and prescription drug coverage, then you are required to provide the Fund Office with a copy of the schedule of benefits (or similar document acceptable to the Fund Office) for such coverage and report to the Fund Office any changes in such coverage within 30 days after such change becomes effective, or certify on an annual basis that such coverage has not changed.

You are required to notify the Fund Office within 30 days after your spouse either enrolls or disenrolls in employer provided coverage.

COORDINATION OF BENEFITS

Applicability

This Coordination of Benefits ("COB") provision applies when a Participant or the Participant's covered Dependent has health care coverage under more than one Plan (defined below). In that case, This Plan (defined below) will not pay benefits for a claim to the extent that Another Plan (defined below) pays benefits as the Primary Plan (defined below). However, if This Plan is the Primary Plan, then it will pay benefits for a claim to the extent allowable under the terms of This Plan. As such, if this COB provision applies, then pursuant to the Order of Benefit Determination Rules, the benefits of This Plan:

a. shall not be reduced when This Plan is the Primary Plan;
b. may be reduced when Another Plan(s) is the Primary Plan and This Plan is the Secondary Plan or Tertiary Plan. This Plan's benefits will be reduced when the sum of:
    i. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
    ii. the benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period.

    In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. The Claim is then charged against any applicable benefit limit of this Plan.

Order of Benefit Determination Rules

1. If there is a basis for a claim under This Plan and Another Plan (whether it has a coordination of benefits rules or not), then such Other Plan shall be the Primary Plan and This Plan shall be the Secondary Plan.
2. However, This Plan shall be the Primary Plan ***if*** the Other Plan's coordination of benefit rules ***and*** This Plan's coordination of benefit rules (described in Subparagraph 3 below) require that This Plan be the Primary Plan.
3. This Plan determines its order of benefits using the first of the following rules which applies:
    a. The Plan that covers the individual as a participant (and not as a dependent) is the Primary Plan, and the Plan that covers the individual as a dependent is the Secondary Plan.
    b. If both This Plan and Another Plan cover the individual as a dependent child and the child's parents ***are not*** separated, divorced, or separated and living apart from each other for at least 6 months (including a divorce from bed and

board) then the Plan of the parent whose birthday falls earlier in the year is the Primary Plan, and the Plan of the parent whose birthday falls later in the year is the Secondary Plan.

i. However, if both parents have the same birthday, the Plan that covered the parent the longest is the Primary Plan.
ii. If the Other Plan does not have the rule described in this subsection (b), but rather has a coordination of benefits rule based on the gender of the parent, and, if as a result, the plans do not agree on the order of benefits, the rule in the Other Plan will determine which Plan is the Primary Plan and which Plan is the Secondary Plan.

c. If both This Plan and Another Plan cover the individual as a dependent child and the child's parents ***are*** separated, divorced, or separated and living apart from each other for at least 6 months (including a divorce from bed and board), then:

i. The Plan of the parent with primary custody of the child will be the Primary Plan.
ii. The Plan of the spouse of the parent with primary custody of the child will be the Secondary Plan.
iii. The Plan of the parent without primary custody of the child will be the Tertiary Plan.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the Primary Plan. This paragraph does not apply with respect to any Claim Determination Period (defined below) or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is the Primary Plan. The Plan that covers that person as a laid off or retired employee (or as that employee's dependent) is the Secondary Plan. If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee longer is the Primary Plan.

Claims Denied by Other Plan

If the claimant is a Dependent who is covered by Another Plan and the Dependents submits (or is required pursuant to this COB provision to submit) a claim for benefits to the Other Plan which the Other Plan will not pay because of the claimant's failure to comply with the Other Plan's rules, benefits will be paid by This Plan as if benefits had first been paid by the Other Plan.

EXAMPLE

Mary is the spouse of a Participant. Mary is covered under an HMO plan provided by her employer. Mary wants to visit her regular gynecologist who is not an HMO participating physician. Mary does not follow the HMO rules by getting a referral from her HMO general practitioner to an HMO gynecologist. Instead, Mary visits her regular gynecologist who is not an HMO participating physician. Mary submits her regular gynecologist's bill to her HMO. Her HMO denies coverage because Mary did not follow the HMO rules. Mary then submits her claim to This Plan. This Plan will only pay the amount of Mary's gynecologist's bill that it would have had to pay if the HMO had provided coverage.

Definitions

1. A "Plan" is any of these which provides benefits or services for, or because of, medical, prescription drug, vision, or dental care or treatment:

a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It does not include school accident-type coverage, group or group-type hospital indemnity benefits of $100 per day or less.

b. Coverage under a governmental plan (including Medicare) or required or provided by law. This does not include a state plan under Medicaid. It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. "This Plan" is the portion of the International Brotherhood of Electrical Workers Local Union No. 126 Health and Welfare Fund that provides benefits for health care, prescription drug, vision, and dental expenses.

3. "Another Plan" or "Other Plan" is a Plan (other than This Plan) under which the Participant or the Participant's covered Dependent has health care coverage.

4. "Primary/Secondary/Tertiary Plan" are defined as follows:

"Primary Plan" is the plan under the Order of Benefit Determination Rules under which benefits are determined before benefits are determined under the Secondary and/or Tertiary Plans, and without considering such Secondary and/or Tertiary Plans' benefits.

"Secondary Plan" is the Plan under the Order of Benefit Determination Rules under which benefits are determined after the Primary Plan, considering the benefits paid under Primary

Plan (which may reduce the benefits payable under the Secondary Plan), but before the benefits are determined under the Tertiary Plan, without considering the Tertiary Plan's benefits.

"Tertiary Plan" is the Plan under the Order of Benefit Determination Rules under which benefits are determined after the Primary and Secondary Plans, considering the benefits paid thereunder (which may reduce the benefits payable under the Tertiary Plan).

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan or Tertiary plan as to a different Plan or Plans.

5. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

6. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Independence Administrators has the right to release or obtain benefit information in order to implement this provision.

FACILITY OF PAYMENT

If payments should have been made under this Plan but were made under any other Plan(s), Independence Administrators may make payments to such other Plan(s) to satisfy the intent of the provision. Benefits under this Plan will then be deemed paid. The Plan will no longer be liable for such payments.

RIGHT OF RECOVERY

Independence Administrators has the right to recover any excess payments made to satisfy the intent of this provision.

REQUIRED INFORMATION

In all of the circumstances described under Coordination of Benefits, the Participant or family member must submit to the Fund a copy of the other Plan and any other information required. Failure to do so will result in a denial of all benefits.

Section III - ***PRESCRIPTION DRUG BENEFIT***

SCHEDULE OF BENEFITS

The Schedule of Benefits lists benefits, maximums, and allowances that your Plan provides for each enrolled person. The coinsurance rates shown in this table are based on your Plan's allowance for each service. The prescription drug program includes a mandatory mail order feature requiring all prescription drugs to be filled through the mail order program if the drug can be obtained through the mail order program.

Prescription Drug benefits are administered under an outside provider contract with Sav-Rx. Some drugs require prior authorization.

SERVICE	If the Covered Person uses a Participating Provider, you will pay:	If the Covered Person uses a Non-Participating Provider, you will pay:
Annual Maximum	Unlimited	Unlimited
Calendar Year Deductible • Per Person	$0	$0
Maximum out of pocket expenses you could pay in a calendar year (includes deductibles, copays, and coinsurance) • Per person • Per family	Combined in and out of network out of pocket maximum: $1,250 $2,500	
Retail Prescription Drugs (limited to 30 day supply) • Generic • Preferred Brand • Non-Preferred Brand • Specialty	100% after $10 copay 80%[1] 80%[1] 80%[2] [1]maximum member payment of $100 per script [2]maximum member payment of $200 per script	80% 80% 80% 80%

Mail Order Prescription Drugs (limited to 90 day supply) • Generic • Preferred Brand • Non-Preferred Brand • Specialty	 100% (no copay) 100% after $10 copay 100% after $10 copay 80%[2] [2]maximum member payment of $200 per script	 80% 80% 80% 80%
Specialty HIA	80% (other than Hep. C) 75% (Hep. C)	80% 75%

Prescription Drug benefits are administered under an outside provider contract with Sav-Rx.

Injectable prescription drugs are covered provided there has been prior authorization by Sav-Rx.

Prescription Drug Benefit for Medicare Primary Participants

The Fund Office will automatically enroll Medicare Primary Participants in a Medicare Part D program with UnitedHealthcare. This plan is referred to as a Medicare part D Employer Group Waiver Plan (EGWP). You will have the option to opt out of this prescription drug program. (You should consult a trusted advisor as to whether opting out of the prescription drug program is advisable. It is the Plan's experience that it is not advisable for most people to opt-out.) We will also provide a secondary prescription benefit through Sav-Rx that will wrap around the Medicare Part D drug program provided by UnitedHealthcare. This will ensure that you will receive a prescription drug benefit that is at least as good as the benefit you received as an active member.

*Section IV - **VISION BENEFIT***

The Vision benefit is for Active Participants and if elected, it is for Disabled and Retired Participants.

SCHEDULE OF BENEFITS

SERVICE	If the Covered Person uses a Participating Provider, the Plan will pay:	If the Covered Person uses a Non-Participating Provider, the Plan will pay:
Examination (for glasses) (once every 12 months from the last date of service)	100%	Up to $35
Clear Standard Lenses (once every 12 months from the last date of service)		
• Single Vision (pair)	100%	Up to $50
• Bifocal or Blended Bifocal (pair)	100%	Up to $60
• Trifocal (pair)	100%	Up to $75
• Progressives (including digital) (pair)	100%	Up to $75
	100%	Up to $100
• Lenticular (pair)	100%	N/A
• Polycarbonate (any age)	100%	N/A
• UV 400	100%	N/A
• Scratch Coat-2 year	100%	N/A
• Photochromics (Solid or Gradient Tints)	100%	N/A
• Anti-Reflective Coatings (includes Bluelight, Crizal, Prevencia & Sapphire and Baskside UV)	100%	N/A
• Mid and Hi-Index Plastic Lenses	100%	N/A
• Rimless Mountings and Drilled Mounts	100%	N/A
• Edge Treatments	100%	N/A
Frames** (once every 24 months)	100%	Up to $50
Contact Lenses (in lieu of all eye glass benefits listed above)***		
• Material Allowance		
• Fitting Fee	Up to $150	Up to $150
	15% off UCR*	N/A
Medically Required Contacts (in lieu of all eye glass benefits listed above)***		

Low Vision Aids (once every 24 months)	100% Up to $650	Up to $350 Up to $650

** UCR: covered in full up to the Usual, Reasonable, and Customary charge.*
*** Within the programs $75 wholesale allowance (approximately $187 to $225 retail)*
**** The contract allowance is applied to all series/materials associated with contact lenses. This includes, but is not limited to, contact exam, fitting, dispensing, cost of lenses, etc. No guarantee the contact allowance will cover the entire contact cost (materials/services).*

Vision benefits are provided under an outside provider contract with Vision Benefits of America (VBA). You can search for a VBA participating provider by accessing the VBA website: www.visionbenefits.com/docsearch.aspx

Since this benefit is provided under an administrative services contract, some of the provisions may differ from those described elsewhere in this Summary Plan Description. For example, the identity of network providers and the time for filing a claim may differ. You must check the service providers benefit booklet for the specific terms. In the event of a conflict between the rules of the Summary Plan Description and the service provider's plan rules, the service provider's plan rules will control. Vision claims must be submitted within one year of the date of service.

Section V ***- DENTAL BENEFIT***

SCHEDULE OF BENEFITS

The Schedule of Benefits lists benefits, maximums, and allowances that your Plan provides for each enrolled person. The coinsurance rates shown in this table are based on your Plan's allowance for each service.

The Dental benefit is for Active Participants and if elected, it is for Disabled and Retired Participants.

SERVICE	PAID BY DELTA DENTAL*
DIAGNOSTIC (deductible and maximum waived) • Periodic exams (once per 6-month period) • Bitewing x-rays (once per 6-month period) • Full-mouth x-ray (once per 3-year period)	100%
PREVENTIVE (deductible and maximum waived) • Prophylaxis (cleaning) (once per 6-month period) • Fluoride treatments (once per 6-month period to age 19) • Sealants (to age 14) • Space maintainers (to age 14)	100%
BASIC RESTORATIVE • Fillings (amalgam "silver" and composite "white" non-molar)	80%
MAJOR RESTORATIVE • Single crowns, inlays, onlays	50%
ORAL SURGERY • Extraction and other oral surgery procedures, including pre- and post-operative care	80%
ENDODONTICS • Root canal, pulpal therapy	80%
SURGICAL PERIODONTICS • Surgical treatment of the gums and supporting structures of the teeth	80%
NON-SURGICAL PERIODONTICS • Non-surgical treatment of the gums and supporting structures of the teeth	80%
PROSTHODONTICS • Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures, implant surgical placement and removal, implant supported prosthetics, including repair and recementation	50%
ORTHODONTICS (deductible waived) • For eligible dependents to age 19	50%
GENERAL ANESTHESIA • Covered when used in conjunction with covered oral surgical procedures	80%

SERVICE	PAID BY DELTA DENTAL*
INDIVIDUAL CALENDAR YEAR DEDUCTIBLE	$25
FAMILY CALENDAR YEAR DEDUCTIBLE	$50
CALENDAR YEAR MAXIMUM BENEFIT PER INDIVIDUAL	$1,000
LIFETIME ORTHODONTICS BENEFIT	$3,000

** For **Delta Dental Premier Dentists**, percentages are based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance. For **Delta Dental PPO Dentists and Non-Participating Dentists**, percentages are based on the PPO Allowed Amount, which is the lesser of the dentist's submitted fee or the PPO Maximum Plan Allowance.*

Payment for Services
Payment for services is dependent on the provider you choose to use. Delta Dental has PPO Participating Providers and Premier Participating Providers. Delta Dental Participating Providers have agreed to accept an agreed amount as payment in full for covered services. The Delta Dental PPO Providers generally offer a better discount than Delta Dental Premier Providers and result in a lower out-of-pocket expense for you. You can access the Delta Dental website for a list of participating providers.

Non-Participating Providers have NOT agreed to a discount and in most cases will result in a higher out-of-pocket expense for you. The following is a description of how each provider is paid.

Payment for Services — Delta Dental PPO Dentist
Payment for covered services performed for you by a PPO Dentist is calculated based on the PPO Allowed Amount. PPO Dentists have agreed to accept a PPO Allowed Amount as the full charge for covered services.

Delta Dental calculates its share of the PPO Allowed Amount ("Delta Dental Payment") using the applicable percentage from the Benefit Summary Chart and sends it directly to the PPO Dentist who has submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Enrollee Payment"). These charges are generally your share of the allowed amount ("Co-payment"), the deductible, charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee) = $100
PPO Maximum Plan Allowance = $70
PPO Allowed Amount = $70
Co-payment (50% of PPO Allowed Amount) = $35
Delta Dental Payment = $35

Enrollee Payment = $35

Payment for Services — Delta Dental Premier Dentist
A Delta Dental Premier Dentist is a Participating Dentist, but is not a Delta Dental PPO Dentist. Premier Dentists have not agreed to accept a PPO Allowed Amount as full payment for services, but instead have agreed to accept a Premier Allowed Amount. Payment for covered services performed for you by a Premier Dentist is calculated based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee) = $100
Premier Maximum Plan Allowance = $80
Premier Allowed Amount = $80
Co-payment (50% of Premier Allowed Amount) = $40
Delta Dental Payment = $40
Enrollee Payment = $40

Payment for Services — Non-Participating Dentist
Non-Participating Dentists have not agreed to accept the PPO Allowed Amount as full payment for services. Payment for services performed for you by a Non-Participating Dentist is also calculated by Delta Dental based on the PPO Allowed Amount, which is the lesser of the dentist's submitted fee or the PPO Maximum Plan Allowance. The portion of the PPO Allowed Amount payable by Delta Dental ("Delta Dental Payment") is limited to the applicable percentage shown in the Benefit Summary Chart.

However, when dental services are received from a Non-Participating Dentist, Delta Dental's payment is sent directly to the primary enrollee. You are responsible for payment of the Non-Participating Dentist's total fee. Non-Participating Dentists will bill you for their normal charges, which may be higher than the PPO Allowed Amount for the service. You may be required to pay the dentist yourself and then submit a claim to Delta Dental for reimbursement. Since the Delta Dental payment for services you receive may be less than the Non-Participating Dentist's actual charges, your out-of-pocket cost may be significantly higher.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee) = $100
PPO Maximum Plan Allowance = $70
PPO Allowed Amount = $70
Co-payment (50% of PPO Allowed Amount) = $35
Enrollee Payment = $100
Delta Dental Payment to Enrollee = $35

Enrollee Out-of-Pocket Payment = $65

Orthodontic Payments
Unless otherwise specified in the contract, Delta Dental will pay half of its orthodontic payment up front, at the time of banding. The remaining half will be paid one year later. If the treatment time is 12 months or less, Delta Dental's orthodontic payment will be paid as a lump sum at the beginning of the orthodontic treatment.

Example Delta Dental PPO Orthodontist:
Submitted Amount (Orthodontist Fee) = $6,000
PPO Maximum Plan Allowance = $4,000
PPO Allowed Amount = $4,000
Co-payment (50% of PPO Allowed Amount) = $2,000
Delta Dental Payment = $2,000
Enrollee Out-of-Pocket = $2,000

Example Delta Dental Premier Orthodontist:
Submitted Amount (Orthodontist Fee) = $6,000
Premier Maximum Plan Allowance = $5,000
Premier Allowed Amount = $5,000
Co-payment (50% of Premier Allowed Amount) = $2,500
Delta Dental Payment = $2,500
Enrollee Out-of-Pocket = $2,500

Example Non-Participating Orthodontist:
Submitted Amount (Orthodontist Fee) = $6,000
PPO Maximum Plan Allowance = $4,000
PPO Allowed Amount = $4,000
Co-payment (50% of PPO Allowed Amount) = $2,000
Delta Dental Payment to Enrollee = $2,000
Enrollee Out-of-Pocket Payment = $4,000

Since this benefit is provided under an insurance contract, some of the provisions may differ from those described elsewhere in this Summary Plan Description. For example, the identity of network providers and the time for filing a claim may differ. You must check the service provider's benefit booklet for the specific terms. In the event of a conflict between the rules of the Summary Plan Description and the service provider's plan rules, the service provider's plan rules will control. Dental claims must be submitted to the service provider within one year of the date of service.

Section VI – *LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT*

LIFE INSURANCE

Active Participant Only **.....$ 10,000.00**
Permanently Disabled or Retired Participant Benefits **.....$ 5,000.00**
NOTE: Only one of the above benefits is payable in the event of death.

The amount of your Life Insurance will be paid to your designated beneficiary in the event of your death.

Permanently Disabled or Retired Participant Benefit
For each permanently disabled or retired Participant who meets all of the eligibility requirements set forth in the Eligibility section, the benefit shall be payable to their designated beneficiary. No permanently disabled or retired Participant shall be entitled to this death benefit unless he/she is also qualified for and maintains coverage for all other medical benefits to which he/she is entitled under this plan.

Continuation of Death Benefit in the Event of Total Disability
There is an extended death benefit privilege, whereby, if you become disabled, as defined in the Policy, prior to reaching age 60, you may continue to be eligible to maintain your death benefit during disability, without having to pay a premium. You should contact the Plan Administrator.

Conversion Privilege
You may have a conversion privilege under this benefit whereby, upon termination of coverage in the Plan, you can obtain an individual life insurance policy. Contact the Plan Administrator for details.

Beneficiary
Your dependent will be the party or parties designated on the Policyholder's records in accordance with such person's election. Any Participant may at any time during the continuance of this benefit change the Beneficiary, without the consent of any previously designated Beneficiary, by a written request upon a blank form furnished by the Fund. The status of a Participant's spouse as Beneficiary shall terminate immediately upon the entry of a judgment or decree of divorce between the Participant and the Participant's spouse. The former spouse shall be recognized as a Beneficiary following the entry of such judgment or decree only if designated by the Participant as Beneficiary after the entry of the judgment or decree on a form prescribed and furnished by the Fund.

Insured Benefit
Both the Life Insurance and Accidental Death and Dismemberment Benefit are provided under an outside provider contract. Should there occur, a conflict between Life Insurance and Death and Dismemberment benefits described in this Booklet and the Master Policy, the Master Policy shall govern.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Active Participants Only **$10,000.00**

One-half of the eligible principal sum indicated above will be paid to the Participant if the Participant loses one eye, a hand, or a foot as the result of an accident. No more than the full benefit will be paid to the Participant if the Participant loses two or more of these members.

The amount of your Accidental Death and Dismemberment benefit will be paid to you in the event of Accidental Dismemberment or to your Beneficiary in the event of your death resulting from an accident.

Limitations:

Accidental Death and Dismemberment shall not be payable for any loss caused wholly, or partly, directly, or indirectly, by:

1. disease or sickness, or by medical or surgical treatment thereof, or
2. ptomaine or bacterial infections, except only septic infections of and through a visible wound accidentally sustained, or
3. suicide, or intentionally self-inflicted injury, while sane or insane, or
4. war, or act of war.

Beneficiary

Your Beneficiary shall be the party or parties designated on the Policyholder's records in accordance with such person's election. Any Participant may at any time during the continuance of this benefit change the Beneficiary, without the consent of any previously designated Beneficiary, by a written request upon a blank form furnished by the Fund. The status of a Participant's spouse as Beneficiary shall terminate immediately upon the entry of a judgment or decree of divorce between the Participant and the Participant's spouse. The former spouse shall be recognized as a Beneficiary following the entry of such judgment or decree only if designated by the Participant as Beneficiary after the entry of the judgment or decree on a form prescribed and furnished by the Fund.

Insured Benefit

Both the Life Insurance and Accidental Death and Dismemberment Benefit are provided under an outside provider contract. Should there occur a conflict between the Life Insurance and Death and Dismemberment benefits described in this Booklet and the Master Policy, the Master Policy shall govern.

Section VII – **WEEKLY ACCIDENT AND SICKNESS BENEFIT**

SCHEDULE OF BENEFITS

The Weekly Accident & Sickness benefit is for Active Participants only.

When you are absent from work because of a non-occupational accident, or because of sickness so as to be totally disabled, and you are wholly prevented from engaging in any and every business or occupation and from performing any work for compensation or profit not covered by Worker's Compensation, weekly payments will be made to you, as described below.

• Benefit Begins	First day of disability due to an accident and eighth day of disability due to a sickness
• Benefit Ends	After 26 Weeks of Disability
Benefit	$400/week

Note: In order to obtain this benefit, you must be treated by a physician. If the Participant has not been treated by a Physician on or before the day benefits would otherwise begin, such benefits shall be payable from the first day thereafter on which the Participant is treated by a Physician. A supplemental medical report will be required periodically to continue disability payments.

In order to obtain a benefit, the following rules shall apply:

1. The disability must be verified in writing on the claim form by a Physician legally licensed to practice medicine.
2. You must be seen by a Physician either in his/her office, at your home or at the hospital. No disability will be considered as beginning more than 7 days prior to the first visit to a Physician. Telephone consultations will not be accepted.
3. The Fund reserves the right and opportunity to have the participant examined, whose injury or sickness is the basis of the claim, by a Physician as often as it may be reasonably required during pendency of the claim.
4. Federal law requires that we withhold Social Security Tax from your Weekly Disability payment.

Benefits Begin

1. Accidents - with the first regularly scheduled work day, provided such disability commences within 48 hours from the date the accident occurred.
2. Sickness - with the eighth day of disability.

Disability Benefit Calculations
The amount of your weekly benefit will be as indicated above. Benefits are payable only while you are under the care of, and treated personally by, a legally qualified Physician. In the event the disability continues, additional or supplemental claim form(s) will be required during the pendency of the claim.

Successive Disabilities
Successive Disabilities due to injuries received in the same accident, or due to the same or related sickness, will be considered as one continuous disability unless, the disabilities are separated by the return to work on a full time basis, after recovery from the injury or sickness causing the previous disability, for at least 35 hours per week for a period of 2 weeks.

Limitations
1. The disability must commence while you are covered for this benefit.
2. This benefit is paid in lieu of any wages.
3. The Fund shall have the right and opportunity to examine the person whose injury or sickness is the basis of the claim by its own physician or physicians when and so often as it may reasonably require during the duration of the claim. The Fund shall have the right to deny all claimants such benefits if they refuse to permit such medical examinations.
4. In no event shall a Participant receive more than 26 weeks of disability benefits in any 52 week period, whether as a result of one or more non-occupational injuries or sickness.
5. Anything contained herein to the contrary notwithstanding, a Participant shall not be eligible for disability benefits if his disability is due to a Pre-existing Condition (as defined in the Trust Agreement and the Eligibility section) unless the disability occurs after the Participant has participated in the Trust Agreement for three (3) consecutive months.

Section VIII – ***VACATION BENEFITS***

Vacation benefits provide you with a convenient way to save for special purposes, like your vacation. The money for this benefit is deducted from your wages and deposited into the IBEW Local No. 126 Vacation Benefit account. Only Employers who have a signed contract with the Union are required to remit to for this benefit on your behalf.

The amount of money an Employer must remit on your behalf is spelled out in the collective bargaining agreement. All of your contributions go directly into the Vacation Benefit account to provide benefits to you and to pay the administrative costs of the benefit.

DEFINITIONS: For purposes of the Vacation Benefit:

BENEFICIARY means the person who is, or may become, eligible to receive vacation benefits from the Plan in the event of your death.

EMPLOYEE means a person who performs work covered under a collective bargaining agreement and works for an Employer who is required to remit a vacation benefit contribution on the Employee's behalf.

EMPLOYER means a company or person, who is party to a collective bargaining agreement or other written agreement, which requires vacation benefit contributions to this Plan on behalf of Employees. The Union is also an Employer if vacation benefit contributions are made to the Plan for their employees and officers.

EMPLOYER REMITTANCES means the payments, for purposes of providing vacation benefits, which must be paid by the Employers to the Plan on behalf of the Employees. This amount is established by the collective bargaining agreement between your Employer and your local union.

ERISA means the Employee Retirement Income Security Act of 1974, its amendments and regulations ("ERISA").

PARTICIPANT means any Employee or Former Employee who is or may become eligible to receive vacations benefits from this Plan or whose Beneficiary may be eligible to receive benefits.

PLAN means the IBEW Local 126 Health & Welfare Fund.

TRUSTEES means the Trustees of the Health & Welfare Fund and persons appointed to succeed them.

UNION means the IBEW Local 126 participating in the Plan.

YOUR RESPONSIBILITIES AS A PARTICIPANT

NOTIFY THE FUND OFFICE IMMEDIATELY IF YOU CHANGE YOUR ADDRESS

If you move, you must notify the Fund Office of your new address. Important Information about your Plan and your vacation benefit check may be sent to you by mail. For you to receive these important materials, the Fund Office must have your correct address on file.

NOTIFY THE FUND OFFICE IMMEDIATELY IF YOU WANT TO CHANGE YOUR BENEFICIARY

If you want to name a new Beneficiary for your vacation benefits in case of your death, notify the Fund Office, in writing, immediately. If you die, the Fund Office can pay benefits only to the person that you have designated in writing as your Beneficiary or as defined in the Plan. The status of a Participant's spouse as Beneficiary shall terminate immediately upon the entry of a judgment or decree of divorce between the Participant and the Participant's spouse. The former spouse shall be recognized as a Beneficiary following the entry of such judgment or decree only if designated by a Qualified Domestic Relations Order or if designated by the Participant as Beneficiary after the entry of the judgment or decree on either of the forms described above.

AMOUNT OF YOUR VACATION BENEFITS

You will receive the total amount of payments your Employer has made to the Fund Office on your behalf, minus any applicable administrative costs and/or service fees.

The Trustees' determination of the amount of Plan benefits payable to you is final, except in cases where clerical errors were made.

The amount your Employer remits on your behalf for vacation benefits to the Plan on is included in your gross salary. Social Security, federal, and state taxes have already been paid on your vacation pay by the time you receive your vacation benefit.

SERVICE FEES

It is required that a service fee be paid by a short-term participant to defray a portion of the expense incurred by the Fund in establishing a vacation benefit account for such a participant. A participant for whom vacation contributions have been made for less than 500 hours in each of two consecutive years shall have deducted from his or her vacation benefit account a service fee in the amount of $25.00. For purposes of this provision, a "year" is defined as the work period from April 1 through March 31.

A Participant who is enrolled as an apprentice in the Northeastern Apprenticeship Training Program will not be assessed the $25.00 service fee.

PAYMENT DATES

Participants are paid semi-annually via check. The amounts collected from October through March are paid out during the first week in June. The amounts collected from April through September are paid out during the first week in December. The payment dates are subject to change at the discretion of the Trustees. You will be notified in advance of any changes to the payment date.

The Plan only governs when vacation benefit checks are distributed. It does not dictate when you actually may take your vacation.

For example, amounts collected from April 2020 through September 2020 will be paid December 2020. And, amounts collected October 2020 through March 2021 will be paid June 2021.

METHOD OF PAYMENT

You may choose to receive your vacation benefit from the following options:

- Receive your semi-annual vacation benefit via check by picking the payment up at the IBEW LU 126 Union Office located at 3455 Germantown Pike, Collegeville PA 19426 during the first full week of June and the first full week of December, Monday through Friday 8:00 am- 4:30 pm.

- Receive your vacation benefits via check mailed to you automatically after the first full week of June and after the first full week of December, but no later than the first full week of July or the first full week of January. A current address must be on file at the Fund Office in order to be eligible for this delivery method. It is the participant's responsibility to keep all records and current address information up to date. In the event the mailed vacation benefit disbursement is returned to the Fund Office, the member or participant has ninety days to pick up the payment. If the participant fails to retrieve their vacation benefit payment after this ninety day period, their check is null and void and the balance of the check is deposited into the Fund's Reserve Account. The member or participant is no longer eligible to receive the past accumulated vacation benefit. The Reserve Account will be used for operation costs and administrative fees associated with the Plan.

SPECIALCIRCUMSTANCES

Vacation Benefit Payments in the Event of your Death

If you die before receiving a vacation benefit, the amount you would have been eligible to receive, based on Employer Remittances made up to the time of your death, is paid to your designated Beneficiary. Your Beneficiary for the vacation benefit is the same person you name as Beneficiary of Death Benefits under the IBEW Local 126 Retirement Fund or, if the Participant is not a participant in the IBEW Local 126 Retirement Fund, then to the Participant's surviving spouse, but if none, the Participant's surviving child(ren), but if none, the Participant's surviving parent(s), but if none, to his or her estate. If the Participant becomes mentally incompetent before receiving vacation benefits, the Participant's accumulated vacation benefits will be paid to his or her guardian.

If a Participant retires permanently from work as an Employee, said Participants will be required to wait until the prescribed period of time for distribution of their benefits.

Early Distribution of Vacation Benefit Checks

The Plan will distribute vacation benefits before the next regular distribution date only:

- Upon your death, if your Beneficiary or executor of your estate sends a written request along with a copy of a death certificate, for early payment to the Fund Office; or

- If you are inducted into the armed forces of the United States or are recalled to active duty for more than 31 days.

Forfeited Vacation Pay

Vacation pay is forfeited permanently if:

- You do not cash your vacation benefit check (or ask that it be reissued) within 12 months after it is first issued;

- The Fund Office cannot send you your vacation benefit check because it does not have a current address for you or your vacation benefit check is not deliverable (the Fund Office will hold the check for you for ninety days (90) following the date of distribution); or

- In case of your death, if your Beneficiary or executor of your estate does not apply for your vacation pay within twelve months of the date of your death.

Amounts forfeited by Participants and the interest earned are deposited into the Fund for administrative and other authorized expenses.

Disqualifications from Receipt of Benefits

Your vacation benefit is based upon deductions made from wages of participants and accumulated for the participants' benefit. The Plan shall not pay any benefits to a participant:

- Where the Employer has failed or refused to deduct the required amounts from the participant's wages, or

- Where, although a deduction has been made, the Employer fails or refuses to remit the sums deducted to the Fund.

*Section IX***– *FILING A CLAIM***

CLAIM FILING PROCEDURE

(THINGS TO DO TO SPEED PAYMENTS OF CLAIMS AND BENEFITS)

In order to process your claim accurately, certain information is required. It is extremely important that you always provide your Physician, or the Fund, with accurate information concerning family members, i.e., names, dates of births, and social security number if required.

Incomplete or incorrect information will result in unnecessary and sometimes lengthy delays in payment of your claim. We are well aware of how frustrating these delays can be to you. To provide you with the fastest claim processing service possible, your assistance will be greatly appreciated. We have provided a checklist of those items below for your reference.

FOR CLAIMS RELATED TO DENTAL, VISION, LIFE INSURANCE, AD&D, DISABILITY AND PRESCRIPTION DRUG BENEFITS

Dental Claim Form – Send all claim forms to Delta Dental of Pennsylvania. You can contact Delta Dental by calling 1-800-932-0783 or by visiting: www.deltadentalins.com

Claims must be filed by the later of (1) the last day of the year following the year in which the charge for services is received by the claimant or (2) 120 days after the date on which the charge for services is received by the claimant.

Claims must be filed by the later of (1) the last day of the year following the year in which the charge for services is received by the claimant or (2) 120 days after the date on which the charge for services is received by the claimant.

Each charge you submit must be accompanied with the Date of Service on which the treatment related to the Charge was performed. We realize that you may prefer to submit Charges for a number of treatments from the same provider all at one time. Submitting claims in this manner will not cause a delay in processing so long as each charge being submitted is accompanied by the date the service was performed. The reason for this is that during different time periods, different benefit allowances may apply due to deductible or co-payment amounts being satisfied.

Since your benefits may be different, depending upon the type of treatment performed, it is important that each Charge and Date of Service be accompanied by a description of the specific treatment performed. Often there are a number of treatments, which might be used to address the same illness or injury.

If you wish to assign payment directly to the provider of service, please be sure to sign the appropriate space on the Statement of Claim being used by the provider.

Vision Claim Form – Send all claim forms to Vision Benefits of America (VBA). You can contact VBA by calling 1-800-432-4966 or by visiting: www.visionbenefits.com
Claims must be filed by the later of (1) the last day of the year following the year in which the charge for services is received by the claimant or (2) 120 days after the date on which the charge for services is received by the claimant.

Life Insurance Claim Form - Send all claim forms to the Fund Office.
Claim Date: Date of Death.
Filing Note: The Beneficiary should complete the Proof of Death Form, which is attainable from the Fund office, and attach thereto an original copy of the death certificate.
Filing Date: Within 90 days of loss, unless proof, satisfactory to the Plan Administrator, is submitted to otherwise show that the claim was filed as soon as reasonably possible.

AD&D Claim Form – Send all claim forms to the Fund Office.
Claim Date: Date of Death or date of Accident in the event of loss of limb or sight.
Filing Note: The Beneficiary should complete the dismemberment statement of claim and/or proof of death form and attach thereto an original copy of the death certificate and accident report. In the case of dismemberment attach a copy of the Medical Report and if appropriate the Police Report if one is available. Claims for Accidental Death and or Dismemberment Benefit must be filed within 90 days of the accident.
Filing Date: Within 90 days of loss, unless proof, satisfactory to the Trustees, is submitted to otherwise show that the claim was filed as soon as reasonably possible.

Weekly Accident and Sickness Claim Form- Send all claim forms to Guardian. You can contact Guardian by calling 1-800-268-2525 or by visiting: www.guardiananytime.com.
Claim Date: The date you are first unable to work as a result of the disability.
Filing Date: The later of (1) the last day of the year following the year in which the charge for services is received by the claimant or (2) 120 days after the date on which the charge for services is received by the claimant.

Prescription Drug Claim Form – Send all claim forms to Sav-Rx. You can contact Sav-Rx by calling 866-233-4239 or by visiting: www.savrx.com.
Claims must be filed by the later of (1) the last day of the year following the year in which the charge for services is received by the claimant or (2) 120 days after the date on which the charge for services is received by the claimant.

When a Claim Form is required, it is always best to use the appropriate Claim Form. These forms contain all the information required to process your claim accurately and quickly. These forms are obtainable from the Union Office or the appropriate Claims Administrator (described above). Please use a separate Claim Form for each family member, and use a separate Claim Form for each different provider of service. Claim forms are required for any accident or injury for which you receive treatment and submit a claim.

Definitions. The following words or phrases shall have the following meanings:

A. **Adverse Benefit Determination** is any denial, reduction, or termination of, or 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 Participant's or Dependent's eligibility to participate in a plan, and including 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, as well as 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..

B. **Authorized Representative** is a person or organization who demonstrates to the satisfaction of the Claims Administrator, in its sole and absolute discretion, that he, she or it has been authorized to act on behalf of a Participant or Dependent with respect to a Claim, or appeal of an Adverse Benefit Determination regarding a Claim. In the case of a Claim involving Urgent Care, a health care professional having knowledge of the Claimant's medical condition shall be permitted to act as Claimant's Authorized Representative.

C. **Board of Trustees** is the Board of Trustees of the I.B.E.W. Local Union No. 126 Health & Welfare Fund or any duly appointed Appeals Committee thereof.

D. **Claim**. A Claim is a written or electronic request for a Plan (non-medical) benefit made by Claimant in accordance with the Plan's procedure for filing benefit claims.

E. **Claimant** is a Participant, Dependent or Authorized Representative of such individuals who submit a Claim.

F. **Claims Administrator** is the Plan Administrator or is the person or entity designated by the Plan Administrator and charged with making benefit determinations.

G. **Disability Claim** is a Claim for which the Plan conditions the availability, payment or commencement of that benefit upon a showing of disability.

H. **Post-Service Claim (applies to dental and prescription drug benefits)** is a Claim for a benefit under the Plan other than an urgent or Pre-Service Claim.

I. **Pre-Service Claim (applies to dental and prescription drug benefits)** is a Claim for a benefit under the Plan for which the Plan conditions the receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

J. **Receipt of Claim**. A Claim is considered received by the Plan when the request contains enough information to permit a determination of eligibility of the person seeking a benefit; adequate information of the activity involved to determine if the service or event is covered by the Plan; and sufficient information, or authorization to obtain information, to permit the Plan to make the dollar payment to the appropriate party. A verbal request for coverage will be considered received on the day of the conversation only if a Claim is received by the Plan within 48 hours of the time of the conversation.

K. **Urgent Claim (applies to dental and prescription drug benefits)** is a Claim for care or treatment that, if the time periods for making non-urgent care determinations are applied, could seriously jeopardize the life or health of a Participant or Dependent

or the ability of the Participant or Dependent to regain maximum function. A Claim will also be considered an Urgent Claim if, in the opinion of a physician with knowledge of the Participant's or Dependent's condition, failure to obtain the care or treatment which is the basis of the Claim would subject the Participant or Dependent to severe pain that cannot be adequately managed without such care or treatment.

INITIAL CLAIM DETERMINATIONS

Urgent Claims (applies to dental and prescription drug benefits). A Claimant or his or her Authorized Representative may submit an Urgent Claim at any time twenty-four hours a day, seven days a week and fifty-two weeks a year. Appropriate steps will be taken to accept such Claims.

As soon as possible, taking into account the medical exigencies, but in no event later than 72 hours after Receipt of an Urgent Claim by the Plan, the Claims Administrator will notify the Claimant of the Plan's benefit determination with respect to the Claim. If the Claimant fails to provide sufficient information for the Plan to make a determination with respect to the Claim, the Claims Administrator will notify the Claimant within 24 hours of the Receipt of the Claim what additional information is required to complete the Claim. The Claimant will have at least 48 hours (taking into account the circumstances) to provide the additional information, and the Claims Administrator will issue a decision on the Claim as soon as possible, but in no event later than 48 hours after the earlier of (i) the Plan's receipt of the additional information, or (ii) the end of the period within which the Claimant was required to provide the additional information.

Notification to the Claimant of the Adverse Benefit Determination will be made by written or electronic media or, when appropriate, orally (e.g., by telephone), followed by written or electronic confirmation within three days.

Concurrent Care Decisions (applies to dental and prescription drug benefits). If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claims Administrator shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

If a Claimant requests to extend a course of treatment (beyond the period of time or number of treatments initially approved by the Claims Administrator) that involves an Urgent Claim, such Claim shall be decided as soon as possible, taking into account the medical exigencies,

and the Claims Administrator shall notify the Claimant of the Plan's benefit determination, within 24 hours after Receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Any appeal of an Adverse Benefit Determination with respect to a request to extend a course of treatment shall be governed by the appeal procedures described below, as appropriate to the type of Claim involved (i.e., Urgent, Pre-Service or Post-Service).

Pre-Service Claims (applies to dental and prescription drug benefits). A Claimant or his or her Authorized Representative may submit a Pre-Service Claim to the Claims Administrator. Within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 calendar days after Receipt of a Pre-Service Claim by the Plan, the Claims Administrator will notify the Claimant of the Plan's benefit determination with respect to the Claim. If the Claims Administrator determines that an extension of the 15-day period is necessary due to matters beyond the Plan's control, the 15-day period will be extended for an additional 15 days, and the Claimant will be notified (within the initial 15-day period) of the circumstances necessitating the extension and the date by which the Plan expects to make a decision on the Claim. If the extension is necessary due to the Claimant's failure to provide sufficient information for the Plan to make a determination with respect to the Claim, the Claims Administrator will notify the Claimant (within the initial 15-day period) what additional information is needed to complete the Claim, and the Claimant will have at least 45 days to provide the additional information. The 15-day period within which the Plan will issue its decision will be tolled from the date on which notice of the extension is sent to the Claimant until the earlier of: (i) the date the Claimant responds to the request for additional information or (ii) the end of the period within which the Claimant was required to provide the additional information.

Failure to Follow Claims Procedures.

A Claimant who fails to follow the Plan's procedures for filing an Urgent or Pre Service Claim will be notified of the failure and the proper steps that should be followed in filing the Claim. For Urgent Claims, such notice will be issued within 24 hours of the initial contact with the Plan. For Pre Service Claims, such notice will be issued within 5 days of the initial contact. This notification may be oral, unless the Claimant (or his or her Authorized Representative) requests written notice.

The above rules apply only if the failure by the Claimant is:

- A communication by a Claimant or his or her Authorized Representative that is received by a person customarily responsible for handling benefit matters under the Plan; and
- A communication that names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

Post-Service Claims (applies to dental and prescription drug benefits). A Claimant or his or her Authorized Representative may submit a Post-Service Claim to the Claims

Administrator. Within a reasonable period of time, but not later than 30 calendar days after Receipt of a Post-Service Claim by the Plan, the Claims Administrator will notify the Claimant of the Plan's determination with respect to the Claim. If the Claims Administrator determines that an extension of the 30-day period is necessary due to matters beyond the Plan's control, the 30-day period will be extended for an additional 15 days, and the Claimant will be notified (within the initial 30-day period) of the circumstances necessitating the extension and the date by which the Plan expects to make a decision on the Claim. If the extension is necessary due to the Claimant's failure to provide sufficient information for the Plan to make a determination with respect to the Claim, the Claims Administrator will notify the Claimant (within the initial 30-day period) what additional information is needed to complete the Claim. The Claimant will have at least 45 days to provide the additional information. The 15-day period within which the Plan will issue its decision will be tolled from the date on which notice of the extension is sent to the Claimant until the earlier of: (i) the date the Claimant responds to the request for additional information or (ii) the end of the period within which the Claimant was required to provide the additional information.

Weekly Accident and Sickness Benefit. A Claimant will be notified of any adverse decision by the Plan with regard to weekly accident and sickness benefits within a reasonable period of time, but in no case later than 45 days after receipt of the Claim by the Claims Administrator. An extension of up to 30 days is allowable for matters beyond control of the Plan. You will be notified of any extension including the reason why the extension is necessary and the date by which the Plan expects to make a decision, prior to the expiration of the initial 45 day period.

If within the first 30 day extension the Plan determines that a decision cannot be made within the extended period due to matters beyond the control of the Plan, an additional extension of up to 30 days is permissible. A Claimant will receive notice prior to the expiration of the first 30 day extension of the reason for the additional extension and the date as of which the Plan expects to make a decision. This notice will also explain the standards used by the Plan in determining whether a Claimant is entitled to a disability benefit, the unresolved issues preventing a decision on your claim, and any additional information needed to resolve those issues. If the additional extension is due to the need for more information, you will have 45 days in which to provide the additional information.

All other claims. A Claimant or his or her Authorized Representative may submit a Claim to the Claims Administrator. Within a reasonable period of time, but not later than 90 calendar days after Receipt of a Claim by the Plan, the Claims Administrator will notify the Claimant of the Plan's benefit determination with respect to the Claim. If the Claims Administrator determines that an extension of the 90-day period is necessary due to matters beyond the Plan's control, the 90-day period will be extended for an additional 90 days, and the Claimant will be notified (within the initial 90-day period) of the circumstances necessitating the extension and the date by which the Plan expects to make a decision on the Claim.

Notice of Claims Decisions. Following Receipt of a Claim, the Claims Administrator shall issue a written or electronic explanation of benefits form or other notice describing the Plan's decision concerning the Claim. If the decision includes an Adverse Benefit Determination, then the notice will include, at a minimum, the following information, provided in a manner that is calculated to be understood by the Claimant:

A. The specific reason or reasons for the Adverse Benefit Determination; Reference to the specific Plan provisions on which the determination is based;

B. When appropriate, a description of any additional information or material necessary for the proper processing of the Claim, and the reason it is needed;

C. A copy of the Plan's appeal procedures and time periods that the Claimant needs to follow in order to appeal the Claim, including when appropriate, a description of the Plan's expedited review process applicable to Urgent Claims, and a statement about the Claimant's right to bring suit pursuant to Section 502(a) of ERISA;

D. With respect to dental, prescription drug and weekly accident and sickness benefit claims, a copy of any internal rule, guideline, protocol or similar criterion that was relied upon in making the Adverse Benefit Determination. Alternatively, the notice may indicate that such rule, guideline, protocol or criterion was relied upon in making the Adverse Benefit Determination and that a copy is available at no cost at the Claimant's request.

E. For a Claim involving a determination of medical necessity, experimental treatment or similar exclusions, the notice will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances. Alternatively, the notice may indicate that such explanation is available at no cost at the Claimant's request.

Appeal Rights and Adverse Benefit Determinations – Prescription Drugs. A Claimant or his or her Authorized Representative shall have the right to appeal an Adverse Benefit Determination. There are two levels of review for Prescription Drugs.

Level One Appeal: The Claims Administrator will facilitate the initial request for an appeal (note that The Claims Administrator may use a third party to perform the review). The review uses the Plan's rules and is based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. Your appeal should include your name, member ID number, your doctor's name and telephone number, the name of the medication any information relevant to your appeal.

A decision will be provide to you and your doctor within 15 days of receipt of your written request. If your request is approved, the Claims Administrator will notify you by phone and send written notification to your doctor. If they are unable to reach you, written notification

will be sent. If your request is denied, written notification will be sent to you and your doctor.

Level Two Appeal: The Level Two Appeal can be made to the Plan's Board of Trustees (or its designated committee or Agent). An appeal must be made within 180 days after the claimant receives notification of the Adverse Benefit Determination at the Level One Appeal.

Appeals may include comments, documents, records and other information relating to the Claim for benefits. A Claimant making an appeal may request, and the Claims Administrator must provide, without charge, access to and copies of all documents, records or other information that is "relevant" to the Claim (as defined below).

All necessary information, including the Plan's decision on appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

The Board of Trustees of the Plan or an Appeals Committee thereof, shall make decisions on appeals of an Adverse Benefit Determinations without regard t the initial Adverse Benefit Determination. In no event will any decision on appeal be decided by the same individual who rendered the initial Adverse Benefit Determination or a subordinate of such individual. In addition, if deciding an appeal of any Adverse Benefit Determination is based in whole or in part on a medical judgment, the Trustees, or their designated Appeals Committee or agent, shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment wand who is neither an individual who was consulted in connection with the original Adverse Benefit Determination nor the subordinate of any such individual. The Plan may make arrangements with individual health care professionals or independent medical review firms to provide such consultation. The decision of the Plan on an appeal of a Claim that involved medical judgment shall identify the medical or vocational experts whose advice was obtained, whether or not the Plan relied on the advice in making its decision.

Appeal Rights for Adverse Benefit Determinations- Dental and Weekly Accident and Sickness Claims. A Claimant or his or her Authorized Representative shall have the right to appeal an Adverse Benefit Determination to the Plan's Board of Trustees (or its designated committee or agent). An appeal must be made within 180 days after the claimant receives notification of the Adverse Benefit Determination.

All necessary information, including the Plan's decision on appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

Appeals may include comments, documents, records and other information relating to the Claim for benefits. A Claimant making an appeal may request, and the Claims Administrator

must provide, without charge, access to and copies of all documents, records or other information that is "relevant" to the Claim (as defined below).

The Board of Trustees of the Plan, or an Appeals Committee thereof, shall make decisions on appeals of Adverse Benefit Determinations without regard to the initial Adverse Benefit Determination. In no event will any decision on appeal be decided by the same individual who rendered the initial Adverse Benefit Determination or a subordinate of such individual. In addition, if deciding an appeal of any Adverse Benefit Determination is based in whole or in part on a medical judgment, the Trustees, or their designated Appeals Committee or agent, shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the original Adverse Benefit Determination nor the subordinate of any such individual. The Plan may make arrangements with individual health care professionals or independent medical review firms to provide such consultation. The decision of the Plan on an appeal of a Claim that involved medical judgment shall identify the medical or vocational experts whose advice was obtained, whether or not the Plan relied on the advice in making its decision.

Special rule for Urgent Care Claims: The Plan will issue a decision on the appeal of an Urgent Care Claim, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

Special Rule for Pre-Service Claims: The Plan will issue a decision on the appeal of a Pre-Service Claim within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Post-Service and Weekly Sickness and Accident Benefit Claims: The Plan will issue a decision on the appeal of a Post-Service Claim in accordance with procedures set forth below for "All other claims".

Appeal Rights for Adverse Benefit Determinations- All other claims. A Claimant or his or her Authorized Representative shall have the right to appeal an Adverse Benefit Determination to the Plan's Board of Trustees (or its designated committee or agent). An appeal must be made within 60 days after the claimant receives notification of the Adverse Benefit Determination.

All necessary information, including the Plan's decision on appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

All other appeals must be submitted to the Plan in writing and may include comments, documents, records and other information relating to the Claim for benefits.

A Claimant making an appeal may request, and the Claims Administrator must provide, without charge, access to and copies of all documents, records or other information that is "relevant" to the Claim (as defined below).

The Plan will issue a decision on the appeal of a Claim no later than the date of the meeting of the Board of Trustees (or an Appeals Committee thereof) that immediately follows the Plan's receipt of the appeal, unless the appeal is filed within 30 days preceding the date of such meeting, in which case a decision on appeal will be made by no later than the date of the second meeting following the Plan's receipt of the appeal. If special circumstances require a further extension of the time for processing, a decision on appeal will be made by no later than the third meeting of the Board of Trustees (or an Appeals Committee thereof) following the Plan's receipt of the appeal. If such an extension of time is required because of special circumstances, the Claims Administrator will notify the Claimant in writing of the extension, describing the special circumstances and the date by which the decision on appeal will be made, before the beginning of the extension. The Claims Administrator will notify the Claimant of the decision on appeal as soon as possible, but not later than 5 days after the decision is made.

Notice of Decisions on Appeal. For each appeal submitted to the Plan, the Claims Administrator shall provide the Claimant with written or electronic notification of the Plan's decision on appeal. In the case of an Adverse Benefit Determination, the notification will include, at a minimum, the following information that shall be provided in a manner calculated to be understood by the Claimant:

A. The specific reason or reasons for the Adverse Benefit Determination.

B. Reference to the specific provisions on which the determination is based.

C. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. A document, record or other information is "relevant" to a Claim if it:
- **1.** was relied upon in making the benefit determination;
- **2.** was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; or
- **3.** demonstrates compliance with the administrative process and safeguards required by law when making the benefit determination.

D. A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under Section 502(a) of ERISA.

E. With respect to dental, prescription drug or weekly sickness and accident benefits claims, a copy of any internal rule, guideline, protocol or similar criterion that was relied upon in making the Adverse Benefit Determination. Alternatively, the notice may indicate that such rule, guideline, protocol or criteria was relied upon in making the Adverse Benefit Determination and that a copy is available at no cost at the Claimant's request.

F. For a Claim involving a determination of medical necessity, experimental treatment or similar exclusions, the notice will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances. Alternatively, the notice may indicate that such explanation is available at no cost at the Claimant's request

G. You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

FOR MEDICAL BENEFIT CLAIMS FROM A DOCTOR OR FACILITY

MOST PREFERRED AND BLUECARD PPO PROVIDERS WILL FILE CLAIMS FOR YOU. SIMPLY PRESENT YOUR IDENTIFICATION CARD AT THE TIME THE SERVICES ARE PROVIDED. WHEN YOU RECEIVE CARE FROM A NON-PREFERRED PROVIDER, YOU WILL NEED TO FILE A CLAIM TO RECEIVE BENEFITS. IF YOU DO NOT HAVE A CLAIM FORM, CALL THE NUMBER LISTED ON THE BACK OF YOUR IDENTIFICATION CARD, AND A CLAIM FORM WILL BE SENT TO YOU. FILL OUT THE CLAIM FORM AND RETURN IT WITH YOUR ITEMIZED BILLS TO INDEPENDENCE ADMINISTRATORS AT THE ADDRESS LISTED ON THE CLAIM FORM NO LATER THAN 20 DAYS AFTER COMPLETION OF THE COVERED SERVICES. THE ITEMIZED BILL SHOULD CONTAIN THE FOLLOWING INFORMATION:

1. **PATIENT'S NAME AND ADDRESS;**
2. **DATE OF SERVICE;**
3. **TYPE OF SERVICE AND DIAGNOSIS;**
4. **ITEMIZED CHARGES;**
5. **PROVIDER'S COMPLETE NAME AND ADDRESS.**

An expense will be considered Incurred on the date the service or supply was rendered.

If it was not possible to file the claim within the 20-day period, your benefits will not be

reduced, but in no event will the Plan be required to accept the claim more than one year after the end of the benefit period in which the Covered Services are rendered.

COVERED PERSON COMPLAINT PROCESS

Independence Administrators has a process for Covered Persons to express complaints. To register a complaint, Covered Persons should call the Customer Service Department at the telephone number on their identification ("ID") card or write to Independence Administrators at the following address:

Independence Administrators
P.O. Box 21974
Eagan, MN 55121

Most concerns are resolved informally at this level. However, if Independence Administrators is unable to immediately resolve the complaint, it will be investigated, and the Covered Person will receive a response in writing within thirty (30) days.

APPEALING A CLAIM DENIAL

Filing an Appeal Independence Administrators maintains procedures for the resolution of appeals. Appeals may be filed within 180 days of the receipt of a decision from Independence Administrators stating an adverse benefit determination. An appeal occurs when the Covered Person or another authorized representative requests a change of a previous decision made by Independence Administrators by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form. Contact Independence Administrators at the address listed below to obtain a form to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

Independence Administrators
P.O. Box 21974
Eagan, MN 55121

The Covered Person or other authorized person on behalf of the Covered Person, may request an appeal by calling or writing to Independence Administrators, as stated in the letter notifying the Covered Person of the decision.

Types of Appeals and Timeframe Classifications

Types of Appeals

The following are the two types of appeals and the issues they address.

- **Medical Necessity Appeal** – An appeal by or on behalf of a Covered Person that focuses on issues of Medical Necessity and requests Independence Administrators to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on the exclusions for Experimental/Investigational services or cosmetic services.

- **Administrative Appeal** – An appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding Independence Administrators' decision that concerns coverage terms such as exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity, this is not the primary issue that affects the outcome of the appeal.

Timeframe Classifications The timeframes described below for completing a review of each appeal depend on whether the appeal is classified as standard or expedited.

Standard appeal timeframes apply to both pre-service appeals and post-service appeals that concern claims for non-urgent care.

Standard pre-service appeal *- An appeal for benefits that, under the terms of the Plan, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available. A maximum of fifteen (15) days is available for internal review of a standard Pre-service appeal.*

Standard post-service appeal *- An appeal for benefits that is not a Pre-service appeal. (Post-service appeals concerning claims for services that the Covered Person has already obtained do not qualify for review as expedited/urgent appeals.) A maximum of thirty (30) days is available for internal review of a standard Post-service appeal.*

Expedited appeal timeframes apply to pre-service requests for urgent care.

Expedited appeal for urgent care *– An appeal that provides faster review, according to the procedures described below, on a pre-service issue. Independence Administrators will conduct an expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Covered Person's life, health or ability to regain maximum function or would subject the Covered Person to severe pain that cannot be adequately managed while awaiting a standard appeal decision. A maximum of seventy-two (72) hours is available for internal review of an expedited appeal.*

Information for the Appeal Review including Matched Specialist's* Report You may submit to Independence Administrators additional information pertaining to your case. You may specify the remedy or action being sought. Upon request at any time during the appeal process, Independence Administrators will provide you or your authorized representative access to, and copies of, all relevant documents and records, including information reviewed by the decision maker(s) on the appeal. Input from a matched specialist is obtained for all

Medical Necessity appeals.

A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the adverse benefit determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

Appeal Decision Makers Employees of Independence Administrators have been designated to act as decision maker(s) on the appeal. The decision maker(s) did not make the adverse benefit determination at issue in the appeal and are not subordinates of the person who made that determination. Each decision maker will review all relevant information for the appeal, whether from the Covered Person or his authorized representative, or obtained from other sources during the investigation of the appeal issues.

Right to Pursue Civil Action If you are enrolled in a group health plan that is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you have the right to bring a civil action under Section 502(a) of the Act after completing the appeal processes described here.

Changes in Appeal Processes Please note that the Appeal processes described here may change due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve the appeal processes, or to reflect decisions of the Plan Sponsor and/or Plan Administrator regarding the administration of the appeal processes for this Plan.

Standard Pre-service and Post-service Appeals

There are two levels of review for standard pre-service and post-service appeals.

- **Level One Standard Appeal**

  The initial request for an appeal will be evaluated and the decision completed within the following timeframes for a standard Administrative or Medical Necessity appeal:

  Standard Pre-service Appeal – within 15 days of receipt of the appeal request
  Standard Post-service Appeal – within 30 days of receipt of the appeal request

  The Covered Person will be sent written notice of the first level decision within the timeframe stated above that applies to the appeal. If the Covered Person's appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell the Covered Person that relevant information is available, and describe how he can appeal to the next level. The first level appeal decision for a standard appeal is final unless the Covered Person exercises his right to appeal the decision as described below.

- **Level Two Standard Appeal**

  If the Covered Person is not satisfied with the first level decision, he or she may request a second level appeal within sixty (60) days. The appeal will be evaluated and the decision completed within the following timeframes for the second level review of a standard Administrative or Medical Necessity appeal:

  Standard Pre-service Appeal – within 15 days of receipt of the appeal request
  Standard Post-service Appeal – within 30 days of receipt of the appeal request

  Written notice of the second level decision will be sent within the timeframes stated above. If the Covered Person's appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, and tell the Covered Person what relevant information is available.

  The second level decision is final with respect to the Covered Person's right to review of an Administrative or Medical Necessity appeal through Independence Administrators' appeal process.

The standard appeal decision is final with respect to your right to appeal through Independence Administrators' internal appeal process.

Expedited Appeals - Process and Timeframes

If your case involves a serious medical condition which you believe may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed while awaiting a standard appeal decision, you may ask to have your case reviewed in a quicker manner, as an expedited appeal. An expedited pre-service appeal consists of one level of internal review for which the evaluation and decision must be completed within 72 hours of receipt of the appeal request.

To request an expedited appeal by Independence Administrators, call Customer Service at the toll free telephone number listed on the back of your ID card. Information related to your appeal will be requested and you will be promptly informed whether it qualifies for review as an expedited appeal or must instead be processed as a standard appeal.

The appeals specialist will review all relevant information for the appeal from the Covered Person or his authorized representative or from other sources that is received in time to permit compliance with the time limits for review of an expedited appeal. You are encouraged to supply additional relevant information to the appeals specialist preparing your appeal.

The expedited appeal review will be completed promptly based on your health condition, but no later than seventy-two (72) hours after receipt of your expedited appeal by Independence Administrators. You will be notified of the decision by telephone and a letter mailed in no more than seventy-two (72) hours. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to your Plan provision(s) and guidelines on which the decision is made, tell you that relevant information is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to you.

The expedited appeal decision is final with respect to a Covered Person's right to appeal through Independence Administrators' internal appeal process.

Legal Actions

With respect to all Claims under the Plan, no legal action against the Plan may be brought in any jurisdiction to obtain Plan Benefits unless a Claimant has exhausted the appeals procedures contained in these Procedures and then not until after a decision has been communicated to the Claimant within the time periods set forth herein. In the event that the Plan fails to communicate a decision to the Claimant within the time periods specified herein, the Claim shall be deemed denied as of the date on which the Claimant was otherwise required to receive notice of the decision.

No legal action may be started against the Plan in any jurisdiction more than 2 years after the time that a Claim was required to be filed with the Claims Administrator, but not including any period between the time an appeal was submitted to the Plan and the time a decision on that appeal was communicated to the Claimant.

Examination - The Claims Administrator or its designee shall have the right to have a Physician of its choice examine a Claimant during the pendency of a Claim as often as is reasonable under the circumstances. Failure to appear for such examination shall bar any further payment of Plan benefits.

NOTICE: Please see the section entitled "NOTICE OF CLAIM" found under the GENERAL PROVISIONS AND DEFINITIONS of this booklet.

Section X – ***CONTINUATION OF HEALTH CARE OPTIONS***

Option 1. CONTINUING HEALTH CARE UNDER SELF-PAY PROVISION

When a Participant or family member no longer qualifies for medical coverage, he or she can continue his or her medical benefits, if he or she complies with the rules for "Self-Pay Coverage" or "Dollar Bank" set forth in the Eligibility Requirements section. If a Participant elects Self-Pay Coverage, he or she will not be entitled to continue medical coverage under COBRA Continuation Coverage, as explained below.

Option 2. CONTINUING HEALTH CARE UNDER COBRA

You, your spouse and dependent should take the time to read this notice carefully.

Introduction
This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical Plan, Prescription Drug Plan, Dental Care Plan and Vision Care Plan (excluding Disability, Life Insurance, Dismemberment Insurance and Legal Services Plans). The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This section gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations, contact Independence Administrators by calling the toll free number on your Plan ID card.

COBRA Continuation Coverage
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, participants, spouses of participants, and dependent children of participants may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a participant, you will become a qualified beneficiary if you will lose coverage under Plan because either one of the following qualifying events happens:

(1) Your hours of employment with a contributing employer are reduced, or
(2) Your employment with a contributing employer ends for any reason except gross misconduct.

If you are the spouse of a participant, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment with a contributing employer are reduced;
(3) Your spouse's employment with a contributing employer ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

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

(1) The parent-employee dies;
(2) The parent-employee's hours of employment with a contributing employer are reduced;
(3) The parent-employee's employment with a contributing employer ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the IBEW Local Union No. 126 Health & Welfare Fund has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or a reduction of hours of employment, death of the participant, or enrollment of the participant in Medicare (Part A, Part B, or both), the contributing employer must notify the IBEW Local Union No. 126 Health & Welfare Fund of the qualifying event within 30 days of any of these events. For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the IBEW Local Union No. 126 Health & Welfare Fund. The Plan requires you to notify the IBEW Local Union No. 126 Health & Welfare Fund within 60 days after the qualifying event occurs. You must send this notice to: IBEW Local Union No. 126 Health & Welfare Fund, c/o Independence Administrators, 602 Office Center Drive, Suite 350, Fort Washington, PA 19034.

Once the IBEW Local Union No. 126 Health & Welfare Fund receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date the Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the participant, enrollment of the participant in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment with a contributing employer, or reduction of the participant's hours of employment with a contributing employer, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the IBEW Local Union No. 126 Health & Welfare Fund in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the IBEW Local Union No. 126 Health & Welfare Fund is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice must be sent to: IBEW Local Union No. 126 Health & Welfare Fund, c/o Independence Administrators, 602 Office Center Drive, Suite 350, Fort Washington, PA 19034.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent child in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former participant dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the IBEW Local Union No. 126 Health & Welfare Fund is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: IBEW Local Union No. 126 Health & Welfare Fund, c/o Independence Administrators, 602 Office Center Drive, Suite 350, Fort Washington, PA 19034.

If you have questions about your COBRA continuation coverage, you should contact the COBRA Department of the IBEW Local Union No. 126 Health & Welfare Fund, c/o Independence Administrators, 602 Office Center Drive, Suite 350, Fort Washington, PA 19034, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the IBEW Local Union No. 126 Health & Welfare Fund informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

*Section XI - **GENERAL PROVISIONS AND DEFINITIONS***

ACCIDENTAL INJURY — A sudden, unforeseen, and identifiable event causing injury to a Covered Person, which is the direct result of the event and which occurs while coverage under the Plan for the Covered Person is in force.

ADMINISTRATIVE SERVICES AGREEMENT — The agreement between the Plan Sponsor and Independence Administrators, under which Independence Administrators provides administrative services to the Plan Sponsor in connection with the Plan.

AMBULANCE — A specially designed and medically equipped vehicle used solely for the transportation of the sick and/or injured.

AMBULATORY SURGICAL CENTER — A Facility that: (1) has permanent facilities and equipment for the primary purpose of performing Surgery on an Outpatient basis; and (2) provides such treatment by or under the supervision of an organized staff of Doctors; and (3) provides nursing services whenever the patient is in the Facility; and (4) does not provide Inpatient accommodations; and (5) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Medicare, or by Independence Administrators; and (6) is not, other than incidentally, a Facility used as an office or clinic for the private practice of a Professional Provider.

AMENDMENT — A supplement made a part of the Plan, which alters the benefits or terms of the Plan.

ANCILLARY PROVIDER — An individual or entity that provides services, supplies or equipment (such as, but not limited to, home infusion therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the Plan.

ANESTHESIA — The administration of regional or local anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation, or loss of consciousness.

APPLICABLE LAW— The provisions of this Booklet will be interpreted in accordance with applicable Federal law and the law of the Commonwealth of Pennsylvania.

ASSIGNMENT — The contributions paid by employers to the Trust Fund shall not be deemed to be wages. Participants and Dependents shall not have any right to receive, from an Employer, an Associate's members, the Union or the Trustees, cash in lieu of benefits to which the Participant or Dependent might be entitled under this Plan. Except as hereinafter provided, Participants and Dependents shall not have any right to assign, transfer, pledge, encumber or alienate their benefits or payments at any time during the term of this Plan or upon termination of either the Trust Agreement or Trust Fund, and any attempt to do shall be null and void and of no effect. Except as prescribed by law, no payment shall be subject to the debts and contracts of any payee, or to any judicial process to levy upon or attach the same for

the payment thereof. Any Participant, however, may authorize the Fund to pay benefits against expenses due to medical care and treatment directly to the persons, or institutions, on whose charges the claim is based. The Fund shall be discharged from all liability to the extent of any payment made in accordance with any authorization.

AUTOMOBILE INJURY CLAIMS
If a Participant, or dependent, suffers an injury arising out of the use of a motor vehicle and seeks the payment of medical benefits from this Fund, and is;

1. an individual who, or
2. the spouse of an individual who, or
3. the child of a Participant, or his spouse, who

is required by applicable state law to maintain insurance coverage for medical benefits with respect to an injury arising out of the maintenance or use of a motor vehicle and such insurance is not maintained as required, then benefits for such injury will be paid by the Fund as if the minimum amount required by applicable state law had been paid by an insurer providing such coverage.

> **EXAMPLE**
> *John is the owner/operator of an automobile. John is required by Pennsylvania law to maintain insurance providing a minimum of $5,000 in medical coverage for any injury arising out of the maintenance or use of the automobile. John does not maintain such required insurance. John, his wife Mary, his child Leo and another Participant in the Plan, Herb, are riding in John's car when it is involved in an accident. Neither John, Mary, nor Leo would be entitled to medical coverage from the Fund for the first $5,000 of their respective medical bills. Herb would be entitled to medical coverage from the Fund*

BIRTHING CENTER — A Facility that: (1) is primarily organized and staffed to provide maternity care by a Nurse Midwife; and (2) is licensed as a Birthing Center under the laws of the state where it is located; or (3) is approved by Independence Administrators.

BLUECARD PPO PROGRAM — A program that allows a Covered Person travelling or living outside of their plan's area to receive coverage for services at an in-network benefit level if the Covered Person receives services from Blue Cross Blue Shield providers that participate in the BlueCard PPO Program.

BLUECARD PPO PROVIDER — A Provider that participates in the BlueCard PPO Program as a Preferred Provider.

CALENDAR YEAR DEDUCTIBLE — The amount of eligible expenses the Covered Person is required to pay each calendar year before the Plan begins to pay benefits.

CERTIFIED REGISTERED NURSE — A Professional Provider who: (1) is a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or

certified clinical nurse specialist; and (2) is certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing.

CLAIM — A request for payment of benefits for services rendered or Supplies received, which is presented to Independence Administrators for payment. Such request must be submitted to Independence Administrators with all statements, questionnaires, certifications, instruments, documents, and affidavits requested by Independence Administrators that are necessary to properly process the request for benefits. Claim forms will be provided by Independence Administrators.

COINSURANCE — The specified percentage of Covered Expense the Covered Person is required to pay.

COLLECTIVE BARGAINING AGREEMENTS — The term "Collective Bargaining Agreements" shall mean the Collective Bargaining Agreement(s) in force and in effect from time to time between the Union, the Association, and the Employers, which obligate the Employer to make contributions to the Fund on behalf of its employees covered by the Collective Bargaining Agreement.

COMPLIANCE WITH CLAIM RULES — In order to obtain benefits, it is necessary that all claimants comply with the applicable claim rules set forth or established by the Trustees. The Trustees reserve the right to deny any claim not in compliance with the applicable claim rules.

CONTRIBUTION RATE— The amount required to be contributed by an employer to the Fund pursuant to the terms of the Trust Agreement.

COVERAGE QUARTER — The term "Coverage Quarter" shall mean a calendar quarter in which a participant is eligible to receive benefits.

COVERED EXPENSE — refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

A. For Covered Services provided by a Facility Provider, "Covered Expense" means the following:

   i. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Outpatient services means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or the BlueCard PPO Provider.

   ii. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Inpatient services means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or the BlueCard PPO Provider.

   iii. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Outpatient services means the lesser of 1.5 times the Medicare Allowable

Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent 50% of the Facility Provider's charges for Covered Services.

iv. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Inpatient services means the lesser of (1.5 times the Medicare Allowable Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent 50% of the Facility Provider's charges for Covered Services.

B. For Covered Services provided by a Professional Provider, "Covered Expense" means the following:

i. For Covered Services by a Preferred Professional Provider or BlueCard PPO Provider, "Covered Expense" means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with Independence Administrators, or the BlueCard PPO Provider.

ii. For a Non-Preferred Professional Provider, "Covered Expense" means the lesser of the Medicare Professional Allowable Payment or the Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent 50% of the Professional Provider's charges for Covered Services.

C. For Covered Services provided by an Ancillary Provider, "Covered Expense" means the following:

i. For Covered Services provided by a Preferred Ancillary Provider or BlueCard PPO Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or BlueCard PPO Provider.

ii. For Covered Services provided by a Non-Preferred Ancillary Provider, "Covered Expense" means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent 50% of the Non-Preferred Ancillary Provider's charges for Covered Services.

D. Nothing in this section shall be construed to mean that Independence Administrators would provide coverage for services other than Covered Services.

COVERED PERSON — (see PARTICIPANT)

COVERED SERVICE — A service, Supply, equipment, device, or drug specified in the Plan for which benefits will be provided when billed for by a Professional Provider, Facility, or Supplier.

CUSTODIAL CARE — Care that is provided primarily to assist the patient in meeting his activities of daily living. Such care is not provided primarily for its restorative or therapeutic value in the treatment of an Illness, injury, disease, or condition.

DEPENDENT — The Participant's: (1) spouse; or (2) natural born or legally adopted child (including a child for whom adoption proceedings have been initiated), including a stepchild; or (3) unmarried child age 26 or older who is unable to earn his own living due to a physical or Mental Illness or handicap (subject to Eligibility —Continuation of Eligibility).

Dependent spouses may not be on active military service.

DOCTOR — A practitioner, other than a Covered Person, who is acting within the scope of his license as a Doctor of medicine; psychiatrist, psychologist, osteopathy; podiatry; dentistry; optometry; chiropractic; licensed speech pathologist; licensed audiologist; licensed teacher of the hearing impaired; or any other practitioner that the Plan must by law recognize as a Doctor legally entitled to render treatment.

DUPLICATE COVERAGE — Please refer to Coordination of Benefits

DURABLE MEDICAL EQUIPMENT — Charges for: (1) non-disposable equipment that is primarily medical in nature, such as wheelchairs and hospital beds; and (2) orthotics or medical devices that are applied to or around the body for care or treatment of an injury or Illness; and (3) assorted medical items necessary for the treatment of respiratory diseases, such as oxygen tanks, oxygen contents, and oxygen masks.

EMERGENCY ACCIDENT TREATMENT — Provider expenses charged for the initial treatment of an Accidental Injury. Such treatment excludes Ambulance services.

EMERGENCY MEDICAL TREATMENT — Provider expenses charged for the initial treatment of a condition with acute symptoms that is life threatening or that could cause serious damage to a bodily function. Such treatment excludes Ambulance services.

EMPLOYER (OR CONTRIBUTING EMPLOYER) - The term "Employer" shall mean an Employer as defined in the Agreement and Declaration of Trust.

EMPLOYMENT WAITING PERIOD — The period, beginning with the date of employment, that an employee must serve continuously before he is eligible to receive benefits under the Plan.

ERRORS IN PAYMENT OF BENEFITS — The Trustees specifically retain the right to recover all monies paid in error to, or on behalf of, any person from such person. Upon discovery of payment "made in error," the Fund shall notify the recipient or dependent of such overpayment, together with a request for repayment. Upon failure to repay the amount due within a reasonable time after such notification, the Trustees may take such legal action as they

deem necessary or, in the case of a Participant of the Fund, the amount of the payment made in error may result in either future claims being denied or having the overpayment amount being deducted from future benefit payments that such Participant or his or her Dependent(s) or Beneficiary may become entitled to under this Plan.

EXPERIMENTAL/INVESTIGATIONAL SERVICES AND SUPPLIES — a drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

- Is the subject of ongoing Phase I or Phase II Clinical Trials;
- Is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
- Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the particular diagnosis or treatment of the Covered Person's particular condition; or
- Is generally recognized by either Reliable Evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established reference compendia:

- The American Hospital Formulary Service Drug Information; or
- The United States Pharmacopoeia Drug Information

recognize the usage as appropriate medical treatment. In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental/Investigational.

In addition to the above criteria that pertains strictly to the use of a drug, biological product or device, any drug, biological product, device, medical treatment or procedure is not considered Experimental/Investigational if it meets all of the criteria listed below in paragraphs A - E:

A. Reliable Evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable Evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.

C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigative settings.

E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

FACILITY — An institution or entity licensed, where required, to provide care. Such Facilities include:

- Alcoholism Treatment Facility
- Ambulatory Surgical Center
- Birthing Center
- Freestanding Dialysis Facility
- Freestanding Outpatient Facility
- Home Health Care Agency
- Hospital
- Psychiatric Hospital
- Rehabilitation Facility
- Skilled Nursing Facility
- Substance Abuse Treatment Facility

FAMILY UNIT — A Participant and his covered Dependents.

FRAUD — No benefit under this Plan will be paid if the person on whose account, or by whom the benefit is claimed, or the provider of service attempts to or does make a misrepresentation of a fact to the Fund with respect to any such claim. In the case of such conduct, the Board of Trustees may, in its sole and exclusive discretion, pay no further benefits to the Participant, or Dependent, involved as to the particular claim or as to any other claims arising during a period of not more than one year after the discovery of the misrepresentation, or attempted misrepresentation of fact by a Participant, Dependent, Beneficiary or Provider of Service. The Board of Trustees shall have the right to finally determine whether or not fraud has been attempted or committed upon the Fund, and unless arbitrary or capricious, its

decision shall be final, conclusive and binding upon all persons.

FUND — The term "Fund" shall mean the Local Union No. 126 Health and Welfare Plan as defined in the Agreement and Declaration of Trust.

HOME HEALTH AGENCY — An agency, association, or part of a Hospital that: (1) provides Skilled Nursing Care in the patient's home for the treatment of a physical Illness or injury that requires medical supervision and treatment; and (2) provides such care by or under the supervision of a Registered Nurse acting under the direction of a Doctor; and (3) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

HOSPICE — A Facility that: (1) is primarily engaged in providing palliative care to terminally ill individuals; and (2) is licensed and operated according to the laws of the state in which it is located and approved by Independence Administrators.

HOSPITAL — A short-term, acute care Facility that: (1) is a duly licensed institution; and (2) is primarily engaged in providing Inpatient diagnostic and medical services for the care or treatment of sick and injured persons; and (3) provides such care by or under the supervision of an organized staff of Doctors; and (4) has organized departments of medicine; and (5) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (6) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Independence Administrators. A Hospital is not, other than incidentally, a:

- Nursing Home
- Place for Rest
- Place for the Aged
- Place for the Provision of Hospice care
- Place for the Provision of Rehabilitation Care
- Place for the Treatment of Alcoholism or other Drug Abuse
- Place for the Treatment of Mental Illness
- Skilled Nursing Facility
- Spa or Sanitarium

HOSPITAL-BASED PROVIDER — A physician who provides Medically Necessary services in a Hospital or Preferred Facility Provider supplemental to the primary care being provided in the Hospital or Preferred Facility Provider, for which the Covered Person has limited or no control of the selection of such physician. Hospital-based providers include physicians in the specialties of radiology, anesthesiology and pathology and/or other specialties as determined by Independence Administrators. When these physicians provide services other than in the Hospital or Preferred Facility, they are not considered Hospital-Based Providers.

ILLNESS — A condition marked by pronounced deviation from the normal, healthy state.

IMMEDIATE FAMILY — The Covered Person's spouse, parent, child, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, or son-in-law.

INCURRED — A charge is deemed Incurred as of the date of the service or purchase giving rise to the charge.

INJURY— Injury means any bodily injury caused by an accident including such sickness as results directly from the accident. "An injury" or "any one injury" means all such injury caused by any one accident.

INPATIENT — A person who is treated as a registered overnight bed patient in a Facility.

INTERPRETATION OF THE PLAN — The Board of Trustees of the Fund, subject to the requirements of law, shall be the sole judge of the standard of proof required in any case and the application and interpretation of the Fund, and the decision(s) of the Board of Trustees are final and binding on all parties.

LEGEND DRUGS — Drugs, biological and compounded prescriptions which, by Federal Law, can be dispensed only pursuant to a prescription, and are required to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription."

LIABILITY FOR PAYMENT OF BENEFITS — The total liability for the payment of all non-insured benefits as provided herein shall be limited to the assets of the Fund

LICENSED PRACTICAL OR VOCATIONAL NURSE (L.P.N. OR L.V.N.) — A nurse who has graduated from a formal practical or vocational nursing education program and is licensed by the appropriate state authority.

LOCALE OF TREATMENT — No benefits shall be paid on account of any charges incurred for treatment rendered in any location other than the United States of America or the Dominion of Canada. Emergency treatment received outside the above locale shall be considered by the Fund for payment.

MAINTENANCE CARE — Care provided to maintain the patient's current level of functioning or to prevent deterioration. Such care is not primarily provided for its therapeutic value in the treatment of an Illness, disease, injury, or condition and does not require participation or administration by professional medical personnel.

MEDICALLY APPROPRIATE/MEDICALLY NECESSARY (or MEDICAL APPROPRIATENESS/MEDICAL NECESSITY) — an intervention will be covered if it is (a) a Covered Service, (b) not specifically excluded, and (c) Medically Appropriate/Medically Necessary. An intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by Independence Administrator's medical director or physician designee, it meets all of the following criteria:

A. It is a "Health Intervention". A Health Intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical

condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; Illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. It is the most appropriate Supply or level of service, considering the potential benefit and harm to the Subscriber.

C. It is known to be "effective" in improving "health outcomes". Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

i. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered new if it is not yet in widespread use for (a) the medical condition, and (b) the patient indications being considered.

"Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

ii. Existing interventions: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion. For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for a determination of Medical Necessity. If no Scientific Evidence is available, professional standards of care should be considered. If professional standards of care do not exist, are outdated, or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence. Existing interventions can meet the contractual definition of Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed

through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. It is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost effective" does not necessarily mean lowest price. An intervention is considered cost effective if the benefit and harm relative to costs represent an economically, efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this Medically Appropriate/Medically Necessary definition.

MEDICARE ALLOWABLE PAYMENT FOR FACILITIES — the payment amount, as determined by the Medicare program, for the Covered Service for a Facility Provider.

MEDICARE ANCILLARY ALLOWABLE PAYMENT — the payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Provider.

MEDICARE BENEFITS — Unless prohibited by 42 United States Code, Section 1395y(b)(1)(A) (concerning discrimination against the working aged with respect to the entitlement of benefits under group health plans), if a Participant or Participant's spouse or Dependent becomes eligible for Medicare ("Medicare eligible individual"), the Medicare eligible individual shall apply for Medicare coverage. If the Medicare eligible individual fails to apply for Medicare coverage, the Fund will provide supplemental benefits only, and Medicare benefits, both parts A and B, will be taken into account when calculating benefits under the Plan; the Medicare eligible individual must still meet the Plan's required deductibles, co-pays and coinsurance payments in addition to paying any costs Medicare would have covered if the Medicare eligible individual had enrolled as required. The Fund will determine a participant's and dependent's benefit allowance, if any, based upon the applicable Medicare statutes and regulations.

MEDICARE PARTS A AND B — "Hospital Insurance Benefits for the Aged and Disabled" under Title XVIII, Part A and/or Part B respectively, of the Social Security Act, as amended from time to time.

MEDICARE PRIMARY PARTICIPANT – (1) a Retired Participant age 65 or older; (2) a Family Member of a Retired Participant who is age 65 or older; or (3) a Family Member who is under age 65 and in receipt of a Social Security Disability Award for twenty four (24) months.

MEDICARE PROFESSIONAL ALLOWABLE PAYMENT — the payment amount, as determined by the Medicare program, for the Covered Service based on the Medicare Par Physician Fee Schedule.

MENTAL ILLNESS — An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominating feature.
Mental or nervous disorders that have a demonstrable organic origin will not be considered Mental Illness.

NON-PREFERRED ANCILLARY PROVIDER — an Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED FACILITY PROVIDER— a Facility Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROFESSIONAL PROVIDER— a Professional Provider who is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROVIDER — a Facility Provider, Professional Provider or Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.,

NURSE MIDWIFE — A Professional Provider who: (a) is certified to practice as a Nurse Midwife; and (b) is licensed by the appropriate state authority as a Registered Nurse; and (c) has completed a program for the preparation of Nurse Midwife that is approved by the state in which the person is practicing.

OPEN ENROLLMENT PERIOD — The 31 day period immediately prior to the anniversary date of the Plan.

ORGANIC DISEASE— includes any health condition in which there is an observable and measurable disease process (biomarker), e.g. inflammation or tissue damage. Non organic diseases or functional disorders, demonstrate no disease process which is visible or which can be established through standard diagnostic testing.

OUTPATIENT — A person who receives services or Supplies while not an Inpatient.

PARTICIPANT (OR ELIGIBLE PARTICIPANT) — An individual who has satisfied the eligibility requirements based upon contributions made on his behalf and has qualified for the Benefit Program during the Benefit Period.

No member of the Board of Directors shall be deemed a Participant unless such person is otherwise eligible as a bona fide employee of the Union, this Fund, the Local Union No. 126 Retirement Plan or the Local Union No. 126 Occupational Safety, Health and Education Trust Fund.

PARTICIPANT INDEBTEDNESS TO THE FUND — The Fund shall have the right to deduct from, or offset against, the payment of any benefits to which a Participant, Dependent, or designated Beneficiary shall be entitled, any sum to which the Participant is indebted to the Fund for any purpose whatsoever.

PAYMENT OF BENEFITS TO MINORS — If a person entitled to benefits under the Fund, of if any other person to whom benefits under the Fund would be payable by reason of the death of a Participant or Dependent, is a minor child, or is otherwise incapable of giving a valid release for any such benefits, the Board of Trustees may, at its option, and until claim is made by the duly appointed guardian or committee of such person, make payment of such benefits in a lump sum or in monthly installments in such amounts as to be determined by the Board of Trustees, to such adult, adults, or institution as have or has, in the opinion of the Board of Trustees, assumed responsibility for the care, custody or support of such person.

PHYSICAL EXAMINATION — The Fund, at its own expense, shall have the right and opportunity to examine the Participant, or Dependent, whose injury or sickness is the basis of the claim when and as often as the Fund reasonably requires during the pendency of a claim. The Fund shall have the right to deny all claimants such benefits if they refuse to permit such medical examinations.

PLAN — International Brotherhood of Electrical Workers Local Union No. 126 Health and Welfare Fund Benefit Plan. The Fund has entered into agreements with other providers of service companies to provide certain benefits which they are best suited to administer. For that reason, the use of the word Plan in this booklet may (if applicable) refer to the Claim Paying Agent for that particular type of claim.

PLAN AMENDMENTS — The Trustees reserve the right to alter the Plan of Benefits or the Rules and Regulations of the Plan at any time, in accordance with the terms of the Restated Agreement and Declaration of Trust.

PLAN SPONSOR — The Trustees of International Brotherhood of Electrical Workers Local Union No. 126 Health and Welfare Fund.

PREFERRED ANCILLARY PROVIDER — an Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services and/or supplies to Covered Persons.

PREFERRED FACILITY PROVIDER — a Facility Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER — a Professional Provider who is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for "in-network" Covered Services rendered to a Covered Person.

PREFERRED PROVIDER— a Facility Provider, Professional Provider or Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider, authorized to perform specific "in-network" Covered Services at the Preferred level of benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK — the network of Providers with whom Independence Administrators has contractual arrangements and BlueCard PPO Providers

PRIOR AUTHORIZATION — Written approval by Independence Administrators for medical or surgical treatment given prior to such treatment that outlines the Plan's liability for such treatment. Such approval will be given only after Independence Administrators: (1) reviews the case; and (2) receives the Covered Person's medical history and an explanation of the condition and treatment to be given (including any Surgical Procedures to be performed) written by his Doctor, and any supporting documentation.

PRIVATE ROOM — Accommodations in a room designed as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing not more than one bed.

PROFESSIONAL PROVIDER — A licensed person or practitioner performing services within the scope of such licensure. The Professional Providers include:

- Certified Registered Nurse
- Chiropractor
- Dentist
- Doctor
- Independent Clinical Laboratory
- Licensed Practical Nurse (LPN)
- Licensed Vocational Nurse (LVN)
- Nurse Midwife
- Optometrist
- Physical Therapist
- Podiatrist
- Psychologist

PROVIDER — A Facility, Professional or Ancillary Provider, licensed where required.

PSYCHIATRIC HOSPITAL — A Facility that: (1) is primarily engaged in providing Inpatient diagnostic, medical, and psychiatric services for the care or treatment of Mental Illness; and (2) provides such services by or under the supervision of an organized staff of Doctors; and (3) provides continuous 24-hour nursing services by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Independence Administrators.

QUALIFYING CLINICAL TRIAL — the systematic, intensive investigation or evaluation of a drug, biological product, device, medical treatment, therapy or procedure that meets all of the following criteria:

a. investigates a service that falls within a benefit category of the Plan;

b. is not specifically excluded from coverage;

c. has a therapeutic effect upon enrolled patients with diagnosed disease;

d. is intended to clarify or establish health outcomes of interventions already in common clinical use as defined by the available Reliable Evidence;

e. does not duplicate existing studies;

f. is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial;

g. is designed and conducted according to appropriate standards of scientific integrity;

h. complies with Federal regulations relating to the protection of human subjects;

i. has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease;

j. is: (1) funded by, or supported by centers or cooperative groups that are funded by: the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA); or(2) conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA;

k. is conducted by a Network Provider. If there is no comparable FDA Approved Clinical Trial being conducted by a Network Provider, the Plan will consider covering an FDA Approved Clinical Trial being conducted by a Non-network Provider.

In the absence of meeting the criteria listed in (a) - (j) above, the Clinical Trial must be approved by the Plan as a Qualifying Clinical Trial.

REASONABLE CHARGE — In relation to charges for services and supplies reasonable charge means the level of fees or charges for comparable services and supplies that is usual and customary in the areas where such services and supplies are provided.

REFERENCE TO MALE AND FEMALE GENDER — Members are referred to herein in the male gender and their spouse in the female gender. In the case of a female member, the male and female gender references should be reversed.

REGIONAL NETWORK DISCOUNT — The percentage reduction from Facility charges for Covered Services that Independence Administrators passes on to its customers as a share of the savings Independence Administrators is expected to realize from its negotiated Hospital contracts. The balance of any savings not passed on to its customers is for the sole benefit of Independence Administrators. The amount of the discount may be changed prospectively from time to time.

REGISTERED NURSE (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree program, or baccalaureate program) and is licensed by the appropriate state authority.

REHABILITATION FACILITY — An institution or part of an institution that: (1) specializes in providing restorative and therapeutic services on an Inpatient and Outpatient basis for the treatment of a physical Illness or injury, Mental Illness, drug addiction and alcoholism; and (2) provides such services by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

RELIABLE EVIDENCE — Only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

RETIRED PARTICIPANT (OR INDIVIDUAL WHO HAS RETIRED) — Means a Participant who has met the eligibility conditions for retiree coverage under the Fund.

ROUTINE COSTS ASSOCIATED WITH A QUALIFYING CLINICAL TRIAL — Routine Costs include: (a) Covered Services under this Contract that would typically be provided absent a Qualifying Clinical Trial; (b) services and supplies required solely for the provision of the Experimental/ Investigational drug, biological product, device, medical treatment or procedure; (c) the clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications; and (d) the services and supplies required for the diagnosis or treatment of complications.

Routine Costs do not include the Experimental/Investigational drug, biological product, device, medical treatment or procedure itself, the services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Qualifying Clinical Trial.

SCHEDULE OF BENEFITS — The Schedule of Benefits, which describes benefits, maximums, and allowances of the coverage provided under the Plan for each Covered Person.

SECOND SURGICAL OPINION/CONSULTATION — A written evaluation by another surgeon/specialist, who is not associated in practice with the first surgeon, as to the Medical Necessity of the surgery recommended by the first surgeon.

SEMIPRIVATE ROOM — Accommodations in a room designated as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing no less than two nor more than four beds.

SICKNESS — Sickness means any mental or physical disorder, including pregnancy, but excluding such sickness as is included within the term "injury". "A sickness," or "any one sickness," means all such sicknesses due to the same or related causes, including all complications and recurrences.

SKILLED NURSING CARE — All covered medical expenses charged for services that are primarily restorative and therapeutic in treatment of a physical Illness or injury that requires medical supervision of a Registered Nurse acting under the direction of a Doctor.

SKILLED NURSING FACILITY — An institution or part of an institution that: (1) specializes in providing Skilled Nursing Care on an Inpatient basis for the treatment of a physical Illness or injury that requires extended medical supervision and treatment; and (2) provides such care by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

SPOUSE — Spouse means a person of the opposite sex to whom you are lawfully married determined exclusively by the laws of the State in which you reside.

SUBSTANCE ABUSE — Any use of alcohol or other drug that produces a pattern of pathological use causing impairment in social or occupational functions or that produces physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE ABUSE TREATMENT FACILITY — A Facility that: (1) is primarily engaged in providing detoxification and/or rehabilitation services for alcoholism and/or other drug abuse and (2) is approved by the Joint Commission on Accreditation of Healthcare Organizations, appropriate government agency, or by Independence Administrators.

SUPPLIES — Charges made by a Hospital or Doctor for nonprescription, nondurable, disposable medical and surgical items that are necessary for the care or treatment of an Illness or Accidental Injury.

SURGERY/SURGICAL PROCEDURE — Treatment of an Illness, injury, or deformity by manual and operative methods.

1. **Cosmetic Surgery —** A Surgical Procedure for the correction of superficial areas of the body to enhance appearance or to change contour. Such surgeries are performed without the expectation of restoring function to the body area.

2. **Elective Surgery —** A Surgical Procedure that is of a non-emergency nature and not required to be immediately carried out.

3. **Reconstructive Surgery —** A Surgical Procedure for the correction, restoration, or improvement of bodily functions, or the relief of pain.

THERAPY SERVICES — The following services and Supplies when prescribed by a Doctor for the treatment of an Illness or injury to promote the recovery of the Covered Person:

1. **Radiation Therapy —** Treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

2. **Chemotherapy —** Treatment of malignant disease by chemical or biological antineoplastic agents.

3. **Dialysis Treatment —** Treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body. This includes hemodialysis or peritoneal dialysis.

4. **Physical Therapy —** Treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain and restore maximum function following disease, injury, or loss of body part.

5. **Respiratory Therapy —** Introduction of dry or moist gases into the lungs for treatment purposes.

6. **Occupational Therapy —** Treatment of a disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

7. **Speech Therapy —** Treatment to restore speech lost or impaired through Illness or injury, or to correct an impairment due to a congenital defect for which corrective Surgery has been performed.

TOTALLLY DISABLED (FOR PARTICIPANT ONLY) — Totally disabled means disabled in such a fashion that the individual is totally and continuously prevented from engaging in any occupation for which such individual is or becomes reasonably suited by age, education, training and experience.

TRUSTEES - The term "Trustee" shall mean the Trustees as defined in the Agreement and Declaration of Trust.

UCR - UCR is the Usual, Customary and Reasonable Charge as determined by the Fund.

UNION - The term "Union" shall mean The International Brotherhood of Electrical Workers Local Union No. 126.

USUAL CHARGE - Usual charge is the most consistent Charge by an individual Physician, or provider, to patients for a given service.

WORK QUARTER - Work quarter shall mean the calendar quarter in which contributions are due and made on your behalf.

OTHER GENERAL PROVISIONS

REGARDING TREATMENT WHICH IS NOT MEDICALLY NECESSARY

Independence Administrators only covers treatment which it determines Medically Necessary. A Preferred Provider accepts Independence Administrators decision and contractually is not permitted to bill the Covered Person for treatment which Independence Administrators determines is not Medically Necessary unless the Preferred Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by Independence Administrators, and that the Covered Person will be financially responsible for such services. A Non-Preferred Provider, however, is not obligated to accept Independence Administrators determination and the Covered Person may not be reimbursed for treatment which Independence Administrators determines is not Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Preferred Provider. You can avoid these charges simply by choosing a Preferred Provider for your care. The term "Medically Necessary" is defined in the ***Definitions*** section.

LIMITATION OF LIABILITY

Independence Administrators will not be liable for any injury(ies) or damage(s) resulting from acts or omissions of any person, institution or other Provider furnishing services or supplies to the Covered Person.
No legal action may be taken to recover benefits provided by the Plan until 30 days after Independence Administrators has received a properly completed claim. In no event may such action be taken later than one year after services or Supplies were performed or provided.

NOTICE OF CLAIM

Payments of benefits will not be made under the Plan unless proper notice is furnished to Independence Administrators that covered expenses have been provided to a Covered Person. **Written notice must be given within 60 days after expenses are Incurred for covered expenses.**

Failure to give notice to Independence Administrators within the specified time will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but **in no event will Independence Administrators be required to accept notice more than one year after covered expenses are Incurred.**

PAYMENT OF BENEFITS

Independence Administrators is authorized by the Plan to make payment directly to Facilities and Preferred Providers furnishing Covered Services for which benefits are provided under the Plan. However, Independence Administrators reserves the right to make the payments directly to the Covered Person. The right of the Covered Person to receive payment is not otherwise assignable unless required by State law.

If any benefit remains unpaid at the death of the Participant, payment will be made to the Participant's estate. If no estate is probated or expected to be probated, Independence Administrators will have the right to make payment to a third party who has paid covered expenses for the Participant, upon receipt of proper documentation of such payment. Independence Administrators will incur no liability due to such payment made pursuant to this provision.

A request for payment of benefits will be deemed to authorize Independence Administrators to institute an investigation and to have access to all pertinent data, including all records of a Hospital and/or Doctor pertaining to the Covered Person.

COVERED PERSON/PROVIDER RELATIONSHIP

1. The choice of a Provider or choice of treatment by a Provider is solely that of the Covered Person.

2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by a Covered Person. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's rendering of, failure or refusal to render Covered Services to a Covered Person.

PAYMENT OF PROVIDERS

1. PREFERRED PROVIDER REIMBURSEMENT

Reimbursement of health care providers who participate in the Preferred Provider Network is intended to encourage the provision of quality, cost-effective care. Set forth below is a general description of the reimbursement programs, by type of Network health care provider.

Please note that these reimbursement programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. If you have any questions about how your health care provider is compensated, please speak with your healthcare provider directly or contact Customer Service.

Physicians
Network physicians, including primary care physicians (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to the Network fee schedule for the specific medical services that the Physician performs.

Institutional Providers

Hospitals
For most Inpatient medical and surgical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

Independence Administrators is implementing a quality incentive program with a few of the Hospitals in the Network. This program will provide increased reimbursement to these Hospitals based on them meeting specific quality criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes, higher nursing staff ratios, and electronic submissions. This is a new incentive program that is expected to evolve over time.

Skilled Nursing Facilities, Rehabilitation Hospitals, and other care facilities
Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Facility. These amounts may vary according to the intensity of the Covered Services provided.

Ambulatory Surgical Centers ("ASCs")
Most ASCs are paid specific rates based on the type of Covered Service performed. For a few services, some ASCs are paid based on a percentage of billed charges.

Physician Group Practices, Physician Associations and Integrated Delivery Systems
Certain physician group practices, independent physician associations ("IPAs") and integrated hospital/physician organizations called Integrated Delivery Systems ("IDS") employ or contract with individual physicians to provide medical services. These groups are paid as described in the physicians reimbursement section outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

Ancillary Service Providers, certain Facility Providers and Mental Health/Substance Abuse Providers

Ancillary service providers, such as Durable Medical Equipment providers, laboratory providers, Home Health Care agencies, and Mental Health and Substance Abuse providers are paid on the basis of fee-for-service payments according to the Network fee schedule for the specific Covered Services performed. In some cases, such as for mental health and substance abuse benefits, one vendor arranges for all such services through a contracted set of Providers. Independence Administrators reimburses the contracted Providers of these vendors on a fee-for-service basis. An affiliate of Independence Administrators has less than a three percent ownership interest in this mental health/substance abuse vendor.

Hospitalists

Independence Administrators currently does not have a hospitalist program in place but is considering implementing such a program in the future. However, Independence Administrators continues to maintain interest in encouraging Hospitals to contract with Physicians who specialize in providing emergency room consultation and inpatient management services.

2. PAYMENT METHODS

The Covered Person or the Provider may submit bills directly to Independence Administrators and, to the extent that benefits are payable within the terms and conditions of this booklet, reimbursement will be furnished as detailed below. The Covered Person's benefits for Covered Services are based on the rate of reimbursement as set forth under "Covered Expense" in the "***Definitions***" section of this Booklet.

Facility Providers

Preferred Facility Providers

Preferred Facility Providers are members of the PPO Network and have a contractual arrangement with Independence Administrators for the provision of services to Covered Persons. Benefits will be provided as specified in the Schedule of Benefits for Covered Services which have been performed by a Preferred Facility Provider. Independence Administrators will compensate the Preferred Facility Providers in accordance with the contracts entered into between such Providers and Independence Administrators. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the PPO Network.

When a Covered Person seeks care from a Non-Preferred Facility Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level specified in the Schedule of Benefits. The reimbursement rate is specified under "Covered Expense" in the Definitions section of this Booklet.

Once Covered Services are rendered by a Facility Provider, the Plan will not honor a Covered Person's request not to pay for claims submitted by the Facility Provider. The Covered Person will have no liability to any person because of its rejection of the request.

Professional Providers

Preferred Professional Providers

Independence Administrators is authorized by the Covered Person to make payment directly to the Preferred Professional Providers furnishing Covered Services for which benefits are provided under this coverage. Preferred Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Preferred Professional Providers will make no additional charge to Covered Persons for Covered Services except in the case of certain Copayments, Coinsurance or other cost sharing features as specified under this program. The Covered Person is responsible, within 60 days of the date in which Independence Administrators finalizes such services, to pay, or make arrangements to pay, such amounts to the Preferred Professional Provider.

Benefit amounts, as specified in the Schedule of Benefits of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to Independence Administrators for determination. The decision of Independence Administrators shall be final.

Once Covered Services are rendered by a Professional Provider, Independence Administrators will not honor a Covered Person's request not to pay for claims submitted by the Professional Provider. Independence Administrators will have no liability to any person because of its rejection of the request.

Emergency Care by Non-Preferred Providers

If Independence Administrators determines that Covered Services provided by a Non-Preferred Provider were for Emergency Care, the Covered Person will be subject to the Non-Preferred cost-sharing levels. For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet. Inpatient

admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by Independence Administrators.

A Non-Preferred Provider who provided Emergency Care can bill you directly for their services, for either the Provider's charges or amounts in excess of Independence Administrators payment for the Emergency Care, i.e., "balance billing." In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance-billing.

Non-Preferred Hospital-Based Provider

When you receive Covered Services from a Non-Preferred Hospital-Based Provider while you are an Inpatient at a Preferred Hospital or other Preferred Facility Provider and are being treated by a Preferred Professional Provider, you will receive the Preferred cost-sharing level of benefits for the Covered Services provided by the Non-Preferred Hospital-Based Provider. For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the **Definitions** section of this booklet.

A Non-Preferred Hospital–Based Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of Independence Administrators payment to the Non-Preferred Hospital-Based Providers, i.e., "balance billing." In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance billing.

Note that when you elect to see a Non-Preferred Hospital-Based Provider for follow-up care or any other service where you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Treatment, if a Non-Preferred Provider admits you to a Hospital or other Facility Provider, Covered Services provided by a Non-Preferred Hospital-Based Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between Independence Administrators payment and the Provider's charge.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet

Inpatient Hospital Consultations by a Non-Preferred Professional Provider

When you receive Covered Services for an Inpatient hospital consultation from a Non-Preferred Professional Provider while you are Inpatient at a Preferred Facility Provider, and the Covered Services are referred by a Preferred Professional Provider, you will receive the

Preferred cost-sharing level of benefits for the Inpatient hospital consultation.

For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet.

A Non-Preferred Professional Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of Independence Administrators payment to the Non-Preferred Professional Providers, i.e., "balance billing." In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance billing.

Note that when you elect to see a Non-Preferred Professional Provider for follow-up care or any other service when you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Care, if a Non-Preferred Professional Provider admits you to a Hospital or other Facility Provider, services provided by Non-Preferred Professional Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between Independence Administrators' payment and the Provider's charge. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet.

Non-Preferred Professional Provider

Except as set forth above, when a Covered Person seeks care from a Non-Preferred Professional Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level specified in the Schedule of Benefits. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Professional Provider, the Covered Person will be responsible to reimburse the Non-Preferred Professional Provider for the difference between Independence Administrators payment and the Non-Preferred Professional Provider's charge.

Ancillary Providers

Preferred Ancillary Providers

Preferred Ancillary Providers include members of the PPO Network that have a contractual relationship with Independence Administrators for the provision of services or supplies to Covered Persons. Benefits will be provided as specified in the Schedule of Benefits for the provision of services or supplies provided to Covered Persons by Preferred Ancillary

Providers. Independence Administrators will compensate Preferred Ancillary Providers in the PPO Network in accordance with the contracts entered into between such Providers and Independence Administrators.

Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the PPO Network. Benefits will be provided to the Covered Person at the Non-Preferred cost sharing level. The Covered Person will be penalized by the application of higher cost sharing. For payment of Covered Services provided by a Non-Preferred Ancillary Provider, please refer to the definition of Covered Expense in the Definitions section of this Booklet. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Ancillary Provider, the Covered Person will be responsible to reimburse the Non-Preferred Ancillary Provider for the difference between Independence Administrators payment and the Non-Preferred Ancillary Provider's charge.

ASSIGNMENT OF BENEFITS TO PROVIDERS

The right of a Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this coverage be transferred, either before or after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the coverage, as required by law.

RIGHT TO RECOVER EXCESS PAYMENTS

Independence Administrators reserves the right to recover claim payments made in excess of the benefits payable for Covered Services under the Plan. Independence Administrators may request that the payee, either a Covered Person or Provider, return the excess payment to Independence Administrators.

GENERAL BENEFIT EXCLUSIONS AND LIMITATIONS

Exclusions:

In addition to the exclusions and limitations provided elsewhere in this Plan, benefits are not payable for the following:

1. Charges incurred because of an injury arising out of employment or because of sickness covered by workmen's compensation or occupational disease law. This exclusion does not apply to any medical or prescription drug benefits incurred with respect to such injury or sickness which is caused by an underlying medical condition;
2. Charges for services or supplies not medically necessary, or treatments, which are not approved by the attending physician, or charges which are not Usual, Customary and Reasonable;
3. Charges for treatments, services and/or supplies provided by the United States government,

and/or any other government, unless you were legally required to pay for such treatments, or for charges that would not have been made had the Plan not been in effect;

4. Charges for venipuncture related to lab work;
5. Smoking cessation products;
6. Fitness programs;
7. Routine physicals for dependent children over the age of 18;
8. Charges associated with any treatment for weight reduction;
9. Charges for hearing aids (except for dependent children under the age of 19);
10. Charges to the extent that they are recovered from any person or organization other than an insurer of the patient;
11. Charges for any other medical, dental, vision, or pharmacy service except as provided in your Summary Plan Description;
12. Charges incurred in connection with a pregnancy of any family member other than the Participant, or Spouse of a Participant;
13. Charges incurred for, or in connection with, experimental services and surgical procedures;
14. Charges related to any treatment in connection with transsexual surgery, artificial insemination, in-vitro fertilization, sexual dysfunction, or infertility treatments;
15. Charges for speech, hearing, or supplies, music therapy, marriage counseling or therapy;
16. Charges for the replacement of artificial limbs or eyes, including fitting of replacements;
17. Charges for any accident, or illness, that is a direct result of an automobile accident. All such expenses must be filed with the automobile insurance carrier as no payment will be considered by the Fund until the maximum liability has been paid by the automobile insurance carrier;
18. Personal convenience items;
19. Any service or supplies that are not medically necessary;
20. Any expenses incurred prior to the effective date of the Participant's or Dependent's coverage under the Fund;
21. Any covered expenses which are covered or provided for by any other Group Plan or Program other than a private insurance plan of the Participant or Dependent;
22. Treatment of bunions (except for capsular or bone surgery), toenails (except for surgery of ingrown toenails), corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain or symptomatic complaints of the feet, except for those dependents covered in this Summary Plan Description;
23. Charges for the completion of any claim forms;
24. Charges in connection with an abortion, unless it is performed to save a mother's life;
25. Charges incurred by an individual after his/her coverage terminates;
26. Charges for any treatment on or to the teeth or gums except as required:
    - **a.** by injury not caused by chewing or biting food or other objects;
    - **b.** for excision of partially or completely unerupted impaction;
    - **c.** for excision of a tooth root without the extraction of the entire tooth; or,
    - **d.** for incisive or excisive procedures on the gums and tissues of the mouth, not performed in connection with the extraction or repair of teeth;
    - **e.** for treatment for periodontal disorders;
27. Charges for medical or prescription drug benefits incurred as a result of an injury or sickness suffered during, or exacerbated by, the commission of a felony by the Participant or Dependent for which he/she is charged with committing. If the Participant or Dependent is not convicted of such felony, he/she may resubmit the related medical and/or prescription drug benefit claims. This exclusion shall not apply to charges of domestic violence related

felonies;

28. Charges in excess of the payment the provider of service accepted as payment in full from any other source, except private insurance;

29. Convalescent, custodial, sanitarium care, travel, or rest cures;

30. Charges resulting from war, whether declared, or undeclared;

31. Charges for cosmetic treatment and/or surgery for purposes other than correction of damage caused by accidental injury or for the correction of a birth defect, providing that the Participant or Dependent, as applicable, is still eligible for benefits as of the date of the cosmetic treatment or surgery. **Reconstructive surgery requires pre-approval from the Fund;**

32. Charges for Counseling or Group Therapy. See General Provisions and Definitions Section for additional information;

33. Charges will not be covered for a Participant's and/or Dependent's mental or nervous disorder when the disorder relates to or arises from a gambling habit;

34. The Trust Fund will not pay, and no allowance toward any deductible amount shall be made, for charges which have been incurred by a Participant or Dependent for or in connection with death or bodily injury caused by self-destruction or attempted self-destruction, including suicide or attempted suicide and/or intentional or deliberate self-inflicted injury. This exclusion does not apply to any medical or prescription drug benefits incurred with respect to any such death or bodily injury which is caused by an underlying medical condition;

35. This section is subject to other benefit exclusions and limitations listed elsewhere in the Summary Plan Description.

Section XII - ***LEGAL NOTICES***

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Effective January 1, 1998, the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") regulates employer group health plans and may affect your decision whether to elect COBRA coverage. The following applies under HIPPA:

Loss of Other Coverage
If you your spouse and /or your dependents might have been eligible to enroll in the Plan at the earliest time but declined coverage during the initial period of eligibility because you, your spouse and/or dependents had other coverage, you, your spouse and/or your dependents may later request enrollment in the Plan. You, your spouse and/or your dependents will be enrolled in the Plan if each of the following conditions is met:

1. At the time coverage under the Plan was previously offered, the employee, spouse and/or dependent was covered under a different group health Plan or had health insurance coverage ("alternate coverage"), and
2. The alternate coverage must have been either: under a COBRA continuation provision and the COBRA coverage was exhausted, or, was not COBRA coverage and the alternate coverage was terminated as a result of loss of either loss of eligibility (including loss as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or because employer contributions towards such alternate coverage were terminated. Loss of eligibility does not include loss of alternate coverage resulting from non payment of premium or fraud; and
3. At the time coverage under the Plan was declined, the employee stated in writing to the Claims Administrator that the alternate coverage was the reason for the decline; and
4. The employee must request enrollment in the Plan no later than thirty (30) days after the date of exhaustion of the alternate coverage described in section 2, above.

If enrollment is granted, coverage will be effective no later than the first day of the calendar month beginning after the date the completed request for enrollment is received. Contact the Claims Administrator for more detailed information.

New Dependents: Enrollment of New Spouses
New spouses will be enrolled in the Plan if each of the following conditions is met:

1. The employee must be either a participant in the Plan or has met the applicable waiting period and is eligible to be enrolled in the Plan but for a failure to enroll during the previous enrollment period; and
2. The new dependent becomes a dependent of the employee through marriage; and
3. The employee must request enrollment of the new spouse in the Plan no later than thirty (30) days after the date of marriage.

Coverage is effective as of the date of marriage. The employee who is eligible, but who previously declined coverage under the Plan, is eligible to enroll in the Plan at the same time that the employee's spouse is enrolled but must provide the Claims Administrator with a copy of the marriage license. The employee and new spouse will be subject to pre-existing condition exclusions permitted under the law in accordance with the Plan's provisions and relevant to timely enrollees.

Contact the Claims Administrator for more detailed information.

New Dependents: Enrollment of Newborns, Adopted Children and Children placed For Adoption

Newborns, Adopted Children and Children placed For Adoption will be enrolled in the Plan if each of the following conditions is met:

1. The employee must be either a participant in the Plan or has met the applicable waiting period and is eligible to be enrolled in the Plan but for a failure e to enroll during the previous enrollment period; and
2. The new dependent becomes a dependent of the employee through birth, adoption or placement for adoption; and
3. The employee must request enrollment of the newborn, adopted child or child placed for adoption in the Plan no later than thirty (30) days after the date of birth or the court's issuance of the decree of adoption or placement for adoption.

Coverage is effective as of the date of the birth, adoption or placement for adoption. An employee or employee's spouse who is eligible but who previously declined coverage under the Plan is eligible to enroll in the Plan at the same time that the employee's newborn, adopted child or child placed for adoption is enrolled.

Contact the Fund Office at 3455 Germantown Pike, Collegeville, PA 19426-1534, (610) 489-1185 for more detailed information.

Notice of Certificate of Creditable Coverage

When requested, the Claims Administrator will provide to a new employer/potential insurer information on categories of benefits provided under the Plan, but will charge cost for disclosing the information.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the

insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). A nurse midwife or physician assistant may be considered an attending provider if licensed in the state to provide maternity/pediatric care in connection with childbirth.

An expectant mother must provide written notification to the Claims Administrator of her pregnancy in advance of admission in order to use certain providers or facilities or to reduce her out of pocket costs. Cost sharing/deductibles will be applied to a hospital stay in connection with childbirth, but the deductible for the later part of the stay greater than the deductible imposed for the earlier part of the stay. Other than for spouses of participants, benefits for Dependents and their newborns in connection with childbirth are excluded from this Plan. Contact the Claims Administrator for more detailed information.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS ("QMCSO")

The Plan will honor and provide benefits to all Dependents of active Participants in accordance with any QMCSO, as defined in ERISA, and in accordance with ERISA's regulations governing QMCSOs. The Participant must provide the Claims Administrator with a copy of the Court Order for the Child to be provided benefits under the QMCSO. If the Participant contests the QMCSO, the Plan will provide and continue providing benefits in accordance with the QMCSO until provided with satisfactory evidence that the QMCSO is no longer in effect or until the Participant is no longer active in the Plan, whichever is sooner. Contact the Claims Administrator for more detailed information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ("WHCRA")

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including Lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. Therefore, the following deductibles and coinsurance apply: 80% co-insurance (after deductible, if out of network). If you would like more information on WHCRA benefits, call the Plan Administrator at (610) 489-1185.

CHIPRA Notice

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.
Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

You may be eligible for assistance paying your employer health plan premiums. A list of State contact information is available through the Fund Office. You should contact your State for further information on eligibility.

Your Rights Under the Federal Family and Medical Leave Act ("FMLA")

If you qualify for FMLA leave from a Contributing Employer, you may be entitled to a continuation of employer contributions.

FMLA covers employers with fifty (50) or more employees. An employee must have worked twelve (12) or more months, plus 1,250 hours in the previous twelve (12) months, for the employer from whom the leave is requested. FMLA requires employers to grant an employee up to twelve (12) weeks of leave during any twelve (12) month period for the birth of a child, and in order to care for such child, the placement of a child with the employee for adoption or foster care, the care of a spouse, child, or parent who has a serious health condition, or because a serious health condition makes the employee unable to perform the functions of his job. A "serious health condition" is an "illness, injury, impairment or physical or mental condition" that involves inpatient care in a hospital, hospice or residential medical care facility or continuing treatment by a health care provider. Family leave may be taken by a biological parent or an individual who takes the place of a biological parent. The

"son or daughter" for whom care is needed may include a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in place of a parent who is under eighteen (18) years of age or eighteen (18) years of age or older and incapable of self care because of a mental or physical disability.

FMLA requires employers whose eligible employees take a family or medical leave to continue coverage in a group health plan on the same conditions as coverage would have been provided if the employee had been continuously employed. The Plan allows Contributing Employers to continue the full plan of benefits for employees who are on a family or medical leave. The Contributing Employers are required to pay the standard monthly local contribution rate on behalf of employees on leave during the last payroll period in the month.

You must contact your employer and establish your right to family or medical leave. If you are granted such leave, your employer should continue to list you on monthly reports which accompany the employer's contributions during family and medical leave. You will be entitled to COBRA continuation. The employees who are on leave will be so designated on the report form. You may be obligated to reimburse your employer for contributions paid in the event that you do not return to work with the Contributing Employer from family or medical leave.

The Plan will only continue coverage pursuant to the FMLA if your employer actually pays contributions. You will otherwise receive notice of your COBRA self-payment rights and be responsible for self-payment. You may have a right to reimbursement if your employer fails to continue contributions required by FMLA.

Section XIII - ***THIRD-PARTY LIABILITY CLAIMS***

Participants and covered Dependents are required to comply with the Fund's procedures for third-party liability claims (including subrogation). The Fund will not pay related claims should a Participant or covered Dependent fail to comply with those procedures.

The purpose of this Section is to insure that the limited funds available to finance the benefits provided by the Fund are not used to provide benefits where other funds may be available to pay the cost of the benefits provided by the Fund. In furtherance of this purpose, in the event that the Fund has made, does make or is obligated to make payments to or on behalf of a Participant or Dependent ("Covered Person") arising out of any Illness or Injury then, as a condition for receiving benefits from the Fund, the Covered Person shall:

(1) Notify the Fund, in writing, that a Claim relating to such Illness or Injury has been filed by the Covered Person against a third party seeking Available Funds,

(2) Notify the Fund, in writing of the name and address of the Covered Person's attorney, provide the attorney with a copy of this Section and any Subrogation/Reimbursement Agreement ("Agreement") the Fund may require the Covered Person to sign in order to receive benefits and require that the attorney comply with the terms of this Section and of any such Agreement.

(3) Keep the Fund informed, in writing, of the progress and/or settlement of his/her Third Party Claim.

(4) Include in all Claims, a claim for benefits paid by the Fund to or on behalf of the Covered Person and/or claimed from the Fund by or on behalf of the Covered Person.

(5) Specifically grant the Fund a first right of reimbursement and reimburse the Fund that portion of the Available Funds which is due to the Plan for benefits paid to or on behalf of the Covered Person as well as for any premiums and other payments paid on behalf of the Covered Person to continue health insurance and/or other coverage pursuant to any Disability Eligibility Credit provisions of the Fund. The right of reimbursement granted to the Fund by the Covered Person includes the right of the Fund to seek reimbursement from any person or entity that holds the Available Funds, including but not limited to, a legal guardian, representative, trustee, parent or dependent

(6) Specifically grant to the Fund subrogation and all rights of recovery and causes of action that the Covered Person may have against the third-party, whether by suit, settlement or otherwise, that may be liable for the Covered Person's Illness or Injury for which the Fund has paid or is obligated to pay benefits on the Covered Person's behalf.

(7) Hold in trust for the Fund's benefit that portion of the total recovery from any source that is due for payments made or to be made. The Covered Person shall reimburse the Fund immediately upon recovery.

(8) Do nothing to impair, release, discharge or prejudice the Fund's rights to subrogation and/or reimbursement. The Covered Person shall assist and cooperate with representatives the Fund designates. The Covered Person shall do everything necessary to enable the Fund to enforce its subrogation and reimbursement rights.

(9) Require and authorize Covered Person's attorney, if any, to withhold from Available Funds any monies due the Fund pursuant to this Section and/or the Agreement and to forward them to the Fund as required by this Section and/or the Agreement. In case of any dispute over what monies are due the Fund, Available Funds shall be escrowed pending resolution of such dispute.

(10) Available Funds shall be considered plan assets under ERISA (without regard to how, or with respect to whom, such Available Funds are held or titled). Further, the Participant and/or covered Dependent who recovers, and any other person who holds (or who has any title to), such Available Funds shall be considered an ERISA fiduciary with respect thereto and may not assign, transfer, pledge, encumber, alienate, spend, or dispose of, the Available Funds.

Counsel Fees. The Fund shall have no obligation to pay any attorney's fees to any attorney retained by the Covered Person to pursue Third Party Claims or to have any attorney's fees or costs withheld from amounts due to the Fund. The Fund shall not be bound by any agreement to the contrary made by the Covered Person. The Covered Person shall be solely responsible for paying all legal fees and expenses in connection with any recovery and the Fund's recovery shall not be reduced by such legal fees or expenses unless the Fund Administrator, in his sole discretion, agrees in writing to discount the Fund's claim.

Right to set-off. The Covered Person agrees that in the event that the Covered Person fails or refuses to comply with the provisions of this Section and/or the Agreement, then the Fund, in addition to any other rights to which the Fund or the Trustees thereof might have, shall have the right to withhold from any payments due or which become due to the Covered Person or to third parties on behalf of the Covered Person any amounts necessary until the Fund is fully reimbursed as described in this Section and/or the Agreement.

Recording or use. The Covered Person hereby authorizes the Fund to record and/or use this Section and/or the Agreement in any proceedings involving the Covered Person including using this Section and/or the Agreement in any Third Party Claims that the Covered Person may have.

Authorization to pay. The Covered Person hereby authorizes any person or entity paying Available Funds to or on behalf of this Covered Person to pay over to the Fund such monies as the Fund is entitled to under this Section and/or the Agreement and this Section and/or the Agreement shall constitute their warrant to do so. In case of any dispute over what monies are due the Fund, Available Funds shall be escrowed pending resolution of such dispute.

Minors. Any Covered Person making a Claim on behalf of any minor child under the Fund's plan of benefits shall make the Agreement on behalf said minor child and agrees that he/she

is authorized to make the Agreement on behalf of said minor child.

Other Insurance. It is agreed that any payment received by a Covered Person from any insurance carrier, from Blue Cross, from Blue Shield or from any like or similar plan for which the Covered Person has paid the full premium in order to secure individual, as distinguished from group coverage, shall be excluded from the requirements of this Section and/or the Agreement.

Rejection of make-whole doctrine. The application of the make-whole doctrine is specifically disavowed by the Fund and by the Covered Person. The Covered Person agrees that the Fund's right to reimbursement, as set forth above, takes first priority on a first-dollar basis over any other claims, regardless of whether or not Covered Person has been fully compensated for all claims for damages or whether the Available Funds include payment for medical or non-medical expenses or are so characterized.

Equitable Lien/Constructive Trust. By making payments on behalf of the Covered Person, the Fund is granted an equitable lien by agreement and constructive trust over the Available Funds, to which the Covered Person consents.

Rejection of Common Fund doctrine. Covered Person agrees to the Fund's express rejection of Common Fund doctrine. The Fund's reimbursement and subrogation rights apply to any recovery by a Covered Person without regard to legal fees and expenses of the Covered Person.

For purposes of this Section, the following terms shall be defined as follows:

(1) The term **"Covered Person"** shall have the same meaning as in Section I of this Summary Plan Description and shall also include any dependent and/or beneficiary of any Covered Person who may be entitled to benefits under the terms of the plan of benefits, as well as any parent(s), heir(s), estate(s), trust(s), guardian(s), representative(s) and any other person or entity that may be entitled to or that may receive a benefit from the Fund.

(2) The term **"Illness or Injury"** shall mean any illness or injury of whatever kind or description, whether arising out of a work related cause or whether unrelated to work of the Covered Person.

(3)The term **"Available Funds"** shall mean monies recovered from third parties through a lawsuit, settlement or otherwise (whether called pain and suffering, weekly indemnity, workers compensation, damages, restitution, wage loss, medical reimbursement, out of pocket expenses or any other term) as a result of the injury or illness.
The terms **"Claim**" or **"Third Party Claim"** shall mean any claim for monetary or non-monetary compensation of whatsoever kind or description whether made by petition (e.g. workers' compensation petition), court complaint, insurance claim or whether merely by written or oral demand.

Erroneous Payments

Notwithstanding any other provision of the Fund to the contrary, any person who receives a benefit (including a payment) under the Fund shall be required to repay to the Fund: (1) any erroneous payment made to or on behalf of such person, including the value of any benefit erroneously provided, whether due to administrative mistake or otherwise; (2) appropriate interest; and (3) in the case of fraud or misrepresentation or in the event repayment is contested, any and all costs of collection (including attorney's fees). In addition, the Trustees may take any reasonable action to recoup such erroneous payment or benefit, together with interest, and where applicable, costs, and including, without limitation, by offsetting future benefits and/or payments.

Section XIV - ***HIPAA PROTECTED HEALTH INFORMATION***

Definition of Protected Health Information
Protected Health Information ("PHI") shall mean the same as that term is defined in Section 164.501 of the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") issued by the Department of Health and Human Services ("HHS") and promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Purpose
This section permits the Fund to disclose PHI to the Board, acting solely in its capacity as the sponsor of the Fund and not as the administrator of the Fund, to the extent that such PHI is necessary for the Board to carry out its administrative functions related to the Fund.

Disclosure to the Board of Trustees
The Fund (or health insurance issuer or HMO with the Fund's permission) may disclose the PHI to the Board of Trustees that is necessary for the Board to carry out the following functions related to the Fund. The Board needs to access participant claim information for the purpose of performing those functions that are designated as "Plan Sponsor" functions under ERISA. Such functions include obtaining premium bids from health plans for providing health insurance coverage under the Fund and modifying, amending, or terminating the Fund or any benefit provided by the Fund. All other access to PHI by the Board is done in the Board's capacity as the administrator of the Fund and is described in the HIPAA Policies and Procedures for the Fund. The Board may use and disclose the PHI provided to it from the Fund (or health insurance issuer or HMO) only for the purposes described in this paragraph.

Conditions on the Use and Disclosure of PHI
The Board agrees to the following conditions on the use and disclosure of PHI received from the Fund:

a. Prohibition on Unauthorized Use or Disclosure of PHI. The Board will not use or further disclose any PHI received from the Fund, except as permitted in this document or required by all applicable law, including but not limited to HIPAA.
b. Minimum Necessary Standards. The Board will make reasonable effort to limit the PHI used, disclosed, or requested to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request.
c. Subcontractors and Agents. The Board will require each of its subcontractors or agents to whom it provides PHI to agree to the same conditions that apply to the Board with respect to such information.
d. Permitted Purposes. The Board will not use or disclose PHI for employment-related actions and decisions or in connection with any other of the benefits sponsored by the Board.
e. Reporting. The Board will report to the Fund any impermissible or improper use or disclosure of PHI not authorized by the plan documents.
f. Access to PHI by Participants. The Board will make PHI available to the Fund to permit participants to inspect and copy their PHI contained in the designated record set.

g. Correction of PHI. The Board will make a participant's PHI available to the Fund to permit participants to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and will incorporate amendments provided by the Fund.
h. Accounting of PHI. The Board will make a participant's PHI available to permit the Fund to provide an accounting of disclosures.
i. Disclosure to Government Agencies. The Board will make its internal practices, books and records relating to the use and disclosure of PHI received from the Fund available to the Department of Health and Human Services or its designee for the purpose of determining the Fund's compliance with HIPAA.
j. Return or Destruction of PHI. When PHI is no longer needed for the purpose for which disclosure was made, the Board must, if feasible, return to the Fund or destroy all PHI that the Board received from or on behalf of the Fund. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Board agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Adequate Separation
The Board represents that adequate separation exists between the Plan and Plan Sponsor. Only the Board will have access to the PHI provided by the plan and only for plan administration functions described above.

Reports of Non-Compliance
Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Fund's Privacy Official. The Fund and the Board will cooperate to remedy the situation and mitigate any harmful effect resulting from the use or disclosure of PHI. After an investigation into the incident, those employees who are found to be in violation of these policies or the HIPAA Privacy Regulations will be sanctioned as is deemed appropriate. The Fund and the Board will cooperate to create new safeguards and procedures so as to prevent a future incident of noncompliance.

Certification
The Fund will disclose PHI to the Board only upon receipt of Certification by the Board that the Board will protect the PHI as described in this section.

Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Disclosure and Use of Protected Health Information
What follows is a Notice of Privacy Practices of the Plan of Benefits of the International Brotherhood of Electrical Workers Local Union No. 126 Health and Welfare Fund (the "Fund"). The Notice establishes the circumstances under which the Fund may share your protected health information with others in accordance with the Health Insurance Portability

and Administrative Accountability Act of 1996 (HIPAA) Privacy Rules.

The Fund may use your protected health information ("PHI") for purposes of making or obtaining payment for your care and conducting health care operations. The Fund has established a policy to guard against unnecessary disclosure of your health information.
YOUR PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED IN THE FOLLOWING CIRCUMSTANCES AND FOR THE FOLLOWING PURPOSES:

To Make or Obtain Payment. The Fund may use or disclose your PHI to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Fund may use or disclose PHI for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants and beneficiaries. Health care operations includes such activities as:

a. Quality assessment and improvement activities.
b. Activities designed to improve health or reduce health care costs.
c. Clinical guideline and protocol development, case management and care coordination.
d. Contacting health care providers, participants and beneficiaries with information about treatment alternatives and other related functions.
e. Health care professional competence or qualifications review and performance evaluation.
f. Accreditation, certification, licensing or credentialing activities.
g. Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
h. Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
i. Business planning and development including cost management and planning related analysis and formulary development.
j. Business management and general administrative activities of the Fund, including member services and resolution of internal grievances.
k. Certain marketing activities.
For example, the Fund may use your PHI to conduct case management, quality improvement, disease management, utilization review, or to engage in member service and grievance resolution activities.

For Treatment Alternatives. The Fund may use or disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health Related Benefits and Services. The Fund may use or disclose your PHI to provide to you information on health related benefits and services that may be of interest to you.

For Disclosure to Plan Sponsor. The Fund may disclose your PHI to the Plan Sponsor, the Trustees of the Fund, for plan administration functions performed by the Trustees on behalf of the Fund. In addition, the Fund may provide summary health information to the Trustees so that the Trustees may solicit premium bids from health insurers or modify, amend or terminate the plan. The Fund may also disclose to the Trustees information on whether you are participating in the plan.

Where Required or Permitted by Law. The Fund also may use or disclose your PHI where required or permitted by law. In that regard, HIPAA generally permits health plans to use or disclose PHI for the following purposes: where required by law; for public health activities; to report child or domestic abuse; for governmental oversight activities; pursuant to judicial or administrative proceedings; for certain law enforcement purposes; for a coroner, medical examiner, or funeral director to obtain information about a deceased individual; for organ, eye, or tissue donation purposes; for certain government-approved research activities; to avert a serious threat to an individual's or the public's health or safety; for certain government functions, such as related to military service or national security; or to comply with Workers' Compensation laws.

Authorization to Use or Disclose Protected Health Information
By law, the following types and uses and disclosures of PHI generally require your authorization: use or disclosure of psychotherapy notes, use or disclosure of PHI for marketing purposes, and disclosure of PHI selling purposes. Except as stated above, the Fund will not disclose your PHI other than with your written authorization. If you authorize the Fund to use or disclose your PHI, you may revoke that authorization in writing at any time.

Your Rights With Respect to Your Protected Health Information
You have the following rights regarding your PHI that the Fund maintains:

Right toRequest Restrictions. You have the right to request restrictions on certain uses and disclosures of your PHI. You have the right to request a limit on the Fund's disclosure of your PHI to someone involved in the payment of your care. However, the Fund is not required to agree to your request, except if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law or the PHI pertains solely to a health care item or service for which you, or person other than the Fund on your behalf, has paid the covered entity in full. If you wish to make a request for restrictions, please contact the Fund's Privacy Officer (see Contact Person below).

Right to Receive Confidential Communications. You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your PHI could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing and mail to the Fund's Privacy Officer (see Contact Person

below). The Fund will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Protected Health Information. You have the right to inspect and copy your PHI, with some limited exceptions. A request to inspect and copy records containing your PHI must be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). If you request a copy of your PHI, the Fund may charge a reasonable fee for copying, assembly and postage, if applicable, associated with your request.

Right to Amend Your Protected Health Information. You have the right to request an amendment to your PHI records that you believe are inaccurate or incomplete. The request will be considered as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). The Fund may deny the request if you do not state why you believe your records to be inaccurate or incomplete. The request also may be denied if your PHI records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend includes information you are not permitted to change, or if the Fund determines the records containing your PHI are accurate and complete.

Right to an Accounting. You have the right to obtain a list of disclosures of your PHI made by the Fund for any reason other than for treatment, payment or health care operations, unless you have authorized the disclosure. The request must be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). The request should specify the time period for which you are requesting the information. The right to an accounting does not extend beyond six (6) years back from the date of your request. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost based fee. The Fund will inform you in advance of the fee, if applicable.

Right to a Copy of this Notice. You have a right to obtain and receive a copy of this Notice at any time, even if you have received this Notice previously. To obtain a copy, please contact the Fund's Privacy Officer (see Contact Person below).

Duties of the Fund

The Fund is required by law to maintain the privacy of your PHI as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify affected individuals following a breach of unsecured PHI. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice by providing you with a copy of a revised Notice within sixty (60) days of the change and by making the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the

United States Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The Fund has designated Richard Muttik as its contact person ("Privacy Officer") for all issues regarding patient privacy and your privacy rights. You may contact this person as follows: Local Union 126, IBEW, 3455 Germantown Pike, Collegeville, PA 19426 or (610) 489-1185.

Section XV ***- PLAN INFORMATION***

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS
LOCAL UNION NO. 126 HEALTH AND WELFARE FUND
3455 Germantown Pike
Collegeville, PA 19426-1534
(610) 489-1185

Employer Identification Number
23-6395223

PLAN ADMINISTRATION:
This Plan is maintained pursuant to Collective Bargaining Agreements between the Association, any Employer and the Union. Copies of the applicable Collective Bargaining Agreements may be obtained by any Participant upon written request to the Plan Administrator, or they may be examined at the Union's Office during normal business hours.

The Board of Trustees is advised by Legal Counsel, Accountants, Investment Managers, and an Administrative Staff in the discharge of their duties.

UNION TRUSTEES

Richard Muttik
Bus. Mgr./Fin. Sec.
Local Union No. 126, IBEW
3455 Germantown Pike
Collegeville, PA 19426

Christopher Wentzel
Assistant Business Manager
Local Union No. 126, IBEW
3455 Germantown Pike
Collegeville, PA 19426

Patrick Casey
Local Union No. 126, IBEW
3455 Germantown Pike
Collegeville, PA 19426

MANAGEMENT TRUSTEES

Jeffrey A. Scarpello
Executive Director
National Electrical Contractors Assoc.
2003 Renaissance Blvd.
King of Prussia, PA 19406

Randy Roberts
H.B. Frazer
514 Shoemaker Road
King of Prussia, PA 19406

Harry Miller, III
Miller Brothers
301 Alan Wood Road
Conshohocken, PA 19428

AGENT FOR SERVICE OF LEGAL PROCESS

The Trustees listed above are designated as agents for service of legal process.

PLAN ADMINISTRATOR HEALTH & WELFARE TRUST FUND
Board of Trustees
c/o Local Union No. 126, IBEW
3455 Germantown Pike
Collegeville, PA 19426
(610) 489-1185

FUND COUNSEL
Cleary, Josem & Trigiani LLP
Constitution Place
325 Chestnut Street, Suite 200
Philadelphia, PA 19106

SUBSTANCE ABUSE AND MENTAL HEALTH COORDINATOR
Active Members
Independence Administrators
1900 Market Street
Suite 500
Philadelphia, PA 19103

Retired Members:
AmeriHealth Administrators
1900 Market Street
Suite 500
Philadelphia, PA 19103

INVESTMENT MANAGER
UBS
Mellon Bank Center
1735 Market Street
Philadelphia, PA 19103

FUND AUDITOR
Novak Francella, LLC
Certified Public Accountants
One Presidential Blvd., Suite 330
Bala Cynwyd, PA 19004

CONSULTANT
Lacher
632 East Broad Street
Souderton, PA 18964
(215) 723-4378

CONTRACT CLAIMS ADMINISTRATOR
Active Members:
Independence Administrators
1900 Market Street
Suite 500
Philadelphia, PA 19103

Retired Members:
AmeriHealth Administrators
1900 Market Street
Suite 500
Philadelphia, PA 19103

IMPORTANT INFORMATION REQUIRED BY
EMPLOYEE RETIREMENT INCOME SECURITY ACT
(ERISA)

RIGHTS AND PROTECTION UNDER ERISA

As a Participant in the I.B.E.W. Local Union 126 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, and union halls, all documents governing the plan and a copy of the latest annual report (Form 5500) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit 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, and copies of the latest annual report (IRS Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Pre-Existing Conditions

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 the other 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 (pension or welfare) benefit under this Plan or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay the costs and legal fees. If you lose, the court may order you to pay the costs and fees, for example, if it finds your claim to be frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator you should contact the nearest area office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Name and Address of Union and Employer Sponsors

Local Union No. 126, IBEW
3455 Germantown Pike
Collegeville, PA 19426
E.I.N. 23-6395223/Plan Number 501

The Line Construction Division of the
Penn-Del-Jersey Chapter of the National
Electrical Contractors Association ("Penn-Del")
2003 Renaissance Blvd.
King of Prussia, PA 19406

Participants and Dependents may receive from the Plan Administrator, upon written request, information as to whether a particular employer, or employer organization is a member of Penn-Del or a contributing employer to the Plan, and if so, that party's address. This information may also be obtained in person from the Union Office during normal business hours.

Type of Plan
Multi-Employer Health, Disability and Welfare Plan.

The Plan Year
Begins on January 1 and ends on December 31 for the purposes of accounting, providing benefits and preparing the reporting and disclosure information which must be submitted to the United States Department of Labor and other regulatory bodies.

Collective Bargaining Agreements
The Plan is maintained pursuant to various Collective Bargaining Agreements between the Union and Employers or Employer Sponsors. A copy of any such Agreement is available for examination by a Participant or Dependent upon written request to the Board of Trustees.

Funding Method
The Plan is financed primarily by employer contributions on behalf of the Participants, the amount of which is specified in the Collective Bargaining Agreement between your Employer and the Union.

The Plan assets are held in a trust, which is administered by the Board of Trustees.

Plan Benefits
This Plan provides Hospitalization, Surgical, Major Medical, Dental, Vision, Prescription Drug, Substance Abuse, Mental Health, Life Insurance, Accidental Death & Dismemberment and Weekly Sick & Accident Benefits.

Source of Benefits

1. The Life Insurance and Accidental Death & Dismemberment are provided under outside provider contracts.

2. The Self-Insured Medical (including Mental Health and Substance Abuse), Prescription Drug, Dental, Vision, Hearing Aid and Prescription Safety Glasses, and Weekly Accident and Sickness (Disability) Benefits are provided directly by the Fund and are administered by third parties. Whenever a contract with a third party administrator contains duplication of coverage provisions which differ from those provided under this Summary Plan Description, the Plan shall govern the provision of coverage.

Governing Provisions

1. Qualification of Plan

The Association and Union have adopted the Plan conditioned upon its qualifications for tax-exempt status under the Internal Revenue Code and the Employment Retirement Income Security Act of 1974 ("ERISA").

2. Non-Alienability of Benefits

No benefits payable under this Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge.

3. Close of Plan Year

The last day of the year for the purposes of maintaining the Plan's fiscal records is December 31.

4. Controlling Documents

The Summary Plan Description, although believed to be an accurate summary, does not cover all details of the Plan's governing documents, including, without limitation its Trust Agreement and its Addenda. In the event of any conflict between this Summary Plan Description and the Plan's governing documents, those documents will govern. A copy of the complete Plan's governing documents may be examined during normal working hours at the office of the Union, and copies may be obtained upon request, from the Trustees, Plan Administrator, or Contract Claim Administrator at a reasonable charge.

5. Amendment/Termination

The Association and the Union specifically reserve the right, at any time and from time to time, to amend or terminate the Trust Agreement for any reason, including to:

- Reduce or eliminate any benefits;

- Revise the eligibility requirements, including eliminating any class of Participants, Dependents, or Beneficiaries from entitlement to coverage or increasing the payments/contributions due to maintain coverage; or,

- Terminate the Trust Fund. This may happen at any time, even after you retire. Upon termination of the Trust Fund the Trustees will not accept any further contributions or

payments. The Trustees will use whatever funds are available to provide benefits to Participants and Dependents who were such as of the date of termination but only until the remaining funds are all utilized.

You will be furnished with a description of any material modification to the Plan.

Section XVI – ***QUESTIONS & ANSWERS***

These questions and answers are designed to provide a basic answer to some of the more frequently asked questions about your plan. For more details, refer to the specific sections in this booklet.

1. **What type of Benefit Plan is the Health & Welfare Fund and how does it work?** The Fund is a self-insured multiemployer health and welfare plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The Fund pays benefits as described in this booklet. In addition, the Fund has purchased insurance to provide Life Insurance and Accidental Death & Dismemberment Benefits.

2. **What is the difference between in network and out of network providers?** "In network" means a provider who has a signed contract to participate with the contracted service provider. "Out of network" providers do not have a signed contract. Contracted service providers offer the Fund contracted discounted rates on services.

3. **Can I ever run out of benefits?** Yes, if you do not work 350 Hours at the current local contribution rate, or you do not have sufficient bank dollars to purchase insurance, or you do not self-pay or sign up for COBRA.

4. **What are my options if I do not work enough hours?** You will be given a choice of self-paying the balance due for regular coverage or signing up for COBRA coverage. Either plan will be good for six consecutive quarters. There must be no break in coverage.

5. **Can I save money using mail order to get my medications?** Absolutely! When you go to a retail pharmacy, you pay 20% of the cost for a 30 day supply. When you use the mail order system, most medications are filled for 90 days and you pay only $10.00 for a name brand or $0.00 if it's a generic. Contact Sav-Rx by visiting www.savrx.com/pdfs/mailorderform.pdf or call 1-800-228-3108.

6. **Does my plan offer fitness reimbursement?** No

7. **Does my plan pay for smoking cessation products and/or programs**? No

8. **Are flu shots covered**? Yes

9. **What do I do when I go to an in-network provider and they do not accept my insurance**? Contact Independence Administrators (Active Participants) or AmeriHealth Administrators (Retired Participants eligible for Medicare) at the toll free number on your Plan ID card.

10. **What do I do when an in-network provider tries to bill me for the difference between the contracted allowance and what they charge?** Contact Independence Administrators (Active Participants) or AmeriHealth Administrators (Retired Participants eligible for Medicare) at the toll free number on your Plan ID card.

11. **What do I do when I'm on Medicare and the provider bills me for more than the Medicare allowance**? Contact AmeriHealth Administrators at the toll free number on your Plan ID card.

12. **What do I do when I use my 20 visits under chiropractic benefit for the year?** You are responsible for paying for any visits over 20.

13. **Will any bills be paid after the timely filing period?** Only if the provider can show proof of timely filing.

14. **How do I add dependents to the plan?** For member's biological children, all that is required is a birth certificate showing you as the parent. If this is not shown, maternity/paternity papers are required.

15. **Are there any options for disability after the 26 weeks?** No. Contact your local Social Security office for long term disability benefits.

16. **How do I get reimbursed for bills that I paid of pocket?** Send your receipts to Independence Administrators (Active Participants) or AmeriHealth Administrators (Retired Participants) and you will be reimbursed according to the plan benefit.

17. **Are GYN exams covered for dependents?** No, GYN exams are not covered for dependents.

18. **Are maternity benefits covered for dependents?** No, maternity benefits are not covered for dependents.

19. **What do I do if I lose my insurance cards?** For Active Participants, contact Independence Administrators at 1-844-864-4352. For Retired Participants eligible for Medicare, contract Amerihealth Administrators at 1-844-352-1706.

20. **What are my vision benefits?** Contact VBA at 1-800-432-4966 and reference group number 4748.

21. **How do I find a participating medical service provider in my area?** Contact Independence Administrators (Active Participants and Retired Participants not eligible for Medicare) or AmeriHealth Administrators (Retired Participants eligible for Medicare) at the toll free number on your Plan ID card. You can also visit their websites (www.myibxtpabenefits.com) / (www.myahabenefits.com)

22. **Are routine colonoscopies covered**? Yes, for Participants over age 50, 100% up to outpatient surgical limits, limited to one procedure every five years.

23. **Am I covered if I travel out of the country?** No, the coverage is only good in the United States and Canada.

24. **Do I have a deductible if I am on Medicare?** There is no annual deductible.

25. **Do I need to pre-certify an upcoming surgery?** Yes. Please call the phone number on your ID card.

26. **Do I need to pre-certify in-patient drug and alcohol rehabilitation and mental illness services?** Yes. Please call the phone number on your ID card.

27. **Do I need a referral to see a specialist**? No.

28. **Are diabetic supplies covered**? Yes.

SECTION XVII- ***HEALTH REIMBURSEMENT ACCOUNT***

ELIGIBILITY AND PARTICIPATION

ELIGIBLE PARTICIPANTS

Any active participant on or after June l, 2019 who is covered under the Plan is eligible to receive an HRA benefit, subject to the terms and conditions below.

SPOUSE AND DEPENDENT COVERAGE

As a Plan participant you can receive reimbursement for eligible claims for you and your family members. (See the section of your SPD, titled "Who is a Family Member? ")

COMMENCEMENT OF PARTICIPATION

Once you have become covered under the Health and Welfare Fund and have accumulated $ 100 of employer contributions in your HRA, you will be provided with a debit card by the Claims Administrator to pay for Qualifying Medical Expenses. Any debit card shall be subject to the debit card's terms of use and any other requirements established by the Claims Administrator for this purpose. If a debit card is used to pay for an expense that is not a Qualifying Medical Expense, the Claims Administrator will deactivate your debit card and take steps to correct the transaction by using legally applicable correction procedures.

TERMINATION OF PARTICIPATION/FORFEITURE

Once your account balance has reached $0 and you have not had any employer contributions made on your behalf for at least 6 months, your account will be terminated. Once you terminate participation, you cannot start receiving HRA benefits again until you again become covered under the Health and Welfare Fund and accumulate $100 of employer contributions in your account.

If you are no longer active, but still have an account balance, you may continue to use your debit card or submit a paper claim for reimbursement for claims incurred, as follows:

- You may continue to use your debit card or submit a paper claim for reimbursement until the date your HRA balance is exhausted.

- If you die while you are participating in the Plan, your eligible family members can continue to use your debit card or submit a paper claim for reimbursement until the date the HRA balance is exhausted.

- If you die and there is a balance in your HRA, that balance will be forfeited if you have no family members, your eligible family members die, or your eligible dependent child(ren) reach age 26. (With respect to eligible dependent child(ren) who reach age 26, the account will be forfeited following a 12 month period to process timely submitted previously incurred claims.)

BENEFITS

REIMBURSEMENTS

The Plan allows you to be reimbursed for Qualifying Medical Expenses. Qualifying Medical Expenses include the following, as determined by the Claims Administrator (unless excluded below),

- Any expense that qualifies as a medical expense under Section 213(d) of the Internal Revenue Code for yourself and your eligible spouse and dependents.
- Any premiums (or premium equivalents) for retiree health insurance or retiree health coverage that you pay for on an after-tax basis.
- Premiums to continue coverage with the IBEW Local 126 Health and Welfare Fund.
- Qualifying Medical Expenses incurred while you were covered under the Health and Welfare Fund, but before your HRA balance first reached $100.

Qualifying Medical Expenses do include the following:

- Any expense paid by another health plan (up to the dollar amount paid by the other health plan);
- Any expenses for over the counter medicines or drugs, unless you have a written prescription for such medicine or drug. Contact the Claims Administrator for additional information;
- Any expenses deemed cosmetic or medically unnecessary as determined by the Plan;
- Any expenses incurred before you become eligible under the health and welfare fund;
- Any employee medical, dental or vision insurance premium (or premium equivalent) not relating to coverage in the Plan; and

- Any expenses or insurance premiums (or premium equivalents) for members of your household that are not your eligible family members under the Plan.

Please keep in mind that you must file any claims for reimbursement of eligible expenses within 12 months of the date of service.

Any credits to the HRA will be reduced by Qualifying Medical Expenses that are properly reimbursed from the Plan participant's HRA.

MISCELLANEOUS

HRA credits will be reduced, on a pro rata basis, by the administrative fees paid by the Plan to the Claims Administrator for processing claims under the Plan. These fees will be withdrawn from HRA balance on a monthly basis. Plan participants can contact the Plan Administrator to obtain the current amount of the fees.

Unused amounts from the prior calendar year will be carried forward to the next calendar year. You may not be reimbursed for an amount of eligible expenses that is greater than your HRA balance at the time the reimbursement is to be made.

No additional amounts will be credited to your HRA once you are no longer engaged in covered employment (including following your retirement), unless the contribution is required by the applicable collective bargaining agreement.

CLAIM REIMBURSEMENT REQUESTS AND APPEALS

During the course of the calendar year, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 12 months following the date the expense was incurred (i.e., the date of service, not the date of payment). In addition, you must submit to the Claims Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan or form of coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment as soon as practicable thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

When you have a claim to submit for reimbursement, you must:

(1) Obtain a claim form from either the website at: https://ibewl26benefits.com or the Claim Administrator;

(2) Complete the Participant portion of the form; and

(3) Attach copies of all detailed billing statements from the service provider showing insurance has paid the covered portion or the Explanation of Benefits from your insurance provider for which you are requesting reimbursement.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. If your claim is denied, you may file an appeal in accordance with the Plan's appeal procedures. (See the section of your SPD, titled "Filing a Claim")

THIRD-PARTY ADMINISTRATOR / CLAIMS ADMINISTRATOR

CompuSys of Utah, Inc. provides certain third-party administration services related to the HRA benefit under the Plan. Contact information is as follows :

CompuSys of Utah, Inc.
2156 West 2200 South
Salt Lake City, Utah 84119
(801) 973-1001
Hours 10:00 a.m. to 7:00 p.m. Eastern Time

If you have any questions about the HRA, please call the number above or visit our website at https://ibewl 26benefits.com — HRA information is located under the Health and Welfare Tab or contact the Plan at:
3455 Germantown Pike, Collegeville, PA 19426
(610) 489-1185
Email: local126@ibewlu126.com

SECTION XVIII- ***HEARING AIDS***

Hearing aid benefits are available to active and retired participants who are age 50 and over and to their spouses. For those participants and spouses, the Fund pays 100% of the charges for eligible hearing aid devices, up to $1,200 maximum benefit per ear. Benefits are payable once in any 48-month period. A prescription is required for the Fund to pay this benefit. You can purchase hearing aids from any provider of your choosing. However, if you use the Fund's approved provider (Amplifon) to purchase your hearing aids, you will also receive the following as part of the hearing aid benefit:

- One year of care (including fitting and calibration)
- Two years of batteries
- Three-year warranty
- Loss and damage protection

SECTION XIX- ***PRESCRIPTION SAFETY GLASSES***

The Fund will cover prescription safety glasses for Active Participants. Prescription safety glasses will be provided by Eyelation. The Fund pays 100% of the charges, up to $300. Benefits are payable once in any 24-month period.