4th District IBEW Health Fund Flexible Choice Plan

Summary Plan Description

2024 Edition

Benefits questions?
4thdistricthealthfund.com

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THE FLEXIBLE CHOICE PLAN

The 4th District IBEW Health Fund ("the *Fund*") offers the Flexible Choice Plan ("the *Plan*") to you—as an *eligible participant*—and your eligible *dependents*. The Plan provides the following *benefits:*

- Medical, including a Health Reimbursement Arrangement (HRA);
- Prescription drug;
- Dental;
- Vision;
- Weekly disability;
- Life insurance;
- Accidental death and dismemberment *(AD&D)*;
- Accident; and
- Member Assistance Program (MAP).

This is your Summary Plan Description (SPD) for the Plan, effective January 1, 2024 (unless otherwise specified). It is intended to help you understand the Plan's benefits. Participating *Employers* contribute to this Plan. Under certain circumstances, you may also contribute. Contributions are based on the negotiated contribution rates as set forth in your *Collective Bargaining Agreement* or *Participation Agreement,* as applicable.

Summaries of Benefits and Coverage. Summaries of Benefits and Coverage (SBCs) are mailed to you annually and available on the Documents & Forms page of the website—**www.4thdistricthealthfund.com**. You may also request a paper copy from the Fund Office. If you have questions about the SBCs, contact the Fund Office at **304-525-0331** or **888-466-9094**.

The Fund Office is available to answer your questions!
Give the office a call at 304-525-0331 or 888-466-9094.

Before You Begin

This SPD provides you with information on how the *Plan* works. It is written in everyday language, but you may still see words and phrases that have specific meanings within the context of this SPD. To help you better understand these terms, they are *italicized* when first used and then included in the "Glossary" section. Also, be sure to read the "Other Information You Should Know" section of the SPD for important information and facts about your rights under the Plan.

This SPD replaces all other SPDs that have been provided to you previously. Please read it carefully, and keep it on hand for future reference. If you are married, please share it with your spouse. If you have questions, contact the Fund Office at:

4th District IBEW Health Fund
9200 U.S. Route 60
Ona, WV 25545
304-525-0331 or **888-466-9094**

This SPD describes the benefits in effect as of January 1, 2024, for eligible participants of the 4th District IBEW Health Fund. This document replaces and supersedes any previous SPD. Full details are contained in the legal Plan Documents. If there is a discrepancy between this booklet and the legal Plan Documents, the legal Plan Documents will govern. The Trustees reserve the right and have the authority to amend, modify and/or eliminate benefits, or terminate the Plan at any time. In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the rules of the Plan.

The Plan is administered and operated by the Plan Administrator in its sole and absolute discretion. The Plan Administrator, and any duly authorized delegate thereof, has the complete authority to administer, apply, and interpret the Plan and any related documents and to decide all matters arising in connection with the operation or administration of the Plan. All determinations made by the Plan Administrator with respect to any matter arising under the Plan and any other Plan Document are final and binding on all parties, subject to every participant's rights under law and under the provisions of the Plan.

VENDOR PARTNERS

Contact the Fund Office for general questions related to Plan benefits, including medical, prescription drug, dental, vision, mental health, and other benefits. For additional information and assistance, contact the vendor partner (e.g., Highmark Blue Cross Blue Shield).

Vendor partners are subject to change. The information in the table below is effective January 1, 2024.

American Benefit Corporation (ABC) is the benefit *administrator* for the 4th District IBEW Health Fund. ABC handles benefit questions, claims, HRA reimbursements, and more. You can contact ABC through the Fund Office.

Contact...	For...	Phone Number	Website
Fund Office (American Benefit Corporation)	General benefits-related questions, including eligibility, dependent information and coverage options Weekly disability benefits and accident benefits Health Reimbursement Arrangement (HRA) Benefits Life insurance and accidental death and dismemberment (AD&D) benefits	304-525-0331 or 888-466-9094	**www.4thdistricthealthfund.com**
Highmark Blue Cross Blue Shield	Medical provider network	800-810-2583	**www.highmarkbcbswv.com**
Sav-Rx	Prescription drug benefits	866-233-IBEW (4239)	**www.savrx.com** Group Number: IBEWD4
Delta Dental of Ohio	Dental benefits	800-524-0149	**www.deltadentaloh.com**
VSP	Vision benefits	800-877-7195	**www.vsp.com**
Lyra Health	Member Assistance Program (MAP) Mental health or substance abuse services	877-363-0489	**4thdistricthealthfund.lyrahealth.com**
LabOne	Laboratory services	800-646-7788	**www.LabCard.com**
Free & Clear	Quit For Life® tobacco cessation program	866-784-8454	**www.quitnow.net**
Home and Community Care	Transition Care Program Care Assist Program	304-316-2187	
American Health Holding, Inc.	Precertification	866-898-9354 Fax: 866-881-9643	

ELIGIBILITY AND PARTICIPATION

Who's Eligible

You are eligible for coverage provided you meet the Plan's eligibility requirements. Eligibility requirements vary depending on whether you are new to the Fund and whether you are a participant working under a Collective Bargaining Agreement or a Participation Agreement.

Participants Working Under a Collective Bargaining Agreement

A Collective Bargaining Agreement is the negotiated contract between your *Local Union* and your Employer, allowing for your participation in the 4th District IBEW Health Fund. You are eligible for coverage based on the amount in your *Dollar Bank.* You become eligible after the minimum required amount to purchase one month of coverage has been credited to your Dollar Bank (without self-contribution). Contributions for each hour worked and reported are credited to your Dollar Bank upon receipt of your Employer's contribution. Credit is granted only for contributions actually paid to the Fund on your behalf. On an annual basis, the Trustees determine the Dollar Bank minimum balance requirement. Contact the Fund Office to find out the minimum balance applicable to you.

- **IBEW *participants* working under an Inside, Outside, Residential, Teledata, CW or CE Collective Bargaining Agreement** have a Dollar Bank and an HRA.
- **IBEW participants working under a Manufacturing or Utility Collective Bargaining Agreement** may not have a Dollar Bank. Eligibility for a Dollar Bank and the required hourly or monthly contribution rate is specified in the Collective Bargaining Agreement. Contributions are not accepted prior to the date the Trustees approve a written Collective Bargaining Agreement.

Track your Dollar Bank balance and eligibility status online at 4thdistricthealthfund.com by logging in to the Member Dashboard.

Participants Working Under a Participation Agreement

A Participation Agreement is the negotiated contract between the Fund and your Employer, allowing for your participation in the 4th District IBEW Health Fund. It is used to provide coverage for those who are not working under the terms of a Collective Bargaining Agreement. You are eligible for coverage based on the payment of required contributions to the Fund on your behalf and based on your employment class, as indicated below:

- **Office staff of a contributing Employer** do not have a Dollar Bank but have an HRA account. Review the Qualifying Schedule for those working under an office staff Participation Agreement in the "If You Work Under an Office Staff Participation Agreement" subsection of the "When Coverage Begins and Cost of Coverage" section. Contributions are not accepted prior to the date the Trustees approve a written Participation Agreement.
- **IBEW and non-IBEW employees of a Local Union, affiliated JATC, or IBEW Federal Credit Union have a Dollar Bank and HRA account**. The hourly contribution rate is identical to the rate established in the home Local Union's Collective Bargaining Agreement. A written Participation Agreement must be signed and approved by the Trustees before contributions are accepted. An IBEW Federal Credit Union is accepted for participation only if membership in the Credit Union is restricted to IBEW participants associated with that Local Union.
- **IBEW alumni employees working for an affiliated National Electrical Contractors Association (NECA) Chapter, a trade council, labor-related governmental agency or similar organization** have a Dollar Bank and HRA account. The hourly contribution rate is identical to the rate established in the home Local Union's Collective Bargaining Agreement. A written Participation Agreement must be signed and approved by the Trustees before contributions are accepted.

Your Dependents

Your dependents are eligible for coverage provided they meet the Plan's eligibility requirements. Your eligible dependents include your:

- **Spouse** to whom you are legally married. This means your current legal spouse as recognized by federal law and the state in which you reside.
- **Dependent children** who are younger than age 26, whether married or unmarried. Unless specifically indicated, your dependent child is eligible for coverage until midnight on the day he or she turns age 26. Dependent children include your:
  - **Biological children** (copy of certified birth certificate required).
  - **Legally adopted children and children placed with you for adoption** (copy of certified court order or proof of adoption or *placement for adoption* and birth certificate required).
  - **Stepchildren** (proof of relationship and copy of certified birth certificate required).
  - **Children covered pursuant to a QMCSO.** You may also cover dependent children for whom Plan coverage is court-ordered through a Qualified Medical Child Support Order (QMSCO) or through a National Medical Child Support Notice (NMCSN). A copy of this Plan's QMCSO procedure is available free of charge from the Fund Office.
  - **Children for whom you have legal guardianship.** This includes:
    - An individual younger than age 26 for whom you have legal guardianship under a court order and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively; or
    - A child you claim as a dependent on your tax return for each *Plan Year* that coverage is provided.

    You must provide the Fund Office with proof of guardianship and the child's age.
- ***Handicapped child.*** Extended coverage is available for an unmarried child who is older than age 26, cannot work, depends on you for principal support, and is unable to earn his or her own living because of a mental, developmental, or physical disability or illness. This child must be covered by the Plan before he or she turns age 26.

  The Fund Office periodically requires substantiation of a child's continued handicap, which may include an examination and proof that the child remains your eligible dependent. Without this proof, coverage may be terminated.

Your eligible dependents become eligible for coverage when you do. When you lose eligibility, your dependents also lose their eligibility for coverage.

You may not be covered under this Plan as both an active participant and a retiree.

A spouse or child of an eligible dependent child is not eligible for coverage under the Plan. Grandchildren, nieces, nephews, siblings, etc., are also not eligible for coverage unless you have initiated the adoption process or you have legal guardianship.

You may elect to disenroll your dependent from coverage under this Plan if he or she is covered under another group health plan. In order to disenroll a dependent, you must provide to the Fund Office proof that the dependent has creditable coverage under another group health plan.

Special Enrollment Periods

If you, or any of your dependents, lose eligibility under another group health plan (or if an Employer stops contributing toward your or your dependent's other coverage), you may be eligible for a *special enrollment period.* However, you **must request enrollment within 30 days** after your or your dependent's other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your eligible dependent(s). However, you **must request enrollment within 60 days** after the marriage, birth, adoption or placement for adoption. If you fail to enroll a newly eligible dependent or provide evidence of your dependent's eligibility on time, coverage begins on the first of the month following the day you sufficiently complete the enrollment (coverage is not retroactive to the date of birth, marriage, adoption or placement for adoption). In addition, the Plan is not responsible for any bills or charges incurred prior to the coverage *effective date.*

You must request a special enrollment within 30 or 60 days (as applicable) of your marriage; the birth, adoption, or placement for adoption of your dependent; or losing your other coverage.

Two additional circumstances allow for a special enrollment period:

- Your or your dependent's *Medicaid* or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy under Medicaid or CHIP.

In either of these circumstances, you must enroll yourself or your eligible dependent within 60 days after you or your dependent is terminated from or determined to be eligible for such assistance.

Federal and state laws require you to enroll any dependents who are receiving health insurance coverage through Medicaid. If you do not enroll your dependents who are receiving health insurance through Medicaid, you will be responsible for any penalties assessed on the Plan by Medicaid due to your failure to follow these rules.

To request a special enrollment period or obtain more information, contact the Fund Office. You are responsible for advising the Fund Office of any changes in address, beneficiaries or dependents.

WHEN COVERAGE BEGINS AND COST OF COVERAGE

If You Work Under a Collective Bargaining Agreement or a Participation Agreement That Provides a Dollar Bank

As long as you meet the eligibility requirements, a Qualifying Schedule determines when coverage begins for you and your eligible dependents.

Qualifying Schedule

If you are subject to a Collective Bargaining Agreement or a Participation Agreement that provides you with a Dollar Bank, coverage takes effect on the first day of the *Benefit Month,* provided your Dollar Bank balance on the first day of the previous month (your *Eligibility Determination Date*) was at least the minimum required balance. Eligibility for coverage continues on a month-to-month basis. For example:

- **December 1:** Charles started working.
- **January:** Contributions from his Employer(s) are received by the Fund and credited to his Dollar Bank.
- **February 1 (Eligibility Determination Date):** Charles' Dollar Bank balance is reviewed for eligibility and it has the minimum required balance to be eligible for coverage.
- **March 1 (Benefit Month):** Charles is eligible for coverage for this month.

If your Dollar Bank balance is not sufficient to continue coverage for the next month, you may continue coverage by making self-contributions.

Eligibility Determination Dates and their corresponding Benefit Months are listed below.

You Receive Employer Contributions to Your Dollar Bank in:	Your Dollar Bank Equals the Minimum Required Balance as Determined by the Trustees on (Eligibility Determination Date):	Coverage Begins (Benefit Month):
December	January 1	February
January	February 1	March
February	March 1	April
March	April 1	May
April	May 1	June
May	June 1	July
June	July 1	August
July	August 1	September
August	September 1	October
September	October 1	November
October	November 1	December
November	December 1	January

Your eligibility continues on a month-by-month basis in accordance with the Qualifying Schedule above. If an Eligibility Determination Date falls on a weekend or a holiday, eligibility for coverage is determined on the next business day.

For each Benefit Month of eligibility, your Dollar Bank balance will be reduced by the required amount, as determined by the Trustees, to purchase a month's coverage. If your Dollar Bank balance on an Eligibility Determination Date is less than the amount needed to purchase a month's coverage, you will receive a self-contribution notice to continue coverage. For more information, see the "Self-Contributions" subsection later in this section.

Cost of Coverage and Your Dollar Bank

Participating Employers contribute to your Dollar Bank based on the Collective Bargaining Agreement or Participation Agreement associated with your Local Union. Deposits into your Dollar Bank accumulate until you are able to purchase coverage.

All Employer contributions received on your behalf are credited to your Dollar Bank, up to a maximum accumulation of $7,436.80. Your accumulation amount is determined after credits are removed on your Eligibility Determination Date.

The Trustees reserve the right to modify the maximum accumulation amount and the amount required to purchase coverage from the Dollar Bank, based on advice from the Fund's professional advisors, and to change the required amount when deemed necessary.

Self-Contributions

If your Dollar Bank balance is not sufficient to purchase a month's coverage, you can continue coverage for yourself and your dependents by making self-contributions. The amount you pay in self-contributions and the limit of self-contributions you can make depend on your Dollar Bank balance.

If Your Dollar Bank Balance Is Not Sufficient to Purchase a Month's Coverage on an Eligibility Determination Date

You may make a self-contribution to continue coverage as long as your Dollar Bank balance is at least 40 times the hourly contribution rate. Your self-contribution equals the difference between the required amount and the balance in your Dollar Bank. There is no limit to the number of partial months you may self-contribute for coverage; there is a limit on the number of full months you may self-contribute.

If you do not make the required self-contribution or your Dollar Bank balance is less than 40 times the hourly contribution rate, the balance in your Dollar Bank will roll forward to the next month. Upon receipt of an **additional** Employer contribution to your Dollar Bank, you may make a self-contribution for the difference between the required monthly amount determined by the Trustees and the balance in your Dollar Bank.

The balance in your Dollar Bank continues to roll forward until (whichever occurs first):

- The month you make the required self-contribution to purchase coverage;
- The month your Dollar Bank balance reaches the required minimum amount, as determined by the Trustees, for coverage without self-contribution, and coverage is provided; or
- The date that 12 months elapse from the last Dollar Bank *activity*.

If Your Dollar Bank Balance Is Zero on an Eligibility Determination Date

You may make a self-contribution to continue coverage. Your self-contribution equals the required monthly amount set by the Trustees. You may make up to 30 consecutive full self-contributions to purchase coverage in this manner. The total number of consecutive months allowed under self-contributions and COBRA continuation coverage combined is 30 months.

To elect continued coverage under the self-contribution program, you must waive COBRA continuation coverage. If you self-contribute and have not waived COBRA, it is assumed you have waived your COBRA rights.

A few additional items to note:

- **If you appeal the denial of Social Security disability benefits** and, in the interim, the maximum period of full self-contributions described in this section expires, you are entitled to make self-contributions for an additional six-month period. You must first submit satisfactory proof of your appeal of that denial. Additional six-month extensions may be granted upon submission of status reports from your attorney.
- **If you exhaust the maximum period of full self-contributions while you are unable to work due to a serious health condition**, you may continue to make self-contributions—in additional six-month increments—until you are able to regain eligibility through active employment (as described under the "Who's Eligible" subsection of the "Eligibility and Participation" section). The illness or injury must prevent you from performing the essential job functions expected of persons in your job position. You must submit a written request for the additional periods of coverage and provide evidence of an occupational injury recognized by a state workers' compensation agency and/or any medical evidence requested by the Fund Office. Once you are released to return to work, you must sign your Local Union's referral book and actively seek employment with a contributing Employer. Those working under a Participation Agreement must return to work immediately. The Board of Trustees has the sole and exclusive right to determine if an illness or injury qualifies you to make extended self-payments.
- **If you become totally and permanently disabled,** as evidenced by your receipt of a Social Security disability award or a workers' compensation total and permanent disability award while eligible for benefits, you may make a self-contribution to continue coverage equal to the required monthly amount. You may continue to purchase coverage in this manner until you either recover and are able to return to work or you retire under a qualified pension plan.

Failure to make the required self-contribution when due will result in termination of coverage. **Late contributions will not be accepted.** Once coverage terminates, you can reinstate coverage only by requalifying as an eligible active participant. See the "Who's Eligible" subsection of the "Eligibility and Participation" section and the "Cost of Coverage and Your Dollar Bank" subsection earlier in this section for more information.

Benefit Credit Bank Program

If you are a newly indentured apprentice or newly organized participant, you may request a loan credit to your Benefit Credit Bank. The initial deposit will equal the amount required to purchase three months of coverage through the Fund, based on your Collective Bargaining Agreement or Participation Agreement. The purpose of this deposit is to allow you to purchase initial eligibility for coverage through the Fund.

To participate in this program, you must:

- Be associated with a Local Union or contributing Employer affiliated with the Fund;
- Begin working or be available for work under a Collective Bargaining Agreement covering participants of the Local Union to which you belong or begin working under a Participation Agreement; and
- Complete and execute an agreement providing for the repayment of the credit extended from contributions posted to your Dollar Bank as the result of *covered employment.*

Administration

Upon receipt of the executed agreement from your Employer or Local Union, two accounts are created. The first is your Benefit Credit Bank, which receives the initial deposit, and the second is your Dollar Bank for the deposit of Employer contributions. An amount equal to the cost to purchase one month's coverage is immediately transferred from your Benefit Credit Bank to your Dollar Bank to purchase coverage for the next calendar month.

On the first day of the month (Eligibility Determination Date) following your employment date, a second transfer from your Benefit Credit Bank to your Dollar Bank equal to the cost of one month's coverage occurs. Your Dollar Bank is then charged the amount required to purchase coverage for the following Benefit Month in accordance with the Qualifying Schedule applicable to active participants, as shown under the "Qualifying Schedule" subsection of the "When Coverage Begins and Cost of Coverage" section.

If sufficient contributions are not received in the month following the start of your employment, a third transfer from your Benefit Credit Bank to your Dollar Bank occurs. The amount equals the difference between the balance in your Dollar Bank and the amount to purchase a month of coverage as of the Eligibility Determination Date.

This process continues until you exhaust the balance in your Benefit Credit Bank or until you earn sufficient contributions to qualify for coverage without further transfers from your Benefit Credit Bank to your Dollar Bank. Transfers from your Benefit Credit Bank to your Dollar Bank are not allowed once repayment of your Benefit Credit Bank begins. (A self-contribution notice is provided any time the balance in your Dollar Bank is not sufficient, as described under the "Self-Contributions" subsection of the "When Coverage Beings and Cost of Coverage" section.)

Repayment of Initial Deposit

Transfers from the Benefit Credit Bank are recouped from your Dollar Bank as follows:

- If on any Eligibility Determination Date, after the deduction for the following Benefit Month, there is a balance in your Dollar Bank, that balance is transferred from your Dollar Bank to your Benefit Credit Bank.
- Excess balances are transferred in such a manner each month (as described above) until the value of your Benefit Credit Bank equals the beginning balance (i.e., an amount equal to the cost of coverage for three months).
- If your Benefit Credit Bank is not completely replenished by the second anniversary of the date your Benefit Credit Bank was created, all deposits to your Dollar Bank from that second anniversary forward will be transferred to the Benefit Credit Bank until the beginning balance in the Benefit Credit Bank is repaid. (In this situation, you will be required to make self-contributions to continue eligibility for Fund benefits.)

The Benefit Credit Bank Program provides new participants with enough credits to cover themselves and their dependents while they work on building up their Dollar Bank.

Reciprocal Agreements

The Fund has entered into reciprocal agreements that allow those working under a Collective Bargaining Agreement to transfer contributions earned in the jurisdiction of another fund to the 4th District IBEW Health Fund. Contributions received from reciprocal funds will be posted in the month received. It is your responsibility to request and complete the ERTS (Electronic Reciprocal Transfer System) designation online and to contact the other fund if contributions are not transferred on a timely basis. For questions on reciprocal agreements, contact the Fund Office.

The Payroll Month is the month the Fund must receive contributions paid by your Employer on your behalf in order for you to be eligible for coverage the following month.

Dollar Bank credits are not available to you if you are subject to a Participation Agreement that covers office staff of a contributing Employer.

If You Work Under an Office Staff Participation Agreement

This section applies to those who work in the office of a contributing Employer and are covered by a Participation Agreement.

Qualifying Schedule

If you are subject to a Participation Agreement, you will have no Dollar Bank credits. You become eligible for coverage based on the payment of required contributions to the Fund on your behalf. Coverage takes effect on the first of the month following the receipt of the required monthly contribution amount by your Employer. Contributions are due on the 15th day of the *Payroll Month* for coverage in the following Benefit Month. Eligibility continues on a month-to-month basis. For example:

- **December 1:** Charles starts working.
- **December 15 (Payroll Month):** Charles' Employer contributes the required monthly amount to the Fund for Charles' coverage.
- **January (Benefit Month):** Charles is eligible for coverage for this month.

Below are the Payroll Months and their corresponding Benefit Months.

Contributions Paid on Your Behalf by the 15th of the Month (Payroll Month)	Coverage Begins (Benefit Month)
January	February
February	March
March	April
April	May
May	June
June	July
July	August
August	September
September	October
October	November
November	December
December	January

If you become ineligible for coverage due to an inadequate contribution for a Payroll Month, you may purchase continuance of benefits in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), as described in the "Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage" subsection of the "Other Information You Should Know" section. Note: It is your Employer's responsibility to notify the Fund Office of your termination of employment.

WHEN COVERAGE ENDS

When Your Coverage Ends

Your coverage ends on the earliest of the following:

- The date the Trustees terminate the Plan;
- The last day of the period when a covered member's Dollar Bank is insufficient to cover the cost of coverage and no self-payment is made;
- The last day of the period when an Employer fails to make a monthly contribution for an employee covered by an office staff Participation Agreement;
- 30 days after you enter full-time military, naval, or air service, subject to the Uniformed Services Employment and Reemployment Rights Act of 1994 *(USERRA)* and federal regulations;
- The last day of the period you fail to be in an eligible class of persons according to the Plan's eligibility requirements;
- The date the benefit (applicable for any benefit) is removed from the Plan;
- The last day of the last month for which you are eligible for COBRA continuation coverage and made the required COBRA continuation coverage self-contribution, or the date any of the events stated in the "Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage" subsection of the "Other Information You Should Know" section occurs, whichever occurs first; or
- The date of your death.

Keep the Fund Office Informed

Contact the Fund Office whenever you or your spouse have a change in name, address, telephone number, e-mail address or marital status (marriage, legal separation or divorce), or if you need to add an eligible dependent or a dependent dies.

When Dependent Coverage Ends

Dependent coverage ends on the earliest of the following:

- The date the Trustees terminate the Plan;
- The date your coverage terminates for reasons other than death;
- 30 days after the dependent enters full-time military, naval, or air service;
- The date the dependent is no longer considered an eligible dependent (as defined in the "Who's Eligible" subsection of the "Eligibility and Participation" section);
- The last day of the last month for which a dependent is eligible for COBRA continuation coverage and required COBRA continuation coverage self-contributions are made, or the date any of the events stated in the "Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage" subsection of the "Other Information You Should Know" section occurs, whichever occurs first; or
- If the dependent is receiving survivor benefits, the date survivor benefits terminate, as outlined on the following page.

Withdrawal of a Participating Group

In the event that your Local Union or group of Employers leaves the Plan, your coverage will terminate immediately; however, if the Trustees determine reserve assets are sufficient to do so, your remaining Dollar Bank assets may be used to purchase coverage for you and your Dependents (if any) for three (3) calendar months immediately following the last day of the month for which Employer contributions are made on your behalf. Any participants without sufficient Dollar Bank assets may make self-payments to maintain coverage during the three-month transition period. You and your Dependents may maintain coverage for a maximum of three (3) total calendar months following the last day of the month for which Employer contributions are made to the Plan. Following this transition period, any remaining Dollar Bank balances will be cancelled and returned to the general assets of the Plan. You may participate in this three-month transition period only if you were a participant working under a collective bargaining agreement or were a non-bargained participant with a Dollar Bank account.

Additionally, assets in your Health Reimbursement Arrangement account may be used to pay for qualifying expenses incurred prior to the date your coverage ends. Twelve months following your termination of coverage, any remaining HRA assets will be forfeited and returned to the general assets of the Plan.

Following the transition period (if any), the coverage and self-payment rights for any participants, dependents, retirees, surviving spouses, and/or COBRA participants affiliated with the withdrawing group will be terminated. It shall be the sole responsibility of the withdrawing group to secure health coverage for such individuals.

If you die, your spouse or beneficiary should:

- Notify the Fund Office;
- Provide the Fund Office with a copy of your death certificate; and
- Apply for life and AD&D benefits, if eligible.

Surviving Spouse and Children

If you die while covered under the Plan, coverage for your eligible dependents continues without contributions (at no cost) until the end of the Benefit Month coincident with the second anniversary of your death or until your spouse remarries, whichever occurs first. This survivor benefit continuance applies only to active participants and covers dependents covered on the date of your death and any of your then unborn children when they meet the definition of "dependents" in the "Who's Eligible" subsection of the "Eligibility and Participation" section. An individual dependent's coverage under this survivor benefit continuance ceases at the end of the Benefit Month described above, when the individual no longer meets the definition of a "dependent," or when the individual becomes eligible for *Medicare,* whichever occurs first.

Rescission of Coverage

Your coverage may be terminated retroactively due to cases of fraud or intentional misrepresentation, or missed self-contributions, including COBRA continuation coverage contributions. If you fail to notify the Fund Office of a divorce or of a child who is no longer eligible, this will be considered a non-payment of contributions. Coverage will terminate retroactively to the date of the event, and you will be responsible for any claims paid from the date of the event.

The Plan does not rescind health coverage once you are covered under the Plan unless you (or persons seeking coverage on your behalf) perform an act, practice, or omission that constitutes fraud or you make an intentional misrepresentation of material fact (as prohibited by the terms of the Plan); and in other instances that may be prescribed in the Treasury Regulations.

In the event that you are suspected of fraudulently obtaining coverage for yourself or eligible dependents, the Fund, at the discretion of the *Board of Trustees,* may offset future benefits, terminate benefits, bring a civil action and/or refer the case for criminal prosecution.

For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance is attributable to a delay in administrative recordkeeping if you do not pay any self-contributions for coverage after termination of employment. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required self-contributions toward the cost of coverage (including COBRA continuation coverage contributions). A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the date of divorce or the date a dependent was no longer eligible under the Plan.

ABOUT RETIREE COVERAGE

Retiree coverage is available to all Participants in the Flexible Choice Plan, including those covered by a Participation Agreement. As a retiree of the Fund, you may be eligible to continue your coverage under the Plan (non-Medicare-eligible participants) or enroll in the Medicare Advantage Plan (Medicare-eligible participants), depending on your eligibility for coverage and for Medicare.

If You Are Not Eligible for Medicare (Generally Under Age 65)

Who's Eligible

As a non-Medicare-eligible retiree, you are eligible to continue coverage under the Plan for yourself and all eligible dependents through self-contributions if you meet one of the following criteria:

- You are a disabled participant who retired under a qualified pension plan; or
- You are a covered participant who:
  - Is completely retired from the industry;
  - Is at least age 57½;
  - Has been eligible for the Plan for at least 48 of the most recent 60 Benefit Months or, if you have not been able to meet the 48-month requirement, has been eligible for the Plan for at least 96 of the most recent 120 Benefit Months prior to retirement; and
  - Is eligible for the Plan at the time of retirement.
- You were formerly a covered participant who is unable to meet the eligibility requirements for covered participants because you accepted a position with the IBEW, NECA, or similar affiliated entity and became covered as a participant under another group health plan. In order to qualify for retiree coverage under this provision, you must:
  - Notify the Board of Trustees in writing that you have accepted a qualifying position and request coverage under the Plan to be terminated;
  - Maintain continuous coverage with the affiliated entity through your final date of retirement; and;
  - Promptly notify the Board of Trustees in writing that you have retired from the industry and wish to resume participation in the Plan.

  Upon your return to the Plan, any Dollar Bank balance available at the time Plan coverage was initially terminated will be restored.

Dependents

When you retire, your eligible dependents are covered by regular medical coverage under the Plan until they are no longer considered an eligible dependent (as defined in the "Who's Eligible" subsection of the "Eligibility and Participation" section) or until they become eligible for Medicare. Note: Once you retire, you cannot change from the Flexible Choice Plan to the Building Trades Plan, or vice versa.

Your dependent may also become eligible for coverage under the Plan, in accordance with special enrollment rights, as described under the "Special Enrollment Periods" subsection of the "Eligibility and Participation" section. Please contact the Fund Office for information.

Once your dependent spouse qualifies for Medicare, he or she will be able to enroll in the Medicare Advantage Plan (see page 16).

If you die, your dependents will be eligible to continue coverage under retiree coverage as long as self-payments are made and the surviving spouse does not remarry. Your dependents will also be eligible to purchase retiree coverage if, at the time you die, you are a covered participant who:

- Is at least age 57½.
- Had been eligible for the Plan for at least 48 of the most recent 60 Benefit Months, or if you had not been able to meet the 48-month requirement, had been eligible for the Plan for at least 96 of the most recent 120 Benefit Months prior to your death; and
- Is eligible for the Plan at the time of death.

When Coverage Begins and Cost of Coverage

Generally, coverage begins when you meet the eligibility requirements, as indicated in the "Who's Eligible" section above, and you make the required self-contributions, as described below.

Self-Contributions for Retiree Coverage

Each month, you receive a notice of your required self-contribution amount from the Fund Office. A due date for receipt of the self-contribution is also provided. **Late self-contributions are not accepted.**

You may submit your self-contribution directly from your checking or savings account. If you elect this option, your bank account is debited for the self-contribution, and you do not have to issue a check. The required amount is deducted from your account on the 15th day of each month and continues until you notify the Fund in writing that you wish to terminate the authorization.

If there is a change to the self-contribution amount, you will receive notice at least 30 days prior to when the new amount will be deducted. When the amount to be deducted is changed, you do not need to complete a new Authorization Form.

Contact the Fund Office for the necessary form for automatic debit of self-contributions.

When Coverage Ends

Coverage for you and your dependents ends on the earliest of the following:

- The date the Plan is terminated;
- The date you meet the current monthly active Dollar Bank charge amount;
- The last day of the period for which any required self-contribution was due and not paid;
- The date your spouse (if you are deceased) remarries; or
- For withdrawal of a participating Local Union, the last day of the month for which contributions are required to the Fund under the terms of the applicable Collective Bargaining Agreement (applicable for retired and other non-active participants).

Waiving Coverage for Non-Medicare-Eligible Retirees

As a retiree, you can waive (decline) coverage for both you and your spouse. To waive coverage, however, you must provide proof of coverage under your spouse's group health plan. In addition, you and your spouse must complete an Election to Decline Coverage Form.

If your spouse is covered under a separate employer group health plan, you can elect coverage under the Plan for yourself, and your spouse is permitted to defer coverage under the Plan until his or her group health coverage terminates. Your spouse must reinstate coverage under the Plan through the Fund immediately upon termination of the separate employer group health coverage.

You and/or your spouse are provided only one opportunity to waive coverage under the Plan and request reinstatement (see the "Reinstatement of Eligibility" subsection below). Once coverage is reinstated under the terms of this provision, if you and your spouse waive coverage again, you will not be able to reinstate coverage. The second waiver of coverage constitutes your permanent termination of participation.

Reinstatement of Eligibility

As a retiree, you may reinstate coverage upon certain conditions:

- Your other group health coverage ends;
- You acquire a dependent; or
- You become entitled to Medicare benefits due to age or disability.

If you fail to reinstate coverage within **30 days** of the earliest applicable reinstatement condition detailed above, your eligibility will permanently terminate and reinstatement of coverage will not be permitted at a later date.

What's Covered (Non-Medicare-Eligible Retirees)

When you retire, your medical and prescription drug coverage has different out-of-pocket maximum amounts, as shown in the table below. Otherwise, you and your covered dependents are eligible for the same medical, prescription drug, dental, vision, life insurance and AD&D insurance coverage you had as an active participant until you (or your dependents) become eligible for Medicare. When you retire, but before you turn age 65, you can access any credits (amounts) in your HRA, but you are not able to contribute any new amounts to that account.

Regardless of whether you are Medicare-eligible, weekly disability benefits are not provided to retired participants.

Out-of-Pocket Maximum: Medical Plan*		
Individual	$550	$1,100
Family	$1,650	$3,300
Out-of-Pocket Maximum: Prescription Drugs*		
Individual	$4,600	Not applicable
Family	$9,200	Not applicable
Out-of-Pocket Maximum: Combined Medical and Prescription Drugs*		
Individual	$7,600	Not applicable
Family	$14,200	Not applicable

* Per Calendar-Year (as of 2024). These amounts are updated on an annual basis

Working Past Normal Retirement Age

Under federal law, the Plan's actively working covered employees age 65 or older and their covered spouses may become eligible for Medicare. Under the Medicare Secondary Payer rules, the Plan will pay first, and Medicare will pay second. Medicare will act as the supplemental coverage, and the Plan will be primary. If you decline coverage under the Plan and elect Medicare exclusively, you and your dependents will not be covered under the Plan.

If You Are Medicare Eligible (Generally Age 65 or Over)

If you retire and become eligible for Medicare, you (and your Medicare-eligible spouse, if applicable) are eligible to be enrolled in the Fund's Medicare Advantage Plan. If you become eligible for Medicare due to age and you have maintained eligibility for the Plan through the Fund from retirement (48 of the 60 most recent Benefit Months or 96 of the 120 most recent Benefit Months immediately preceding retirement), you will be enrolled automatically in the Medicare Advantage Plan.

It is important that you enroll in both Medicare Parts A and B and pay the applicable premium for Medicare Part B as soon as you become Medicare-eligible. If you are eligible for Medicare but your spouse is not, regular retiree coverage continues for your spouse until he or she becomes Medicare-eligible.

Important: You (and your Medicare-eligible spouse, if applicable) must be enrolled in Medicare Parts A and B. Proof of Medicare enrollment must be sent to the Fund Office within 60 days of the receipt of Medicare.

Disabled participants entitled to Medicare must be enrolled in the Medicare Advantage Plan to maintain their coverage.

You (and your Medicare-eligible spouse, if applicable) are responsible for enrolling in Medicare Part B (enrollment in Part A is automatic when you sign up for the Social Security benefit). Otherwise, you cannot be enrolled in the Medicare Advantage Plan.

What's Covered

The Medicare Advantage medical plan includes vision, hearing, and a wellness/gym membership benefit. The prescription drug plan has a secondary level of coverage through Sav-Rx. The two prescription drug plans work together to provide the greatest level of benefits. For example, if a medication is not covered by the Medicare Advantage Plan, it should be covered by the Sav-Rx plan.

For more information on what's covered, what's not and any plan limitations, visit the **Retiree Benefits page** on **4thdistricthealthfund.com** and look for the Medicare Advantage Plan documents.

When Coverage Ends

Your coverage ends when you lose eligibility, switch to Original Medicare, waive your coverage, or enroll in another plan. It's important to note that you can only be enrolled in one Medicare Advantage program at a time. If you enroll in another plan, you will be removed from the Fund's Medicare Advantage Plan.

For more information about the Fund's health plan benefits for Medicare-eligible retirees, including being enrolled in the Medicare Advantage Plan, waiving coverage, and what is covered, please see the Retiree Benefits page on the 4th District Health Fund benefits website **4thdistricthealthfund.com**.

Additional Benefits for Medicare-Eligible Retirees

Dental coverage is not available to Medicare-eligible retirees. When you become eligible for Medicare, you will have the option to continue your life and accidental death and dismemberment insurance as an individual policy. A full retiree schedule of benefits is available on **www.4thdistricthealthfund.com** or by contacting the Fund Office to have a copy mailed to you.

YOUR MEDICAL COVERAGE

The Plan provides you and your covered dependents with comprehensive medical coverage. This coverage provides financial protection when you need it most and includes a Health Reimbursement Arrangement (HRA), as described in this section.

About the Health Reimbursement Arrangement (HRA)

You may have access to an HRA to reimburse *qualified medical expenses*. If eligible, your Employer contributes toward your HRA on your behalf for each hour you work. This contribution is part of the negotiated Employer hourly contribution to the Plan. Contributions are not credited to your HRA until they are received. There may be a lag between the time contributions are required on your behalf and when they are available for your use.

You can use your HRA, up to your account balance, to reimburse qualified expenses as they are incurred. Or, as your HRA balance grows, save up and use your balance for future qualified expenses. Any unused HRA balance is rolled over from year to year, so it is possible to use these accumulated funds to pay for larger qualified expenses you may have in the future. When you use the money in your HRA to reimburse qualified expenses, you don't pay taxes on the amount.

While there are no up-front or set-up fees for those who participate in an HRA, the Board of Trustees may, in its sole discretion, opt to institute an administrative fee to cover administrative costs. Such fees, if instituted, will be deducted from each participant's HRA, regardless of whether the participant has been drawing reimbursements from his or her HRA. In addition, forfeited HRA balances will be used to pay administrative expenses or will be returned to the general assets of the Fund at the sole discretion of the Trustees. If the interest generated by the participants' HRA exceeds administrative costs, the Board of Trustees reserves the right, in its sole discretion, to declare an annual interest or dividend payment to all participant HRAs. Such payments may be used only for qualified expenses.

HRA Eligibility

You become eligible for your HRA once you become eligible for the Plan, as described in the "Eligibility and Participation" section.

You continue to be eligible until the earliest of the following:

- You opt out (see "HRA Opt-Out Provision" later in this section), or
- The first day of the month following 36 consecutive months during which there is no activity in your HRA.

Your HRA is considered active only when contributions are paid into your HRA and/or reimbursements are made from your HRA. You forfeit your HRA after a 36-month period in which there is no activity. If you lose eligibility for your HRA, you are offered an opportunity to continue coverage under COBRA continuation coverage (see the "Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage" subsection of the "Other Information You Should Know" section for details).

Self-employed participants such as sole proprietors, 2% shareholders of an S-Corp, partners in a limited or general partnership, or members of a limited liability company may not have an HRA.

After termination of your HRA eligibility, assets in your HRA may be used to pay for qualifying expenses incurred prior to the date eligibility ends. Twelve months following the termination of eligibility, any remaining HRA assets will be forfeited and returned to the general assets of the Plan.

Using Your HRA

You can use your HRA to reimburse certain out-of-pocket qualified medical expenses incurred by you and your eligible dependents. The expenses that qualify are those defined under Section 213(d) of the Internal Revenue Code (see the "Qualifying Expenses" subsection later in this section for details). You must first receive reimbursement from any other medical plan or health Flexible Spending Account (FSA) before you can submit the qualified expense to your HRA for reimbursement. You also cannot claim any qualified expense you reimburse through your HRA as a deduction on your personal income tax return.

The maximum reimbursement you can receive each year is the amount available in your HRA. Your HRA cannot go below a zero balance.

To register on the Fund's app to view your HRA balance, your username is your first name initial, your last name, and the last 4 digits of your SSN. Your password is your last name, your date of birth (DDMMYY), and the last 5 digits of your SSN. Example: If your name is John Doe and you were born on January 5, 1990, your username and password would be:

Username: jdoe1111

Password: doe05019011111

Your HRA balance is reduced by any reimbursement you receive from your HRA for a qualified expense. To find out what your HRA balance is, call the Fund Office, download the Fund's app by searching "4th District Health Fund" in the App Store (Apple) or Google Play (Android), or visit **www.abchldg.com** (you can always check your HRA transactions and balance on the American Benefit Corporation website). After the end of the Calendar Year, the unused amount (if any) in your HRA will roll over to the following year, provided you continue to meet the Plan's eligibility requirements. There is currently no cap on your HRA balance.

You may submit qualified expenses you incur each *Coverage Period.* A new Coverage Period begins each Calendar Year, and an expense is considered "incurred" when the service is performed, not when you pay for the service. You must submit all qualified expenses no later than 12 months from the date on which the qualified expense was incurred. All claims must be filed within 12 months from the date the claim was incurred; otherwise, they will be denied as untimely.

You have two options for submitting claims for reimbursement.

- **By mail.** Submit a claim in writing to the Fund Office. You will need to get an HRA claim form from the Fund Office before you submit your claim. The claim must include:
  - The individual(s) on whose behalf the expenses were incurred;
  - The nature and date of the expenses;
  - The amount of the requested reimbursement; and
  - A statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source.

  Your claim must include the bills, invoices, or other statements from an independent third party (e.g., a *hospital,* physician, or pharmacy) showing who incurred the expense, the date and amount of the expense, and any additional documentation that the Fund Office may request. If your claim is approved, you'll receive a check in the mail (your aggregated claims must total at least $25 before you receive reimbursement).

  If you do not cash your check within 12 months of the date your reimbursement is issued, you will forfeit the amount, and it will revert back to the Plan. In no event will a forfeited amount be paid in cash to any other person.

- **Debit card.** You may use your HRA Debit Card to pay for qualified expenses. You are sent an HRA Debit Card automatically once you become eligible for an HRA, and you can request additional cards for your eligible dependents.

  Your HRA Debit Card is linked to your HRA, so reimbursement is an almost paperless process. You may use your debit card only to pay for qualified expenses at the time you receive the service, and your debit card will deactivate after a 36-month period in which there is no activity in your HRA.

If it is determined that you and/or your dependents received an overpayment or a reimbursement is made in error, you will be required to refund the overpayment or erroneous reimbursement to your HRA. If you do not refund the overpayment or erroneous reimbursement, the Fund reserves the right to offset your future reimbursements equal to the overpaid or erroneous reimbursed amount. The Fund also reserves the right to deactivate your HRA Debit Card.

Keep Your Receipts

You must have the proper proof—typically a letter of medical necessity, Explanation of Benefits, physician's statement, store receipt, or for over-the-counter drugs, a doctor's prescription—to show you used your HRA for a qualified expense.

There is a possibility that the Fund Office may ask you to verify a purchase and you will need to show the receipt, an Explanation of Benefits, or a physician's statement as proof, even if you used your HRA Debit Card. You may also need your receipts for tax purposes.

You can mail or fax your receipts to the Fund Office immediately after using your HRA Debit Card. The system is then updated so that when the qualified expense is processed, the substantiation required is already recorded, and no follow-up is necessary. **Mail receipts to the American Benefit Corporation, HRA Department, 9200 U.S. Route 60, Ona, WV 25545 or fax to 304-525-6005.**

Qualified Expenses

Only qualified expenses under Internal Revenue Code Section 213(d) that are not reimbursed by the Plan, or any other plan, are eligible for reimbursement through your HRA. A qualified expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. A sample list of qualified expenses is below and continues on the next page. As you review the list, note that certain items require a receipt and a letter of medical necessity to be reimbursed.

Expenses Eligible for HRA Reimbursement

- Acupuncture (excluding remedies and treatments prescribed by acupuncturist)
- Alcoholism treatment
- Ambulance
- Artificial limbs/teeth
- Chiropractors
- Christian Science practitioner's fees
- Contact lenses and solutions
- Copayments
- Cosmetic surgery if the surgery or procedure is necessary to ameliorate a deformity that arises from—or is directly related to—a:
  - Congenital abnormality; or
  - Personal injury that results from an accident or trauma.
- Costs for physical or mental illness confinement
- Crutches
- Deductibles
- Dental fees (including expenses not covered under Fund's dental coverage. See the "Your Dental Coverage" section for more information.)
- Dentures

- Diagnostic fees
- Dietary supplements*
- Drug and medical supplies (syringes, needles, etc.)
- Eyeglasses prescribed by your doctor
- Eye examination fees
- Eye surgery (cataracts, LASIK, etc.)
- Hearing devices and batteries
- Hospital bills
- Insulin
- Laboratory fees
- Laser eye surgery
- Obstetrical expenses
- Oral surgery
- Orthodontic fees
- Orthopedic devices
- Oxygen
- Physician fees
- Premiums you pay for your health, disability, or long-term care coverage (including self-contributions to maintain eligibility for the Plan and COBRA payments)
- Premiums for qualified, Employer-sponsored insurance coverage
- Prescribed medicines (including your copayment amounts under the Plan)
- Psychiatric care
- Psychologist's fees
- Routine physicals and other non-diagnostic services or treatments
- Smoking cessation programs
- Smoking cessation over-the-counter drugs
- Surgical fees
- Vitamins*
- Weight-loss programs*
- Weight-loss over-the-counter drugs*
- Wheelchairs
- X-rays

When you use your HRA Debit Card at a medical, dental, or vision care provider, you will need to provide the Fund Office with a copy of that receipt, an Explanation of Benefits, or a physician's statement to be reimbursed for the qualified expense.

Expenses Not Eligible for HRA Reimbursement

Expenses associated with the following list are not considered qualified expenses. As a result, these are not eligible for reimbursement from your HRA. This list is not exhaustive.

- Dancing/swimming lessons (even if recommended for the general improvement of the individual's health)
- Diaper service
- Expenses for a trip or vacation that's taken for a non-medical reason (even if on a physician's advice)
- Funeral services
- Group medical insurance premiums from your spouse's employer

* A receipt and a doctor's note of medical necessity are always required to be reimbursed for these expenses.

- Health club dues or membership fees
- A hot tub or Jacuzzi®
- Meals and lodging away from home for medical treatment not received at a medical facility
- Nursing services for a healthy baby
- Psychoanalysis received as a part of training to be a psychoanalyst
- *Custodial care*
- Bottled water
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing
- Transportation expenses of any sort, including transportation to receive medical care
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician
- Household and domestic help (even if recommended by a qualified physician due to your, your spouse's, or your dependent's inability to perform physical housework)
- Long-term care services
- Cosmetic surgery, or other similar procedure, that is directed at improving your appearance and does not meaningfully promote proper bodily function or prevent or treat your illness or disease.

HRA Opt-Out Provision

You may opt out of participating in an HRA. If you do, however, you will not be able to re–enroll for the duration of time you are eligible for coverage under the Plan. If you elect this permanent opt-out provision, any money in your HRA is forfeited and reverts to the general assets of the Plan.

If you elect the permanent opt-out provision, you cannot elect to receive any HRA money as wages in lieu of a contribution to an HRA. If you have questions or to request an HRA Opt-Out Form, please contact the Fund Office.

Note: If you are eligible for an HRA, you are considered to have Employer–sponsored coverage. As a result, this prevents you from being eligible for a government–issued subsidy if you purchase health insurance coverage on the Health Insurance Marketplace. For information regarding coverage through the Health Insurance Marketplace and federal subsidies, see **www.healthcare.gov** or call 800–318–2596.

* A receipt and a doctor's note of medical necessity are always required to be reimbursed for these expenses.

HOW YOUR MEDICAL COVERAGE WORKS

The reasonable and customary charge is the recognized amount charged for a covered service or supply. It is the lower of the provider's charge for furnishing the service or supply, or a percentage of the charged rate. See the "Glossary" section for a full definition.

As long as you meet the eligibility requirements, the Plan provides coverage for you and your eligible dependents. The Plan pays benefits for eligible expenses incurred only for *covered services* and only while coverage under the Plan is in effect.

The Plan pays benefits:

- Up to the benefit maximums;
- Up to the *reasonable and customary charge* (for *out-of-network* expenses) or up to the *negotiated fee amount* (for *in-network* expenses);
- For covered services, when provided by an *eligible provider;* and
- For *medically necessary* treatment, prescribed by a legally qualified physician, that is not considered *experimental or investigative treatment.*

You can receive care from an in-network or out-of-network provider. The Plan pays benefits at the higher in-network benefit level when you receive care from a provider who participates in the Highmark Blue Cross Blue Shield Association Preferred Provider Organization (PPO) network.

Claims subject to the No Surprises Act may be treated differently. See the subsection titled "Protections from Surprise Medical Bills" for more information.

A Snapshot of Your Medical Coverage

	In-Network	Out-of-Network
Calendar-Year Deductible	**You Pay**	**You Pay**
Individual	$1,050	$2,100
Family	$3,150	$6,300
Note: Your in-network and out-of-network eligible expenses cross-apply and accumulate toward both your in-network and out-of-network deductible requirement.		
Calendar-Year Out-of-Pocket Maximum (including deductible)		
Individual	$5,000	No Limit
Family	$5,000	
Prescription Drug Out-of-Pocket Maximum		
Individual	$1,600	No Limit
Family	$8,200	
Combined Out-of-Pocket Maximum		
Individual	$6,600	No Limit
Family	$13,200	
Note: Your in-network and out-of-network eligible expenses cross-apply and accumulate toward your in-network *out-of-pocket maximum.*		
	Plan Pays	**Plan Pays**
Coinsurance	80%	60%
Adult Well Care*		
Annual gynecological exam and Pap smear (including office visit expense)	100%, no deductible	Not covered
Annual prostate exam (including PSA test)	100%, no deductible	Not covered

* You must use PPO providers when receiving preventive, well-care services.

	In-Network	Out-of-Network
	Plan Pays	**Plan Pays**
Annual routine physical exam (including associated laboratory and radiology services) **and adult immunizations** (includes office visit expense)	100%, no deductible	Not covered
Bone density testing for osteoporosis (for people age 60 and older)	100%, no deductible	Not covered
Diagnostic colonoscopy (provided in accordance with American Cancer Society guidelines)	100%, no deductible	Not covered
Diagnostic sigmoidoscopy (one every three Calendar Years, beginning at age 50)	100%, no deductible	Not covered
HPV testing	100%, no deductible	Not covered
Mammography screening (one baseline: age 35 to 40; annually: age 40+)	100%, no deductible	Not covered
Additional covered preventive services for adults are listed in the "Preventive Care" subsection of the "What's Covered" section.		
Child Well Care*		
Routine new baby care for children younger than age 2 (for hospital and office visits, laboratory, and radiology services)	100%, no deductible	Not covered
Routine physical exam for children age 2 through 26 (for office visits, laboratory, and radiology services)	100%, no deductible	Not covered
Necessary immunizations	100%, no deductible	Not covered
HPV vaccine for girls and boys between the ages of 9 and 26	100%, no deductible	Not covered
Also see the Centers for Disease Control and Prevention website at www.cdc.gov for additional immunization and vaccine information.		
Chiropractic Care		
Chiropractic care (up to $500 per Calendar Year, per person)	80%	60%
Organ Transplant Services		
Organ transplants (a $10,000 allowance applies for transportation and lodging prior to, during, and after the transplant procedure for the patient and one family member or companion if a Blue Distinction Facility is used)	100%, no deductible when care is received from a Blue Distinction Provider; 80% otherwise	Not covered
Communication Devices		
Hearing aids for children age 18 and younger (up to a lifetime maximum benefit of $1,500)	80%	Not covered
Augmentative communication devices for children age 18 and younger (subject to a lifetime maximum benefit of $7,500)	80%	Not covered
Augmentative communication devices for individuals 19 and older (device must be eligible under Medicare)	80%	Not covered

* You must use PPO providers when receiving preventive, well-care services.

	In-Network	Out-of-Network
Behavioral Health Treatment	**Plan Pays**	**Plan Pays**
Lifetime maximum for substance abuse treatment	Unlimited	
Mental health or substance abuse outpatient treatment	80%	60%
Mental health or substance abuse inpatient treatment**	80%	60%
Outpatient Laboratory Program		
Laboratory testing at any in-network facility (Lab One or Highmark Blue Cross Blue Shield Association PPO providers)	100%, no deductible	60%
Member Assistance Program, provided by Lyra Health		
Member Assistance Program (MAP)	Visits 1–8: 100%, no deductible	

** Requires precertification. See the "Precertification" subsection of the "How Your Medical Coverage Works" section.

In-Network Versus Out-of-Network Providers

When you need care, you have the option to go to an in-network or out-of-network provider.

In-network providers are doctors, hospitals, clinics, and other health care facilities that agree to charge a negotiated fee amount for covered services. In-network providers also meet certain criteria and standards to ensure you receive quality care and that plan administration is cost effective and efficient. Plus, when you use in-network providers, your Calendar Year deductible is either waived or lower, the Plan pays a higher percentage of eligible expenses (coinsurance), and you are protected from high-cost expenses by an out-of-pocket maximum. In-network providers participate in either the Highmark Blue Cross Blue Shield Association Preferred Provider Organization (PPO) network or the Lyra Health network.

You also can receive care from providers outside the network. However, when you do, your deductible requirement and coinsurance are higher because providers outside the network do not agree to offer negotiated fee amounts for covered services.

The following charges are covered at the in-network level, even if they are received out-of-network:

- Hospital-based provider (*emergency* room physician, radiologist, pathologist, anesthesiologist, etc.) when necessary for emergency-related treatment
- Emergency ambulance service
- Medical professional providing services to a covered patient during a period of hospital confinement in a network facility and under the care of an attending physician participating in the network.

However, if you seek follow-up care for any of the above from a specialist or other provider outside the network following a period of hospital confinement, the Plan pays benefits at the out-of-network benefit level.

Certain out-of-network emergency services, out-of-network services at an in-network facility, and air ambulance services are also payable at in-network rates. See the subsection titled "Protections from Surprise Medical Bills" for more information.

How to Find a Highmark PPO Provider (In-Network Provider)

To find an in-network provider who participates in the Highmark Blue Cross Blue Shield Association Preferred Provider Organization (PPO) network, call 800-810-2583 or go online at **www.highmarkbcbswv.com**.

If you rely on information in the Plan's provider directory that inaccurately states that an out-of-network provider is in-network, you will only be subject to in-network cost sharing amounts. These cost-sharing amounts will be applied toward the in-network deductible and/or in-network out-of-pocket maximum in the same manner in-network cost share would be applied.

Save Money With In-Network Providers

The example below compares what Charles pays for covered hospital services at an in-network hospital and what he pays for the same covered services at a hospital outside the network. It assumes Charles has not satisfied his Calendar Year deductible requirement.

	In-Network	Out-of-Network
Hospital charge	$4,381	$4,381
In-network negotiated fee amount	$1,593	N/A
Net covered charges	**$2,788**	**$4,381**
Deductible (paid by Charles)	$1,050	$2,100
Eligible expenses subject to reimbursement	$1,738	$2,281
Plan pays	$1,390.40 (80% of $1,738)	$1,368.60 (60% of $2,281)
Charles pays	**$1,397.60 (20% of $1,738 + deductible)**	**$3,012.40 (40% of $2,281 + deductible)**

The Plan will pay benefits for covered care received both in- and out-of-network. However, you'll almost always pay less when you receive care in-network. Plus, your required deductible, coinsurance and out-of-pocket maximum are all lower for in-network care.

Charles saves $1,614.80 using an in-network provider. This example reflects actual savings from when Charles uses an in-network provider. Your actual savings may vary, depending on the specifics of your expense.

In-Network Mental Health and Substance Abuse Providers

You have access to a Member Assistance Program (MAP) offered through Lyra Health. Entirely confidential and provided at no cost to you, the MAP is designed to help you and your family contend with issues ranging from the basic (e.g., finding the right daycare) to the more complicated (e.g., coping with the death of a loved one).

Lyra Health counselors can advise you on how to make the most of the Plan's mental health and substance abuse benefits, direct you to in-network providers, and assist with issues related to drug or alcohol abuse, or eating disorders. Learn more in the "Member Assistance Program (MAP)" subsection of the "Special Fund Programs" section.

For more information or to find a provider in the Lyra Health network, contact Lyra Health at 877-363-0489 or visit **4thdistricthealthfund.lyrahealth.com**.

Protections From Surprise Medical Bills

Under a federal law called the No Surprises Act, you have protection against surprise medical bills from out-of-network providers and facilities. This law mainly applies to out-of-network emergency services, services provided by out-of-network providers at Network facilities, and out-of-network air ambulance services.

Out-of-Network Emergency Services

Covered Emergency Services are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum, even if the services were received from an out-of-network Emergency facility. This means you will be responsible for the network cost-share amount. The Plan will count any cost-sharing payments toward the in-network deductible and/or the payments made for in-network Emergency Services.

Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive Emergency services from an out-of-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amount paid by you.

Out-of-Network Providers at Network Facilities

Unless you consent to receiving services from the out-of-network provider (as described in this section), covered services performed by out-of-network providers with respect to visits at Network Health Care Facilities are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount, and the Plan will count any cost-sharing payments incurred for these services toward the in-network deductible and/or the in-network out-of-pocket maximums under the Plan in the same manner it would count cost-sharing payments made for in-network services.

Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive services from an out-of-network provider at a network facility, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

Out-of-Network Air Ambulance Providers

Covered Air Ambulance Services are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount, and the Plan will count any cost-sharing payments incurred for covered Air Ambulance Services toward the in-network deductible and/or the in-network out-of-pocket maximums in the same manner it would count cost-sharing payments made for in-network services.

Your cost sharing will be based on the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

If you receive Air Ambulance Services from an out-of-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, including payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

Waiving Surprise Medical Bill Protections

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. You may be able to waive these protections for (1) services from an out-of-network provider at a Network Health Care Facility or (2) services from an out-of-network emergency facility or provider after you are stabilized. This can occur if you are notified by the out-of-network provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and waive the protections.

If you give informed consent to be treated by the out-of-network provider, then the Plan will treat these services as out-of-network. This means you will be subject to out-of-network cost sharing, the provider can bill you for the balance directly, and the provider can balance bill you for the difference between what the provider charges and the amount paid by the Plan and the cost-sharing amounts paid by you.

You may not waive No Surprises Act protections for ancillary services provided by an out-of-network provider in a Network Health Care Facility. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

Payments to Out-of-Network Providers at Network Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities

For claims subject to the No Surprises Act from out-of-network providers at Network Health Care Facilities, out-of-network Air Ambulance Providers, and out-of-network emergency facilities, the Plan will pay the provider or facility the Out-of-Network Rate minus any cost-sharing amounts (copayments, coinsurance, and/or amounts paid towards deductible) you paid.

Continuing Care

If you are receiving care from a network provider that becomes out-of-network, you may have certain rights to continue your course of treatment if you are a "continuing care patient."

A continuing care patient is a patient who

- **a.** is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- **b.** is undergoing a course of institutional or inpatient care from the provider or facility;
- **c.** is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- **d.** is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- **e.** is or was determined to be terminally ill (as determined under the Social Security Act) and is receiving treatment for such illness from such provider or facility.

A serious and complex condition means a condition that

- **a.** in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- **b.** in the case of a chronic illness or condition,
  - **i.** is life-threatening, degenerative, potentially disabling, or congenital; and
  - **ii.** requires specialized medical care over a prolonged period of time.

If the Plan terminates its contract with your Network provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, you will be notified of the change and informed of your right to elect to receive transitional care from the provider. You may choose to continue your course of treatment under the same terms and conditions as would have applied for an in-network provider for up to 90 days after the notice is provided or until you no longer qualify as a continuing care patient (whichever is earlier). These providers cannot balance bill you during this time.

Termination of a contract includes the expiration or nonrenewal of the contract but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

How the Plan Pays Benefits

When you or a covered dependent have a medical expense, you share the cost of covered services with the Plan. In general, you will pay the entire cost of covered expenses out-of-pocket until you reach your deductible. The Plan fully covers certain expenses, like covered preventive care, even if you have not yet met your deductible. After you meet your deductible, you will share the cost of covered expenses with the Plan through coinsurance until you meet your out-of-pocket maximum. If you meet your out-of-pocket maximum, the Plan will pay the entire cost of covered expenses.

Deductibles

The individual deductible is the amount you pay during a Calendar Year before the Plan pays benefits.

The family deductible is the amount you and your covered dependents collectively must pay within a Calendar Year before the Plan pays benefits. Each covered individual must meet his or her individual deductible requirement before the Plan pays benefits. If three or more of your covered family members meet their individual deductible requirement in a Calendar Year (excluding any Deductible Amount Carryover, defined below, from the previous year), you satisfy the family deductible requirement for all covered family members.

Deductible Amount Carryover

The eligible expenses you incur during the last three months of a Calendar Year not only apply to your individual deductible requirement for that year, but carry over and apply to your individual deductible requirement for the following Calendar Year.

Family Members in One Accident

If two or more of your covered family members are in the same accident, and as a result, incur eligible expenses in a Calendar Year, and the combined amount of such eligible expenses equals the individual deductible requirement, each family member will be deemed to have met his or her individual deductible requirement for the Calendar Year.

Out-of-Pocket Maximums

Your out-of-pocket maximum is the most you pay during a Plan Year before the Plan pays 100% for covered services. Your out-of-pocket maximum does not include amounts over the reasonable and customary charge (if you receive care out-of-network) or charges for services that the Plan does not cover. The out-of-pocket maximum includes your deductible, coinsurance, and/or copayments (for prescription drug coverage).

You have two separate out-of-pocket maximums, one for medical and one for prescription drug eligible expenses. These two maximums do not cross-apply. This means that even if your total out-of-pocket costs meet your in-network medical out-of-pocket maximum, you still need to meet the prescription drug out-of-pocket maximum before the Plan pays 100% of your in-network covered prescription drug expenses.

Any amount you pay toward in-network and/or out-of-network covered services does cross-apply to and accumulate toward your in-network out-of-pocket maximum. This means that if you have an out-of-network out-of-pocket eligible expense, it will apply to your in-network out-of-pocket maximum.

Coinsurance

Coinsurance is the percentage of an eligible expense you pay after you meet the Plan's annual deductible requirement. It applies to eligible in-network and out-of-network expenses.

Precertification

Precertification is a review process where physicians, nurses, and/or pharmacists work with your physician to determine whether a procedure, treatment, or service is a covered benefit. Note: Precertification is not a guarantee of coverage; no benefits will be provided for a confinement or service that is not medically necessary or otherwise covered under the Plan.

Certain medical expenses must be precertified by American Health in order to be covered at the in-network level. You must receive approval before the expense occurs. Otherwise, you may be required to pay the entire expense out of pocket.

Precertification Process

In order to complete a precertification review, you and your prescribing physician must provide American Health Holding, Inc. (American Health) with your diagnosis and treatment plan by telephone or in writing to:

American Health
Phone: 866-898-9354
Monday–Friday, 8:00 a.m.–9:00 p.m.
Fax: 866-881-9643

Then, American Health will:

- Advise you by telephone, electronically, or in writing if the proposed treatment plan is medically necessary; and
- Conduct concurrent review if necessary.

If your admission or services are precertified, benefits are subject to all Plan provisions and payable as shown throughout this SPD.

If it is determined at any time that your proposed treatment plan, either partially or totally, is not a covered expense under the terms and provisions of the Plan, benefits for services may be reduced or services may not be covered.

Appeals for Denial of Precertification

You may appeal a denial of precertification. The first level of internal appeal will be conducted through American Health. If American Health denies the appeal, you may appeal to the Board of Trustees. For more information about this second level of appeals, refer to the "Claims Appeal Procedure for Medical, Prescription Drug, and Vision Benefits" subsection of the "How to Claim Benefits" section.

Benefits Requiring Precertification

The following benefits require you to complete the precertification process unless otherwise noted.

- **Inpatient hospitalization.** American Health must be notified at least 48 hours before a nonemergency hospital admission. If you are admitted to the hospital due to an emergency, American Health must be notified within 48 hours or the first business day following admission.
- **Skilled nursing.** American Health must be notified prior to services being rendered.
- **Surgical procedures.** American Health must be notified prior to any surgical procedure being rendered.
- **Inpatient hospitalization for mental health and/or substance abuse treatment.** American Health must be notified prior to services being rendered.

WHAT'S COVERED

The Plan pays benefits for the following covered services, provided to diagnose or treat an illness.

- Treatment by a doctor
- Surgery
- Hospital care and treatment, including daily room and board charges (up to the average semi-private room rate)
- Inpatient services at other health care facilities (where there is no annual visit limitation or annual day limitation), including (up to a combined maximum of 60 days per Calendar Year):
  - Skilled nursing facilities,
  - Rehabilitation hospitals,
  - Residential treatment facilities,
  - Sub-acute facilities, and
  - Mental health/substance abuse facilities
- Care provided by a registered graduate nurse who is not a member of your household or a member of your or your dependent's immediate family
- Anesthesia, including its administration
- Diagnostic X-ray and laboratory services
- Oxygen, including the rental of equipment for its administration (for stationary and portable tanks associated with concentrator units, the Plan limits benefits to two refills per month)
- X-ray, radium, and radioactive isotope therapy
- Rental of *durable medical equipment* when required for temporary therapeutic use
- Whole blood and blood plasma, including its administration
- Licensed professional ambulance services for emergency transportation to a local hospital when medically necessary.

  The Plan pays benefits for transportation to the nearest facility that can provide covered services to treat your condition. If local appropriate care is not available, the Plan pays the reasonable and customary charge to transport you outside your local area to the nearest facility able to provide the necessary care. Air ambulance services are covered only in emergencies and only when the use of a surface ambulance would cause a serious risk to your life or health. The Plan does not pay benefits for transportation outside the United States and Canada
- Casts, splints, crutches, trusses, and braces
- Artificial limbs and eyes required as a result of an injury or disease that occurs while your coverage is in effect, including medically necessary replacements
- Treatment by a physiotherapist, when provided under a doctor's supervision
- *Hospice* services, including bereavement counseling, drugs, and supplies, received in your home or in a hospice facility, provided:
  - Your life expectancy, as certified by a physician, is six months or less;
  - Pain control and symptom relief, rather than curative care, is considered by the physician to be more appropriate, and he or she refers you to the hospice program; and
  - You are formally admitted to the hospice, and the physician concurs with the treatment plan

- Medical and surgical services provided in connection with a mastectomy, including:
  - Reconstruction of the breast on which the covered mastectomy was performed;
  - Surgery and reconstruction of the other breast, if desired, to produce a symmetrical appearance; and
  - Prosthesis and treatment of physical complications of all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with you and the attending physician
- Hearing aids for children age 18 and younger, up to a maximum benefit of $1,500
- Testing performed to determine the cause of infertility
- A wig, up to a maximum benefit of $1,500, if prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of disease such as:
  - Burns resulting in permanent alopecia;
  - Lupus;
  - Alopecia areata, alopecia totalis, alopecia universalis;
  - Fungal infections not responding to a course of anti-fungal treatment resulting in near or complete cranial hair loss;
  - Chemotherapy; or
  - Radiation therapy
- Vision exams necessary to test diabetic individuals for retinopathy
- Outpatient laboratory services provided at a freestanding in-network provider
- Speech therapy, up to 20 visits per Calendar Year, if your dependent child is receiving treatment for delayed communication skills
- Clinical trials, provided you or your covered dependent have cancer or another life-threatening condition or disease. See the “Clinical Trials” subsection of this “What’s Covered” section
- Diabetic shoes, up to one pair in a Calendar Year and up to a lifetime maximum benefit of $250.
- Diagnosis and treatment of autism spectrum disorders. Treatment for autism spectrum disorders includes the following:
  - Medical care: services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;
  - Habilitative or rehabilitative care: professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;
  - Pharmacy care: medically necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority;
  - Psychiatric care: direct or consultative services provided by an individual licensed by the appropriate licensing agency in the state in which the individual practices;
  - Psychological care: direct or consultative services provided by an individual licensed by the appropriate licensing agency in the state in which the individual practices;
  - Therapeutic care: services provided by licensed speech therapists, occupational therapists, or physical therapists; and
  - Applied behavior analysis prescribed or ordered by a licensed health professional. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Preventive Care

The Plan pays 100% of eligible in-network preventive care services, up to the reasonable and customary charge. You do not have to meet a deductible requirement before the Plan pays benefits. **The Plan does not pay benefits for out-of-network preventive care services.**

The Plan pays benefits for the following **adult** (covered individuals age 18 and older) preventive care services:

- **Abdominal aortic aneurysm** screening (a one-time screening) if you are a certain age and have never smoked
- **Alcohol misuse** screening and counseling services
- **Anemia** screenings, provided on a routine basis while you are pregnant
- **Annual physical exam** with your family physician and/or an OB-GYN physician
- **Anxiety screening,** including those who are pregnant or postpartum
- **Aspirin** use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk and are not at increased risk for bleeding, have a life expectancy of at least 10 more years, and are willing to take low-dose aspirin for at least 10 years; or in pregnant women after 12 weeks of gestation if they are at high risk for preeclampsia
- **Bacteriuria urinary tract** or other infection screenings you receive while pregnant
- **Behavioral counseling interventions** for healthy weight and weight gain in pregnancy
- **Behavioral counseling interventions** to promote a healthy diet and physical activity for adults with cardiovascular-disease risk factors
- **Blood pressure** screenings
- **BRCA** risk assessment and counseling for genetic testing, if you are considered high risk
- **Breastfeeding support services** for pregnant and postpartum women, including consultation, counseling, education by clinicians and peer support services, and breastfeeding equipment and supplies. Equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies.
- **Breast cancer mammography** screenings, every one to two years, if you are older than age 40
- **Breast cancer chemoprevention** counseling, if you are considered high risk
- **Breastfeeding** interventions to support and promote breastfeeding
- **Cervical cancer** screenings between ages 21 and 65
- **Cervical dysplasia** screenings at 21 years of age
- **Chlamydia infection** screenings, if you are age 24 or younger and sexually active or are over 24 and considered high risk
- **Cholesterol** screenings, if you meet certain age requirements or you are considered high risk
- **Colorectal cancer** screenings for adults age 45 to 75
- **Contraceptive methods and counseling** for all FDA-approved, granted, or cleared contraceptive methods, sterilization procedures, and patient screening, education and counseling services and provision of contraceptives for all women with reproductive capacity, as prescribed by a health care provider, including in the immediate postpartum period. Contraceptive care includes follow-up care (e.g. management, evaluation and changes, including removal, continuation, and discontinuation of contraceptives)

- **Counseling** for sexually transmitted infections (STIs)
- **Counseling and screening** for human immunodeficiency virus (HIV)
- **Counseling to prevent obesity** for women aged 40 to 60 years with normal or overweight body mass index (BMI) to maintain weight or limit weight gain
- **Depression** screenings
- **Diet** counseling, if you are considered high risk for chronic disease
- **Fall prevention** exercise interventions for community-dwelling adults 65 years or older who are at increased risk for falls
- **Folic acid** supplements, if you may become pregnant
- **Gonorrhea** screenings, if you are under age 24 and sexually active or over age 24 and considered high risk
- **Hepatitis B** screening, if you are considered high risk or at your first pre-natal visit, if you are pregnant
- **Hepatitis C** screenings, for virus infection in adults
- **HIV risk assessment and prevention education** as determined by risk
- **Human papillomavirus (HPV)** testing, once every three years beginning at age 30
- **Immunization vaccines,** including the following (doses, recommended ages, and recommended populations vary):
  - Haemophilus influenzae type b;
  - Hepatitis A;
  - Hepatitis B;
  - Herpes zoster;
  - Human papillomavirus;
  - Influenza;
  - Measles, mumps, rubella;
  - Meningococcal;
  - Pneumococcal;
  - Tetanus, diphtheria, pertussis; and
  - Varicella
- **Lung cancer screening** for adults age 50 to 80 who have a 20-pack-per-year smoking history and currently smoke or have quit within the past 15 years.
- **Obesity screening** and behavioral intervention services if you have a BMI of more than 30
- **Osteoporosis** screenings, if you are older than age 65, or younger than 65 and postmenopausal at increased risk, depending on risk factors
- **Preeclampsia screening** if you are pregnant
- **Preeclampsia prevention** low-dose aspirin, provided as a preventative medication after 12 weeks of gestation, if you are considered high risk for infection
- **Preexposure Prophylaxis (PrEP)** for the prevention of HIV infection for persons at high risk of HIV
- **Perinatal depression preventive intervention** for pregnant persons at increased risk
- **Rh incompatibility** screenings, if you are pregnant, including follow-up testing if you are considered high risk

- **Screening and counseling** for interpersonal and domestic violence
- **Screening** for gestational diabetes
- **Screening** for prediabetes and type 2 diabetes in adults aged 35 to 70 years who are overweight or obese
- **Sexually transmitted infection (STI)** prevention counseling services if you are considered high risk.
- **Statin preventive medications** for individuals between the ages of 40 and 75, depending on risk factors
- **Syphilis** screening if you are considered at high risk or pregnant
- **Tobacco smoking cessation interventions** for adults and pregnant persons
- **Tuberculosis** screening if you are considered high risk
- **Type 2 diabetes** screenings if you have high blood pressure
- **Unhealthy drug use screenings**, including pregnant and postpartum persons
- **Well-woman visit** at least one visit annually for women to receive recommended preventive services that are age- and developmentally appropriate. Well-woman vists include prepregnancy, prenatal, postpartum, and interpregnancy visits.

The Plan pays benefits for the following additional preventive care services for your covered children (generally younger than age 18):

- **Alcohol and drug use** assessments
- **Anemia** screening at 12 months of age
- **Anxiety screening** for adolescents, including those who are pregnant or postpartum
- **Autism** screening for your children between age 18 and 24 months
- **Behavioral** assessments
- **Bilirubin concentration** screening for your newborn
- **Blood pressure** screenings
- **Blood screening** for your newborn
- **Congenital hypothyroidism** screening for your newborn
- **Critical congenital heart defect** screening for your newborn
- **Depression** screening routinely for adolescents
- **Developmental** screenings for your children younger than age three and surveillance throughout their childhood
- **Dyslipidemia** screenings once between 9 and 11 years of age; once between 17 and 21 years of age
- **Fluoride chemoprevention** supplements for your child if fluoride is not in his or her water source
- **Fluoride varnish** application
- **Gonorrhea** preventive medication for your newborn
- **Head circumference and weight for length** measurement for infants and young children
- **Hearing** screenings for your newborn and adolescents
- **Height, weight, and body mass index** measurements
- **Hematocrit or hemoglobin** screenings
- **Hemoglobinopathies** or sickle cell screening for your newborn
- **HIV** screening once between 15 and 18 years of age

- **Immunization** vaccines for your children from birth to age 18, including the following (doses, recommended ages, and recommended populations vary):
  - Diphtheria, tetanus, acellular pertussis;
  - Haemophilus influenzae type b;
  - Hepatitis A;
  - Hepatitis B;
  - Human papillomavirus;
  - Inactivated poliovirus;
  - Influenza;
  - Measles, mumps, rubella;
  - Meningococcal;
  - Pneumococcal;
  - Rotavirus; and
  - Varicella
- **Interpersonal and domestic violence** screening for adolescents
- **Iron** supplements for your children between 6 to 12 months who are considered at risk for anemia
- **Lead** screening for your children who are considered at risk for exposure
- **Medical history** for your children throughout their development
- **Obesity** screening and counseling services
- **Oral health** risk assessments
- **Phenylketonuria (PKU)** screenings for this genetic disorder in your newborn
- **Primary care interventions** for prevention of tobacco use in children and adolescents
- **Sexually transmitted infection (STI)** prevention and counseling services, and screenings for your adolescent who is considered high risk
- **Skin cancer** behavioral counseling services for children, parents of young children, adolescents and young adults (persons aged 6 months to 24 years) with fair skin type
- **Tobacco use** interventions to prevent initiation of tobacco use in school-aged children and adolescents
- **Tuberculin** testing for your child who is considered high risk for tuberculosis
- **Unhealthy drug use screenings** for adolescents age 12–17, including pregnant and postpartum persons
- **Vision** screenings

Covered preventive care services may change from time to time based upon the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

Remember, the Plan pays benefits only for covered preventive care services provided by an in-network provider (a provider in the Highmark Blue Cross Blue Shield or Lyra Health network). The Plan does not pay benefits when services are received from an out-of-network provider. In addition, the Plan does not pay benefits at the 100% level when preventive care is provided to treat illness or injury. The Plan pays benefits for covered services to treat or diagnose an illness or injury at the 80% or 60% benefit level, as described in this SPD.

Organ Transplant Provisions

When an organ or tissue is secured from a living donor, the Plan pays benefits for the donor's and/or recipient's unpaid medical expenses as outlined below:

- When this Plan covers the recipient, the Plan pays benefits for the donor's eligible expenses as part of the recipient's claim provided the:
  - Donor does not have health insurance coverage, or
  - Donor's health insurance plan denies coverage for the expenses incurred.
- When this Plan covers the recipient and the donor has coverage under a health insurance plan, the donor's expenses will be covered as part of the recipient's claim by coordinating between the two plans. This Plan will pay the lesser of normal benefits or the balance unpaid by the donor's health insurance plan.
- If both the recipient and the donor are covered by this Plan, the Plan pays benefits for each individual's eligible expenses up to the normal benefit amounts under the individual/separate claims.

Blue Distinction Centers for Transplants Program

The Blue Distinction Centers for Transplants (BDCT) Program recognizes quality medical facilities with established experience and skill in performing transplant procedures and providing necessary follow-up care. The Plan pays benefits only if you are a candidate for certain transplants, you obtain proper authorization, and your transplant is performed at a BDCT network facility.

In addition, your transplant procedure must follow a nationally recognized protocol for the diagnosis requiring the transplant. The Plan pays benefits for the following types of transplant procedures:

- Heart
- Heart/lung
- Lung
- Liver
- Pancreas/kidney
- Pancreas
- Liver/kidney
- Bone marrow/stem cell

The Plan pays benefits of up to $10,000 for transportation and lodging prior to, during, and after your transplant procedure (for you and one family member or companion) if you use a Blue Distinction Center. For specific information about transplant benefits, please contact the Fund Office.

If you precertify your expense and use a Blue Distinction Center for Transplants for your surgery, you will pay nothing for covered transplant-related expenses. Plus, you'll have the benefit of a high-quality medical facility with experience in the care you need.

Laboratory Services

LabOne, Inc. administers the Lab Card program for necessary laboratory tests performed on an outpatient basis. When LabOne performs the testing, the Plan pays 100% of your LabOne eligible expense. In addition, LabOne sends your eligible expense directly to the Fund Office. As a result, you do not have to complete or file a claim form, and you generally do not have to pay the cost of the test in advance with your provider.

Lab Card performs routine outpatient laboratory testing, such as pap smears, throat cultures, and blood and urine testing. Your LabOne program does not cover lab work you receive from another laboratory, tests ordered during a hospital confinement, or laboratory testing you may need on an emergency basis.

You may call LabOne at 800-646-7788 if you have additional questions about the program.

Other Laboratory Services

The Plan pays 100% of covered services you receive at an in-network laboratory facility (i.e., within the Highmark Blue Cross Blue Shield [BCBS] network), including hospitals for outpatient laboratory testing. All in-network laboratory testing, except testing that you receive while confined in a hospital, is covered at 100%, with no deductible requirement.

The Plan pays 80% of eligible laboratory expenses you incur while confined in an in-network hospital (subject to the Calendar Year deductible requirement).

If you go outside the network, the Plan pays 60% of eligible laboratory expenses (inpatient or outpatient) after you meet the Calendar Year deductible requirement.

Contact the Fund Office to locate an in-network laboratory, or locate an in-network laboratory facility online at **www.highmarkbcbswv.com**.

Clinical Trials

The Plan pays benefits for certain clinical trials. To be considered a covered service, a clinical trial must be a phase I, II, III, or IV clinical trial. It must also be a:

- Federally funded or approved trial,
- Trial conducted under an FDA investigational new drug application, or
- Drug trial that is exempt from requirement of an FDA investigational new drug application.

The Plan pays benefits for your clinical trial, provided you are diagnosed with cancer or another life-threatening condition, and you:

- Submit proof that your health care professional (who must be an in-network provider) is referring you to the clinical trial and that the clinical trial is considered appropriate for your care, or
- Provide medical and scientific information to the Fund Office that demonstrates that the clinical trial is appropriate for you.

If your clinical trial is approved, the Plan pays benefits for the reasonable routine covered services furnished in connection with your participation in the clinical trial. These services must already be considered covered services under the Plan. For example, if you require temporary hospitalization or monitoring in connection with the trial, and there is an expense for the services, the Plan considers the services as covered services and pays benefits for the eligible expenses. Routine costs do not include:

- Investigational items, devices, or services;
- Items and/or services provided for the sole purpose of data collection and analysis needs;
- Services that are inconsistent with widely accepted and established standards of care for a particular diagnosis; or
- Any other items that the Fund Office determines are not eligible routine expenses.

The Plan reserves the right to use reasonable medical management techniques to interpret and apply coverage provisions related to clinical trials. The Plan does not discriminate against you on the basis of your involvement in an approved clinical trial.

WHAT'S NOT COVERED

The Plan does not pay benefits for the following services. If you have questions about this list or how the Plan pays benefits, contact the Fund Office.

General Limitations

The Plan does not pay benefits for the following:

- Medical care or treatment provided by or received in any facility that's owned or operated by the federal government, unless a charge is made to you.
- Medical care or treatment provided by or received in any facility that's owned or operated by a state or its political subdivision, unless there is an unconditional requirement for you to pay without regard to rights against others (contractual or otherwise).
- Care provided for a disease or injury for which you are entitled to benefits under any workers' compensation law or act, or any accidental injury that arises out of or during the course of your employment. Working owners participating in the Plan are expected to purchase workers' compensation coverage for themselves, if they anticipate working on the job. This exclusion does not apply to occupational injuries that occur to a working owner who is visiting the job site but not actively engaged in work on the job site.
- Any confinement, treatment, care, service, or supply that is not recommended or approved by a physician, including any period of disability when you are not under the regular care of a physician.
- Bodily injury, disease, or sickness that is caused by:
  - Any act of war (declared or undeclared),
  - Any act of international armed conflict,
  - Any conflict that involves the armed forces of any international body, or
  - Insurrection or any military service-connected injury or sickness.
- Treatment or services that the Plan deems not to be medically necessary unless otherwise provided herein.
- Treatment or services for a non-accidental, self-inflicted injury or condition, unless due to a physical or mental condition.
- Any loss, expense, or charge that results from your participation in a riot or results from your commission of a felony (regardless of whether charges are filed).
- Any loss, expense, or charge for which you would not be responsible for payment in the absence of coverage under this Plan.
- Any expense or portion of expense for which benefits are payable under any other Plan provision or for which benefits are provided by any other group medical plan.
- Any expense or portion of expense that exceeds the reasonable and customary charge of such service or supply, as determined by the Plan. The Plan makes such determination by comparing the expense against the charge made to other individuals (of similar age and sex) for the same type of illness in the locality where the service or supply is furnished. Claims subject to the No Surprises Act may be treated differently. See the subsection titled "Protections from Surprise Medical Bills" for more information.
- Dental treatment, except for the necessary repair of natural teeth due to an accidental injury.
- Cosmetic surgery except when performed on a child to correct a deformity present at birth or to repair disfigurement that results from an accidental injury.

- Any loss, expense, or charge that results from appetite control or any treatment of obesity (except for surgery to treat morbid obesity and weight loss medications prescribed consistent with SavRx clinical guidelines).
- Expenses associated with professional combative sporting events. For purposes of this limitation, a professional combative sporting event is one in which the participant receives compensation.
- Any expense or charge for a service or supply that is:
  - Not provided in accordance with generally accepted medical standards within the U.S.,
  - Considered an experimental or investigative treatment, or
  - Investigative and not proven as safe or effective.

  This exclusion does not preclude the Plan from paying benefits for approved clinical trials.
- Fertility treatments, including any expense related to the following:
  - In vitro fertilization,
  - Artificial insemination,
  - Gamete intrafallopian transfer (GIFT) embryo transplants,
  - Surrogate parenting, and
  - Donor semen, or similar types of procedures.
- Reversal of sterilization.
- Vision therapy, unless treatment is required for strabismus, esotropia, or exotropia.
- Certain health examinations, including normal eye exams, hearing exams, the purchase of and fitting for glasses, and the purchase of and fitting for hearing aids (except as specifically provided for as a covered service in this SPD).
- Radial keratotomy, LASIK, LASEK, or similar surgeries.
- High-dose chemotherapy with autologous transplantation (HDC-ABMT) for solid-type tumors (including, but not limited to, cancerous breast tumors).
- Personal hygiene and convenience items, including (but not limited to):
  - Air conditioners, air purifiers, humidifiers, and de-humidifiers;
  - Whirlpools and swimming pools;
  - Allergy-free pillows, blankets, mattress covers, electric heating units, or orthopedic mattresses;
  - Exercise equipment, vibratory equipment, or health club memberships;
  - Elevators or stair lifts;
  - Clinical thermometers, scales, or elastic bandages; and
  - Devices or surgical implantation for simulating natural body contours.
- A wig or hairpiece for the diagnosis of androgenetic alopecia (male pattern baldness).
- Charges for failing to keep a scheduled visit or completing claim forms.
- Out-of-network telephone and/or remote doctor visit fees.
- Travel and accommodations, even if prescribed by a physician, unless otherwise noted in this SPD.
- Services you or your dependent receive from a member of your immediate family or from anyone who resides with you in your household.
- Physical therapy (or any other type of therapy) that you receive that—based on your prognosis or medical history—will not result in a reasonable chance of improvement in your condition.

- Rental or purchase of any durable medical equipment or any other equipment that is not considered necessary or is considered solely for therapeutic treatment of your injury or sickness.
- In-hospital items such as telephones, TVs, cosmetics, newspapers, magazines, laundry services, guest trays, beds or cots for guests or other family members, personal comfort items, or any other items not considered medically necessary.
- Educational services and devices.
- Over-the-counter drugs or medicines, and drugs or medicines that are not legally dispensed by a registered pharmacist or physician according to a doctor's written prescription (including a prescription for more than a 90-day supply of a drug or medicine that is obtained at one time).
- Psychotherapy, counseling, or other services in connection with developmental disorders, learning disabilities, or intellectual disability.
- Hypnotherapy, biofeedback, other forms of self-care or self-help training, and related diagnostic testing.
- Expenses associated with confinement and services in a halfway house or group home.
- Any transplant services performed at a non-Blue Distinction Center for Transplants Program facility.
- Gene therapy, including any services, supplies, and/or drugs related to gene therapy.
- The additional costs associated with the following preventable medical errors:
  - Surgery on the wrong patient or the wrong body part,
  - The performance of the wrong surgical procedure, and
  - Foreign objects inadvertently left in a patient following surgery.

The Plan pays benefits for the screening and evaluation necessary to diagnose autism spectrum disorder, which includes autism disorder, Asperger Syndrome, Rett Syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. This coverage does not extend to treatment of the autism spectrum disorder, regardless of whether the treatment is prescribed by a physician or provided by qualified providers. The Plan does not cover applied behavioral analysis, intervention, or modifications for the disorders.

Lifetime Maximum Benefits

The Plan does not apply a lifetime maximum to *essential health benefits.*

The Plan does apply a lifetime maximum of $50,000 on nursing services you might receive from a graduate nurse in your home.

Hearing aids for children age 18 and younger are subject to a lifetime maximum benefit of $1,500. Augmentative communication devices for children age 18 and younger are subject to a lifetime maximum benefit of $7,500.

The Plan pays benefits for diabetic shoes up to one pair per Calendar Year and up to a lifetime maximum benefit of $250.

The Plan pays benefits for wigs up to a maximum lifetime benefit of $1,500 if prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of disease such as burns resulting in permanent alopecia; lupus; alopecia areata, alopecia totalis, alopecia universalis; fungal infections not responding to a course of anti-fungal treatment resulting in near or complete cranial hair loss; chemotherapy; or radiation therapy.

For more information on lifetime maximums, contact the Fund Office.

YOUR PRESCRIPTION DRUG COVERAGE

The Plan pays benefits for covered prescription drug services when you fill your prescription:

- At a retail pharmacy that participates in the *Pharmacy Benefit Manager's* (PBM's) network, or
- Through the PBM's Mail Order Pharmacy

Sav-Rx is the current PBM. That said, the Plan pays benefits only when you fill your prescription at a Sav-Rx participating pharmacy (retail or mail order). Once you become eligible for this Plan, you will receive a personalized Sav-Rx Prescription Benefits ID card that lists your eligible dependents. To receive benefits, you must present your Prescription Benefits ID card along with your doctor's prescription to any participating Sav-Rx pharmacy.

The Plan pays benefits only when you fill your prescriptions through a Sav-Rx participating pharmacy. Check to make sure your pharmacy is part of the Sav-Rx network before you fill your prescriptions. To locate a Sav-Rx participating pharmacy, go to www.savrx.com and enter the group number "IBEWD4," or call Sav-Rx at 866-233-IBEW (4239). Please note that not all chains or pharmacies are in the Sav-Rx network, including Walmart, Sam's Club, and certain Rite-Aid locations.

A Snapshot of Your Coverage

Prescription Drug Tier	Retail Pharmacy (up to a 34-day supply)	Preferred Network Retail Pharmacy (up to a 90-day supply)	Mail Order Pharmacy (up to a 90-day supply)
	You Pay*	**You Pay***	**You Pay***
Generic Drug	10% (minimum $10; maximum $100)	10% (minimum $30; maximum $300)	$15 copayment
Preferred Brand Name Drug	20% (minimum $15; maximum $100)	20% (minimum $45; maximum $300)	20% (minimum $40; maximum $200)
Non-Preferred Brand Name Drug	30% (minimum $30; maximum $100)	30% (minimum $90; maximum $300)	30% (minimum $60; maximum $200)

* If the cost of your medication is less than your minimum amount, you are responsible for the actual cost of the medication plus the dispensing fee.

To take full advantage of the Plan's benefits, fill your prescribed short-term medication through a retail pharmacy that participates in the Sav-Rx network. The Plan does not pay benefits if you fill your prescriptions at a pharmacy that does not participate in the Sav-Rx network. For your long-term *maintenance drugs,* use a Sav-Rx ***preferred*** network pharmacy that participates in the Sav-Rx network or the Sav-Rx's Mail Order Pharmacy.

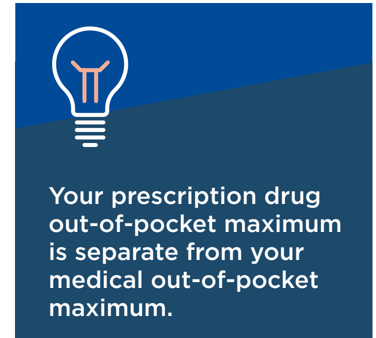
The benefit the Plan pays depends on the type of drug—*generic, preferred brand name,* or *non-preferred brand name*—you receive and whether you fill your prescription at a retail pharmacy or through the Mail Order Pharmacy. When you go to a Sav-Rx participating pharmacy, be sure to present your personalized Sav-Rx Prescription Benefits ID card. You then pay your copayment/coinsurance amount as indicated in the chart above and sign a form indicating that you received your prescription.

If the cost of your medication is less than your minimum copayment amount, you are responsible for the actual cost of the medication plus the dispensing fee. For example, if your preferred brand name drug costs $7 (the Plan's minimum copayment is $15 retail/$40 mail order), you pay $7 plus the dispensing fee. You do not pay the applicable minimum copayment.

Prescription Drug Out-of-Pocket Maximum

The annual prescription drug out-of-pocket maximum is the most you pay out of your own pocket for eligible expenses each year. Once you meet the maximum, the Plan pays 100% of all eligible expenses for the rest of the year. This means that the Plan pays benefits for covered prescription drug services as shown in the "A Snapshot of Your Coverage" subsection until you reach the prescription drug out-of-pocket maximum. Then the Plan pays 100% of your eligible expenses for the remainder of the Calendar Year. Note: Your prescription drug out-of-pocket maximum is separate from your medical out-of-pocket maximum.

Prescription Drug Out-of-Pocket Maximum	
Individual	$1,600
Family	$8,200



Your prescription drug out-of-pocket maximum is separate from your medical out-of-pocket maximum.

Specialty Drugs

Specialty drugs are generally high-cost drugs used to treat serious and/or chronic conditions. If your drug is part of the High Impact Advocacy Program (see "Sav-Rx Prescription Drug Coverage Programs" below) you must fill your specialty medications through the Sav-Rx Specialty Pharmacy. If your specialty drug is not part of the High Impact Advocacy Program, you may fill your specialty medication through a participating pharmacy, the Mail Order Pharmacy, or the Specialty Pharmacy.

The Plan also provides benefits for voluntary self-injectable specialty drugs, according to the table below.

Prescription Drug Tier	Sav-Rx Retail Pharmacy
	You Pay*
Generic Specialty Drug	10% (minimum $10; maximum $100)
Preferred Brand Name Specialty Drug	20% (minimum $15; maximum $100)
Non-Preferred Brand Name Specialty Drug	30% (minimum $30; maximum $100)

* If the cost of your medication is less than your minimum amount, you are responsible for the actual cost of the medication plus the dispensing fee.

Sav-Rx Prescription Drug Coverage Programs

Sav-Rx, the Pharmacy Benefit Manager, administers prescription drug programs to help you save money and ensure you are receiving the right prescription for your condition or illness.

Specialty Drug Program

The Sav-Rx Specialty Drug Program includes a precertification process. This process helps manage high-cost drug therapies by ensuring they are prescribed for an appropriate condition, and they're prescribed at an acceptable dose and quantity given the condition. If you are prescribed a specialty drug, you may also be enrolled in a manufacturer support program, which offers you a local nurse navigator to help you better manage your chronic condition.

Step Therapy Program

Step Therapy helps you if you take a prescription on a regular basis for an ongoing condition like arthritis, asthma, or high blood pressure. It helps you find an effective medication to treat ongoing conditions while keeping costs as low as possible. Step Therapy requires you to first try a more cost-effective drug to treat your medical condition before other *brand name drugs* will be covered.

For example, if Drug A and Drug B can both treat your medical condition, the Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Plan then covers Drug B. In this example, Drug A is the first step in the Step Therapy Program and is usually a generic drug.

Generic drugs are tried first because they can provide the same health benefits as brand name drugs but at a lower cost. Drug B is considered a back-up drug (Step 2 and Step 3 drugs). These are brand name drugs, such as those you see advertised on TV, and their costs are based on the Step number (i.e., Step 2 drugs tend to cost less than Step 3 drugs).

Examples of typical therapeutic classes and medicines that require Step Therapy include, but are not limited to:

- Proton pump inhibitors (like Prevacid/Nexium)
- Statins for cholesterol
- Sleep aids
- SSRI/SNRI antidepressants
- Nasal sprays
- Osteoporosis medications
- ARB antihypertensives and combination antihypertensive
- Lyrica
- Overactive bladder and migraine medications
- Tekturna
- Glaucoma agents

Mandatory Generic Program

The Sav-Rx Mandatory Generic Program is designed to help decrease prescription drug costs for both you and the Fund. Before you try a prescribed brand name drug, you'll try a generic equivalent. The substitution applies to generic medications that are rated by the U.S. Food and Drug Administration (FDA) as being equivalent to the brand name medication.

In certain situations the brand name medication is medically necessary. In these situations your prescribing physician must submit a written letter of medical necessity indicating the medical reason why you require the brand name product. If the medication is clinically appropriate, you are not required to pay the difference in cost, only your applicable brand name coinsurance.

If your prescribing physician does not submit a letter of medical necessity and you still fill the brand name drug, you will be responsible for the brand name drug coinsurance PLUS the difference in cost between the generic equivalent and the brand name drug.

If you fill a prescription for a brand name drug without a letter of medical necessity from your prescribing physician, you will be responsible for the brand name drug coinsurance PLUS the difference in cost between the generic equivalent and the brand name drug.

High Impact Advocacy Program

This program manages the use of selected specialty medications to reduce or eliminate your out-of-pocket expense. To receive your medication at the most affordable cost, your prescription will be filled at the Sav-Rx Specialty Pharmacy. Sav-Rx will facilitate your enrollment into a manufacturer-sponsored coupon program.

Prior Authorization Program

This program is an extension of the Specialty Drug Program and targets medications that do not qualify as specialty medications but do benefit from additional clinical management. This requirement helps to ensure that members are receiving the appropriate drugs and quantities for the treatment of specific conditions as approved by the U.S. Food and Drug Administration (FDA).

Therapeutic Quantity Limits Program

This program ensures the proper utilization of certain medications based upon FDA-approved manufacturer labeling. The program places therapeutic limits on particular classes of medications including, but not limited to:

- Narcotic pain relievers
- Migraine medications
- Respiratory and asthma medications
- Nasal medications
- Sedative hypnotics

Infusion Medications

Infusion medications will only be covered under the prescription drug benefit (subject to limitations), except if administered in a medically necessary inpatient or emergency room setting, or if there are special circumstances as determined by the Board of Trustees in its sole discretion. To be covered under the prescription benefit, infusion medications must be filled by a Sav-Rx pharmacy or a pharmacy that has partnered with Sav-Rx.

What's Covered

Prescription drugs are covered according to the information in the "Your Prescription Drug Coverage" section. For a complete list of covered prescription drug services, please visit the Sav-Rx website at **www.savrx.com** (Group Number: IBEWD4) or call Sav-Rx at 866-233-IBEW (4239).

Preventive Prescription Drugs

The health plan offers certain preventive drugs at no cost to you, according to the guidelines of the Affordable Care Act (ACA). They include:

- Medicine and supplements to prevent certain health conditions for adults, women, and children
- Medicine and products for quitting smoking or chewing tobacco (tobacco cessation)
- Medicine used prior to screenings for certain health conditions in adults
- Contraceptives for women
- Cholesterol-lowering medications

For a full list of covered preventive prescriptions, visit the Sav-Rx website at **www.savrx.com** (Group Number: IBEWD4) or call Sav-Rx at 866-233-IBEW (4239).

If you have questions on any of these programs, contact Sav-Rx at 866-233-IBEW (4239).

What's Not Covered

A point-of-sale purchase of a prescription is not a claim for benefits. If you elect to have your prescription filled by a pharmacy other than a participating Sav-Rx pharmacy, no benefits are payable by the Plan.

Prescription drug benefits are subject to the "General Limitations" subsection of the earlier "What's Not Covered" section. In addition:

- The maximum supply you can receive at a Sav-Rx participating pharmacy is a 34-day supply.
- The maximum supply you can receive through a Sav-Rx preferred participating pharmacy or the Sav-Rx's Mail Order Pharmacy is a 90-day supply.
- The Plan limits benefits for prescription drugs prescribed to treat erectile dysfunction to six pills in any 30-day period. An exception applies for Cialis (or a substantially similar brand) when prescribed to treat a diagnosis of benign prostatic hyperplasia (BPH). In this instance the Plan limits the prescribed medication to one tablet per day, 2.5mg or 5mg (or a similar brand's dosage), and only when precertified by Sav-Rx.
- You pay the full cost of prescription non-sedating antihistamines. However, Singulair will be covered (subject to the coinsurance) for severe allergic rhinitis. Your physician must precertify though Sav-Rx and certify that you suffer from severe allergic rhinitis and that all other medications have failed to provide you the appropriate level of relief.
- The Plan pays benefits for topical creams (for short-term treatment of a skin condition) only when obtained through a retail pharmacy.
- If you are age 24 and older, the Plan pays benefits for Retin-A only upon receipt of your physician's statement indicating the medication's medical necessity.
- The Plan does not pay benefits for:
  - Diet medications, nutritional and diet supplements, or vitamins (except pre-natal);
  - Fertility drugs;
  - Lifestyle drugs, including, but not limited to, Propecia and Renova;
  - Vaccines, taxoids, and non-RSV disease prevention drugs, except as otherwise provided in this SPD;
  - Over-the-counter drugs and medications not legally dispensed by a registered pharmacist or physician (according to a written prescription of a doctor);
  - Fluoride preparations, except as otherwise provided in this SPD;
  - Contraceptive devices, injectables, and kits, except as otherwise provided in this SPD; and
  - Experimental or investigative drugs.

The Plan's Coordination of Benefits provision applies to covered prescription drug services. If you or a dependent has primary prescription drug coverage under another plan, the prescriptions for you or your covered dependent will be covered through this Plan on a secondary basis. Be sure to submit your prescription drug claims through your primary plan first and then submit the balance to the Fund Office for benefits under this Plan (since this Plan is considered the secondary plan).

The maximum supply you can receive at a Sav-Rx participating pharmacy is a 34-day supply. The maximum supply you can receive through Sav-Rx's preferred participating pharmacy or the Sax-Rx's Mail Order Pharmacy is a 90-day supply.

YOUR DENTAL COVERAGE

Your dental coverage is designed to help you meet the expense of preventive dental care. The Plan only covers preventive care services. You may visit any dentist you wish; however, when you receive care from a dentist who participates in the Delta Dental network, you have a higher Calendar Year maximum.

You may submit a claim for any qualified expense that is not covered by the Plan to your Health Reimbursement Arrangement (HRA) for reimbursement.

To locate a participating Delta Dental PPO or Premier provider, you may visit **www.deltadentaloh.com** or call customer service at **800-524-0149**. The selected provider should then be contacted for an appointment and advised of the availability of benefits through this program.

A Snapshot of Your Coverage

Regardless of whether you see a Delta Dental network provider or a provider outside the network, your coverage is the same. However, the maximum Calendar Year dollar amount that the Plan pays per covered individual is higher if you remain in-network for covered services. In addition, even though the Plan pays the same percentage of covered services for both in-network and out-of-network care, in-network providers agree to charge lower negotiated rates for covered services. As a result, your out-of-pocket costs are lower because the Plan bases the percentage you pay on a lower negotiated amount, as shown below:

Orthodontic treatments are not covered by the Plan.

Benefit	In-Network	Out-of-Network
Calendar Year Deductible	**You Pay**	
Individual	None	
Family		
Calendar Year Maximum (applies to all covered services)	**Plan Pays**	**Plan Pays**
Individual	Up to $900	Up to $750
Note: The Calendar Year maximum does not apply to pediatric oral services provided to your dependent children younger than age 18.		
Preventive Care Covered Services	**Plan Pays***	
• Oral exams and routine cleanings, twice per Calendar Year • Bitewing X-rays and fluoride applications for children younger than age 19, once per Calendar Year • Sealants for dependent children younger than age 19, once every three consecutive Calendar Years • Full-mouth X-rays, once every three consecutive Calendar Years • Brush biopsy to detect oral cancer • Emergency treatment to relieve pain • Cleanings following periodontal therapy	100%, of covered expenses, up to the ***reasonable and customary charge.*** There is no deductible.	

* If you receive care out-of-network, the percentage you and the Plan pay (coinsurance) is based on the maximum allowed fee for the covered service. The Plan pays benefits only up to the maximum allowed fee. In addition to your coinsurance and deductible requirement, you are responsible for any amount in excess of the reasonable and customary charge.

In-Network Versus Out-of-Network Providers

When you or your eligible dependents need preventive dental care, you have the option to use dentists who participate in the Delta Dental network—a large, national network of dentists and specialists who agree to provide services at a lower negotiated rate. The Plan offers you access to two Delta Dental networks—the Delta Dental PPO (PPO network) and the Delta Dental Premier network. Here's how the networks work:

- You can use either the **Delta Dental PPO (PPO network)** or the **Delta Dental Premier® network.**
  - The PPO network does not have as many participating providers; however, these dentists agree to accept deeper discounted rates for preventive services, saving the Plan money and allowing your annual maximum to go further.
  - The Premier network has a larger number of participating providers; however, their discounted rates are not as low as the rates accepted by dentists who participate in the PPO network.
- The Plan covers the cost of service up to the reasonable and customary charge (for out-of-network expenses) or up to the *negotiated fee amount* (for in-network expenses). You are responsible for any amounts over the reasonable and customary charge.
- If you reach the Plan's Calendar Year maximum (**$900** per year of eligible expenses when you use in-network providers; **$750** per year of eligible expenses when you use out-of-network providers), the charges you incur for the remainder of the year are your responsibility. However, if you use an in-network provider, your cost is still based on the in-network provider's discounted rate.

How to Find Delta Dental Providers

To see if your dentist participates in the Delta Dental PPO or Delta Dental Premier Network, or to find a local participating dentist, visit **www.deltadentaloh.com** and follow these instructions:

- Click "Find a Dentist."
- Click "Delta Dental PPO and Delta Dental Premier."
- Select "Delta Dental PPO Plus Premier" from the dropdown and search by your current location or enter your zip code.
- Click "Find Dentists" to view your results.
- You can then filter the results by office hours, languages spoken, provider gender, and more.

You may also call Delta Dental's Customer Service department at **800-524-0149** to obtain a customized list of participating dentists. Representatives are available Monday through Friday, 8:30 a.m. to 8:00 p.m. Delta Dental's Automated Service Inquiry (DASI) system is available 24 hours a day, seven days a week. If your current dentist does not participate in the Delta Dental PPO or Delta Dental Premier networks but is interested in joining, you can recommend your dentist for membership. Just go to **www.deltadentaloh.com**, look for "Refer a dentist" near the bottom of the page, and fill out the online form.

What's Covered

Regardless of whether you receive care from a provider in one of the Delta Dental networks or you go outside the network for care, the Plan pays benefits for the following covered services.

Preventive expenses:

- Periodic oral examination (twice per Calendar Year)
- Intra-oral x-rays—complete series (one series in a consecutive three-Calendar-Year period)
- Bitewing x-rays (one set in a Calendar Year)
- Prophylaxis, with or without oral examination (twice per Calendar Year)
- Periodontal prophylaxis
- Topical application of stannous fluoride for individuals younger than age 19 (once per Calendar Year)
- Sealants for dependent children (one series in a consecutive three-Calendar-Year period)

What's Not Covered

Dental benefits are subject to the "General Limitations" subsection of the earlier "What's Not Covered" section. In addition, no benefits will be provided for:

- Charges in excess of the reasonable and customary charge or for unnecessary treatment
- Services not generally recommended and approved by a legally qualified dentist or physician
- Services and supplies which are cosmetic in nature
- Treatment by someone other than a dentist, except scaling, cleaning of teeth, and topical application of fluoride, which may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a dentist
- Oral hygiene and dietary instruction
- A plaque-control program
- Dental care or services paid for or furnished by at the direction of any governmental agency
- Dental procedures which are included as covered medical expenses under the Comprehensive Benefit
- Temporary services
- Infection control/sterilization procedures
- Veneers
- Space maintainers, fixed, unilateral
- Amalgam fillings
- Silicate cement
- Simple extractions
- General anesthesia and IV sedation, when necessary and in connection with oral surgery
- Acrylic or plastic fillings
- Composite acrylic resin filling
- Root canal therapy, including treatment plan and follow-up care
- Apicoectomy

- Gingivectomy or gingivoplasty
- Osseous surgery
- Periodontal scaling
- Repairs and adjustments of dentures
- Replace broken tooth on complete or partial denture
- Recement bridge
- Surgical extractions, impacted teeth
- Crown restorations
- Gold inlay fillings
- Bridge pontics and abutment crowns
- Partial or complete dentures
- Dental implants

Ability to Opt Out of Dental Coverage

You have the opportunity to opt out of the Fund's dental coverage, which is provided at no additional cost to you. If you opt out, your overall benefits package is reduced. Once you opt out of dental coverage, you can reinstate dental coverage once per year by providing advance written notice to the Fund Office. The Fund Office must receive advance written notice by the first day of the Plan Year (October 1).

To opt out of dental coverage, you must provide written notice to the Fund Office. Your dental coverage ends on the first day of the month following the date the Fund Office receives your written notice. For more information regarding opting out of dental coverage, please contact the Fund Office.

You are not required to do anything to continue receiving dental coverage from the Fund, and there is no financial benefit or other incentive in choosing to opt out of such coverage.

YOUR VISION COVERAGE

The Plan provides you and your covered family members vision coverage through an arrangement with VSP Vision Care. You receive discounted services and a higher level of coverage when you use a VSP provider.

A Snapshot of Your Coverage

	VSP Provider	Non-VSP Provider
Vision Exam	Plan pays 100% (once every Calendar Year)	Plan pays 100%, up to $30
Glasses and Sunglasses	You receive 20% savings (complete pair of prescription glasses and sunglasses, including lenses [photochromatic, tinted, progressive, coatings, scratch-resistant, and polycarbonate] and frames, within 12 months of a WellVision Exam)	Not covered
Contacts	You receive 15% discount on contact lens examination (not including contact lenses, fitting, and evaluation)	Not covered

Visit eyeconic.com for prescription eyeglasses, contacts, and non-prescription sunglasses, all with free shipping and returns. It's the only retail website offered by VSP's provider network, meaning you'll pay the lower VSP provider price for all purchases.

In-Network Versus Out-of-Network Providers

When you use a VSP provider, your annual eye exam is covered in full. In addition the Plan offers you discounted fees for lenses, frames, and contact lenses. At the time of your appointment show your vision care provider your VSP ID card.

If a non-VSP provider performs your eye exam, the Plan pays 100% of the cost of the exam, up to $30. The Plan does not pay benefits for any other vision services or supplies you may receive from a non-VSP provider.

You may submit a claim for any qualified expense that is not covered by the Plan to your **Health Reimbursement Arrangement** (HRA) for reimbursement.

How to Find a VSP Provider

To locate a participating VSP provider, visit **www.vsp.com** call 800-877-7195.

Getting the most out of your vision coverage through the Plan is easy. Here's what you need to do:

- Register at **www.vsp.com** by clicking "Create an Account" at the top of the page. As a registered user, you can review your vision coverage, search for a provider, and print your ID card.
- Choose a participating VSP provider, a participating retail chain, or any out-of-network provider.
- Tell your provider you have coverage under the Plan through VSP. There's no ID card necessary. However, as a registered user, you can print one from **www.vsp.com**.

If you are not eligible for coverage at the time you receive vision care services, or in the event the service you receive is not a covered service under the Plan, contact the Fund Office. The Fund Office can provide additional information regarding adverse benefit decisions.

Laser Vision Correction

The Plan does not cover laser vision correction services. However, if you receive laser vision correction services through a participating VSP provider, the Plan provides a 15% discount on the regular price of such services or a 5% discount on the promotional price of such services. This discount applies only if you receive covered services through a contracted facility.

To find a VSP participating provider and schedule a pre-operative exam to determine if laser vision correction is right for you, visit www.vsp.com or call **800-877-7195**.

If you receive laser vision correction services through a participating VSP provider, the Plan provides a 15% discount on the regular price of such services or a 5% discount on the promotional price of such services.

What's Not Covered

The Plan only pays benefits for a vision exam. The limitations described under the "General Limitations" subsection of the earlier "What's Not Covered" section apply to your vision coverage under the Plan. In addition, the Plan does not pay benefits for:

- Lenses (including non-prescription and safety lenses)
- Frames (including safety frames)
- Medical or surgical treatments, including LASIK, LASEK, or similar surgery
- Drugs or medications
- Examinations or materials not specifically listed as a covered service
- Replacement of lost, stolen, or broken glasses
- Services or materials provided by federal, state, local government, or worker's compensation
- Procedures, training, or materials not specifically listed as covered services under the Plan
- Parts or repair of frames/sunglasses.

Ability to Opt Out of Vision Coverage

You have the opportunity to opt out of the Fund's vision coverage, which is provided at no additional cost to you. If you opt out, your overall benefits package is reduced. Once you opt out of vision coverage, you can reinstate vision coverage once per year by providing advance written notice to the Fund Office. The Fund Office must receive advance written notice by the first day of the Plan Year (October 1).

To opt out of vision coverage, you must provide written notice to the Fund Office. Your vision coverage ends on the first day of the month following the date the Fund Office receives your written notice. For more information regarding opting out of vision coverage, please contact the Fund Office.

You are not required to do anything to continue receiving vision coverage from the Fund, and there is no financial benefit or other incentive in choosing to opt out of such coverage.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) COVERAGE

The Plan provides life and accidental death and dismemberment (AD&D) insurance coverage through Metropolitan Life Insurance Company (MetLife). This coverage is designed to help provide for your beneficiary in the event of your death and pays a benefit if you suffer a covered loss due to an accident.

Life Insurance Coverage

The Plan provides you with life insurance coverage. If you die from any cause, the Plan pays your designated beneficiary a death benefit equal to $25,000.

To claim a benefit in the event of your death, your beneficiary should complete a life insurance claim form and return it along with any required documentation to the Fund Office. For more information, see the “Life Insurance and Accidental Death and Dismemberment Benefits Claims” subsection of the “How to Claim Benefits” section.

If you are diagnosed with a terminal illness or injury, and death is expected within 24 months, you can apply for an accelerated life insurance benefit. This benefit, payable while you are still living, equals up to 50% of your life insurance benefit, to a maximum of $12,500. If you apply and receive an accelerated life insurance benefit, your beneficiaries will receive a life insurance benefit when you die that is adjusted for the amount already paid.

AD&D Coverage

The Plan pays an AD&D benefit if you suffer a covered loss due to an accident. The amount the Plan pays depends on the covered loss, as shown in the table below.

Covered Loss	AD&D Benefit
Loss of life	$30,000
Loss of any combination of hand, foot, or sight in one eye Loss of speech and loss of hearing Paralysis of both arms and both legs	$30,000
Loss of an arm permanently severed at or above the elbow Loss of a leg permanently severed at or above the knee	$22,500
Loss of a hand permanently severed at or above the wrist but below the elbow Loss of a foot permanently severed at or above the ankle but below the knee Loss of sight in one eye Loss of speech or loss of hearing Paralysis of both legs Paralysis of the arm and leg on either side of the body	$15,000
Loss of a thumb and index finger on the same hand Paralysis of one arm or one leg	$7,500

If you die as a result of an accident, the Plan pays an AD&D benefit to your designated beneficiary. Your beneficiary for your AD&D insurance coverage is the same person(s) you designate for your life insurance coverage.

If you die as a result of an accident, the Plan pays an AD&D benefit to your designated beneficiary. Your beneficiary for your AD&D insurance coverage is the same person(s) you designate for your life insurance coverage. For all other covered losses, the Plan pays the AD&D benefit to you.

To claim AD&D benefits, you or your beneficiary should complete an AD&D claim form and return it along with any required documentation to the Fund Office. For more information, see the “Life Insurance and Accidental Death and Dismemberment Benefits Claims” subsection of the “How to Claim Benefits” section.

WEEKLY DISABILITY BENEFITS

The Plan pays you a weekly disability benefit if, while you are covered, you become totally disabled due to a *non-occupational sickness or injury.*

Your weekly disability benefit is offset by any disability benefit you receive from Social Security, as well as any disability pension benefit you are eligible to receive.

Weekly Benefit Amount

If eligible, you receive a weekly disability benefit equal to $400 for up to 26 weeks (less mandatory Social Security withholding).

Your weekly disability benefit is offset by any disability benefit you receive from Social Security, as well as any disability pension benefit you are eligible to receive. If the total weekly value of your Social Security and disability pension benefit(s) exceeds the weekly disability benefits you are eligible to receive from this Plan, then the Plan does not pay you a weekly disability benefit.

Totally Disabled

You are considered totally disabled and eligible for a weekly disability benefit if you are unable to work due to any injury or disease:

- That does not arise out of or in the course of your employment or
- For which you are not entitled to any benefits under any workers' compensation, occupational disease law, or similar legislation.

When Benefits Begin

If it is determined that you are eligible for a weekly disability benefit, your benefit begins on the:

- First day of your disability due to injury or
- Eighth day of your disability due to sickness

For more information about weekly disability benefits contact the Fund Office. Note: This benefit is subject to income tax. If you receive a weekly disability benefit from the Plan, you will receive a tax statement at year-end.

Successive Periods of Disability

If you have a successive disability that is separated by less than two weeks of continuous full-time active work, the Plan considers your disability as part of your initial 26-week benefit period when determining the benefits available to you. You are eligible for a new 26-week benefit period once per calendar year if your subsequent disability begins after you return to full-time active work and is due to an injury or disease that is entirely unrelated to the cause of your previous disability.

What's Not Covered

Weekly disability benefits are subject to the "General Limitations" subsection of the earlier "What's Not Covered" section. In addition, the Plan does not pay benefits for any:

- Period of disability that begins after you retire;
- Period of disability that begins before you are eligible to participate in the Plan;
- Spouse or child who becomes disabled; or
- Disability that results from an occupational illness or injury.

ACCIDENT BENEFITS

If, while eligible for the Plan, you or your covered dependents suffer from an accidental injury and incur expenses for treatment, the Plan pays up to $300 to help offset the accident-related expenses. To be eligible for the benefit, you or your dependent must:

- Have an accident-related injury and
- Incur an accident-related expense within three months of the accident.

The $300 accident benefit applies to the following covered services (without application of the deductible) before your medical coverage under the Plan begins paying benefits:

- Physician or surgeon services
- Hospital confinement and related treatment
- Treatment provided in the outpatient department of a hospital
- Services received from a registered nurse
- X-rays and laboratory examinations
- Braces, crutches, artificial limbs or eyes, dressings, and rental of other durable medical equipment
- Physical therapy treatments

Be sure to provide the Fund with information relative to your accident (i.e., how, when, and where the injury occurred). Otherwise, claims cannot be processed. The Plan applies your accident benefit prior to any benefits you may be eligible for under the Plan's medical coverage. In addition, the Plan limits your accident benefit to $300 for any one accident.

What's Not Covered

Accident benefits are subject to the "General Limitations" subsection of the earlier "What's Not Covered" section. In addition, the Plan does not pay benefits for:

- Eye refractions or the purchase or fitting of glasses or contact lenses
- Charges incurred to treat an illness
- Prescription drugs or medicines
- Treatment not certified by a doctor as being necessary in connection with an accidental bodily injury
- Treatment received more than three months following the date the injury occurred

SPECIAL FUND PROGRAMS

Member Assistance Program (MAP)

The Member Assistance Program (MAP) is provided through Lyra Health at no cost to you and your family members. It provides confidential counseling and work-life services to help you handle personal and/or work concerns constructively, before they become major issues. Here are highlights:

- Lyra's Care Navigator Team is available 24 hours a day, seven days a week.
- You can meet with a counselor for up to eight sessions, free of charge.
- MAP counselors are available to discuss personal concerns and relationship issues, including those involving your children, substance abuse, job pressures, stress, anxiety, depression, grief and loss, and other matters—all in confidence.
- You have access to legal information and resources, including consultation from licensed attorneys on legal issues such as wills, debt obligations, divorce, or bankruptcy.
- You can consult with a fraud resolution specialist if you are a victim of identity theft and need to restore your credit.
- Get help with finding quality childcare, eldercare, and/or pet care.
- You can access financial information, resources and tools to assist you with issues like debt, saving for college, estate planning, and taxes.
- Lyra Health is your gateway to the treatment you or a family member may need for mental health and substance abuse.
- Lyra's Care Navigator Team is available to help you make the most of your mental health and substance abuse benefits, pre-authorize any treatment, explain program benefits, and assist with issues related to drug, alcohol abuse, or eating disorders.

Call **877-363-0489** to speak with a counselor. To learn more about the MAP, visit **4thdistricthealthfund.lyrahealth.com**.

Care Assist and Transition Care Programs

Home and Community Care provides a Transition Care Program and a Care Assist Program if you are scheduled for an outpatient procedure or have been admitted to the hospital. These programs help you navigate the health care system and stay healthy to avoid hospital readmission.

Transition Care Program

If you are admitted to a hospital, Home and Community Care contacts you to help coordinate your post-discharge care. The Home and Community Care Patient Navigators understand the benefits offered to you through the Plan and can help you balance your available benefits with the complexities of the health care system. They advocate on your behalf to ensure your pathway to recovery is free of any obstacles.

Care Assist Program

If you are scheduled for an outpatient procedure, Home and Community Care may call you to help with filling medications, coordinating your medical records between providers, scheduling check-ups and evaluations, and ordering the durable medical equipment you need for the recovery process.

Other Home and Community Care Services

Through the two programs, Home and Community Care can assist you and your covered dependents in a variety of ways. These include:

- **Assisting with post-discharge needs.** Home and Community Care is available to answer questions and provide support.
- **Scheduling medical appointments.** Home and Community Care can schedule your follow-up doctor visits, facilitate communication, and coordinate care with your providers.
- **Locating health care providers.** Home and Community Care can locate alternate providers for your medical needs.
- **Coordinating delivery of medical records.** Home and Community Care can have your medical records delivered to your doctor.
- **Assisting with community resources.** Home and Community Care can connect you with resources to facilitate your care and recovery.
- **Coordinating prescription fills.** Home and Community Care can help get your post-discharge prescriptions filled and see that you receive them.

Quit For Life Program

The Quit For Life Program can help you set a clear path to quitting tobacco usage. You and your adult dependents can participate in the Quit For Life Program. This program is provided at no cost (other than the cost for prescribed drugs) and covers:

- Up to five coaching calls from a Quit Coach
- Online support via the Quit Now website—www.quitnow.net and
- Non-prescription nicotine replacement therapy (such as the patch, gum, or lozenges) upon recommendation of a Quit Coach.

Call **866-784-8454**, or log on to www.quitnow.net for details or to enroll.

Note: The Plan covers prescription and over-the-counter smoking cessation products at 100%, with no coinsurance, for up to two 90-day treatments per year. After that, prescription smoking cessation products are subject to the coinsurance and limitations outlined under the “Your Prescription Drug Coverage” section.

The Plan covers prescription and over-the-counter smoking cessation products at 100%, with no coinsurance for up to two 90-day treatments per year.

HOW TO CLAIM BENEFITS

This section describes the procedures for filing claims for benefits from the Plan. It also describes the procedures for you to follow if your claim is denied, in whole or in part, and you wish to appeal the decision.

Claims for payment of covered services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the applicable claim form. If your health condition requires multiple services and you have additional claims to file after the first service/treatment, file them periodically. You or the provider must submit all claims **no later than 90 days from the date on which the services were incurred.** Failure to furnish the claim within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of the claim within that time period and that written proof was provided as soon as reasonably possible. However, all claims must be filed within one year from the date the claim was incurred, and if they are not submitted, they will be denied as untimely.

Claims Filing Procedures

Medical Benefits Claims

When you use a PPO network provider, you do not need to file a claim. In most cases the provider will submit all necessary claim information to the Fund's Claims Administrator on your behalf. Any reimbursements are sent directly to the provider.

Regardless of whether the provider participates in the PPO network, when you receive health care services, you should:

- Show your ID card to the service provider and
- Ask the provider to file a claim for you.

In some cases, for instance if you receive your care from a non-PPO provider, you may have to submit a claim for benefits directly to the Fund's Claims Administrator. If you must submit a claim for health care services received, you should:

- Obtain an itemized bill from the hospital, doctor, or medical facility. An itemized bill generally includes all of the following:
  - Patient's name and address
  - Date of service
  - Type of service and diagnosis
  - Itemized charges
  - Provider's complete name, address, and tax identification number.
- Download a claim form, available on www.4thdistricthealthfund.com or request a form from the Fund Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form.

Payment for eligible benefits will be made to the health care vendor unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not considered filed until it is received by the Fund Office. The Fund Office will process your claim within 30 days of the date it is filed, unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund may request additional information from you or the provider. You and/or your physician will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Plan, you will be notified by the Fund Office that the claim is denied, with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination. See the "Notice of the Adverse Benefit Determination" subsection in this section.

Health Reimbursement Arrangement (HRA) Claims

A claim is defined as any request for a reimbursement from your HRA, 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 request is approved, reimbursement will be paid from your HRA. See the "About the Health Reimbursement Arrangement (HRA)" subsection of the "Your Medical Coverage" section for details on how the HRA works. If your request is denied, you have certain appeal rights and are entitled to a full and fair review of the denial by the Board of Trustees. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. Upon concluding the review, the Board of Trustees or appointed designee will issue a written decision reaffirming, modifying, or setting aside the Plan's former action. The Trustees' written decision will conclude the appeal process under the Plan.

Prescription Drug Benefits Claims

When you use a Sav-Rx participating pharmacy, you do not need to file a claim. In most cases the participating pharmacy will submit all necessary claim information to the Fund's Claims Administrator on your behalf. Any reimbursements are sent directly to the pharmacy.

If you elect to have your prescription filled by a pharmacy other than a participating Sav-Rx pharmacy, no benefits are payable by the Plan.

If you are not eligible for benefits at the time you fill a prescription or in the event that the prescription is not a covered drug under the Plan, you must contact the Fund Office for additional information regarding the adverse benefit decision. The Fund Office will provide you with a Notice of the Adverse Benefit Determination. See the "Notice of the Adverse Benefit Determination" subsection in this section.

Dental Benefits Claims

If you seek care from a dentist who participates in Delta Dental PPO or Delta Dental Premier network, your dentist will fill out and file your claims for you. Out-of-network dentists may not fill out and file claims for you. If this is the case, you can print a claim form from **www.deltadentaloh.com** and send the paperwork to:

> Delta Dental
> P.O. Box 9085
> Farmington Hills, MI 48333-9085

If you are not eligible for benefits at the time you obtain services from your dental care provider or in the event the desired service is not covered under the Plan, you will receive a written *Notice of the Adverse Benefit Determination.* See the "Notice of the Adverse Benefit Determination" subsection in this section.

Vision Benefits Claims

When you use a VSP provider, you do not need to file a claim. In most cases the participating provider will submit all necessary claim information to the Fund's Claims Administrator on your behalf. Any reimbursements are sent directly to the provider.

For a Non-VSP provider, you may submit a claim for any qualified expense that is not covered by the Plan or is incurred with a provider outside the VSP network to your Health Reimbursement Arrangement (HRA) for reimbursement.

If you are not eligible for benefits at the time you obtain services from the vision care provider or in the event that the desired service is not covered under the Plan, you must contact the Fund Office for additional information regarding the adverse benefit decision. The Fund Office will provide you with a Notice of the Adverse Benefit Determination. See the "Notice of the Adverse Benefit Determination" subsection in this section.

Life and Accidental Death and Dismemberment (AD&D) Benefits Claims

Claims for life insurance and AD&D will be provided through Metropolitan Life Insurance Company (MetLife). However, you, or your beneficiary in the event of your death, must contact the Fund Office in order to obtain a claim form. You must submit the completed claim form, with all required documentation, to the Fund Office.

MetLife will notify your beneficiary of the decision on the claim for benefits within 90 days. In the event that MetLife needs additional time to review the claim for benefits or needs additional information, your dependent will be provided with the information on the status prior to the expiration of the initial 90-day period.

When the claim for life insurance benefits falls within the policy exclusions, your beneficiary will be notified by MetLife that the claim is denied with an explanation of the reasons for the denial. Your dependent will receive a Notice of the Adverse Benefit Determination. See the "Notice of the Adverse Benefit Determination" subsection in this section.

Life insurance and AD&D benefits are fully insured by MetLife, meaning the Board of Trustees does not have discretion to make benefit determinations or render decisions on appeals related to these benefits. For additional information regarding the claims and appeals process, please refer to the benefits booklets from MetLife, which may be obtained by contacting the Fund Office.

Weekly Disability Benefits Claims

If you become disabled due to a non-occupational sickness or injury, you should submit a claim to the Fund Office as soon as possible. In order to begin receiving your weekly benefits, the following must happen:

- Your claim must be accompanied by any information or proof requested and reasonably required to process such a claim, and
- You and your treating physician should complete a Weekly Disability Benefits Claim Form and submit it along with your claim.

The Fund Office will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond its control, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Fund Office notifies you of the delay.

If, prior to the end of the first 30-day extension period, the *Plan Administrator* determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for an additional 30 days.

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

If the Fund Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund Office receives the information from you, you will be notified of the decision on the claim within 30 days.

The Fund Office will provide you with a Notice of the Adverse Benefit Determination. See the following section for more information.

Notice of the Adverse Benefit Determination

The Notice of the Adverse Benefit Determination, sent to you in writing by the Fund Office, contains the following:

- The specific reasons for the adverse benefit determination
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material or information is necessary
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy
- A notice of your right to a written explanation of any exclusion which affects your claim and
- A description of the Plan's appeals procedure.

Notice of the Adverse Benefit Determination for Weekly Disability Benefits

The Notice of the Adverse Benefit Determination for Weekly Disability Benefits, sent to you in writing by the Fund Office, contains the following:

- The specific reasons for the adverse benefit determination
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material or information is necessary
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of *ERISA* following an adverse benefit determination on review
- One of the following:
  - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion does not exist; or
  - If the adverse benefit determination is based on medical necessity, because the treatment was experimental, or another similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your benefit determination
- A discussion of the decision to disagree with or not follow:
  - The views presented by your health professionals
  - The views presented by medical or vocational experts whose advice was obtained on behalf of the Plan and/or
  - A disability determination by the Social Security Administration.

Claims Appeal Procedure for Medical, Prescription Drug, and Vision Benefits

You or your authorized representative may appeal the decision by the Fund Office to deny any claim for medical, prescription drug, or vision benefits in whole or in part. If you name an authorized representative, he or she must be designated in writing to act on your behalf, and the extent of the person's authority must be clearly indicated in the authorization. Additionally, any point-of-service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this review procedure.

You may file a written notice of appeal to the Board of Trustees at any time within 180 days after the mailing of the Notice of the Adverse Benefit Determination. In review of your appeal, the Board of Trustees will follow the internal and external review standards set forth by the Patient Protection and Affordable Care Act (see next section). Your appeal only needs to state your name, address, Social Security number, and the fact that you are appealing a decision of the Fund Office, giving the date of the Notice. The appeal should be addressed as follows:

> Board of Trustees
> 4th District IBEW Health Fund
> 9200 U.S. Route 60
> Ona, WV 25545

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Board of Trustees shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Board of Trustees will consider your appeal of a claim for payment of services that you already obtained, called a "post-service claim," at its next regularly scheduled quarterly meeting. In the event that your appeal is received less than 30 days prior to the scheduled meeting date, it will be reviewed at the second quarterly meeting following the receipt of the appeal. You will be notified of the decision of the Board of Trustees as soon as possible after the meeting but in no case later than five days after the decision is made.

Internal Review Standards

The Patient Protection and Affordable Care Act requires non-grandfathered health plans, like the Fund's Plan, to have specific rules for internal appeals processes. For internal appeal reviews, the following standards apply:

- An adverse benefit determination includes rescissions of coverage, pre- and post-service claim determinations, exclusions, limitations, and eligibility determinations;
- Benefit determinations relating to urgent care claims generally must be made to claimants within 24 hours of receipt of the claim;
- Claimants must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The information must be provided as soon as possible and sufficiently in advance to give claimants reasonable opportunity to respond;
- Notices must be provided in a culturally and linguistically appropriate manner;
- All claims and appeals must be handled in a way that is designed to ensure impartiality; and
- Notices to claimants must provide additional content such as identifying information on the claim, denial codes, description of available appeals processes, and contact information for health insurance consumer assistance.

External Review Standards

The Patient Protection and Affordable Care Act requires non-grandfathered health plans, like the Fund's Plan, to have specific rules for external appeals processes. A claimant may request an external appeals review after an initial claim denial and subsequent internal review claim denial if the denied claim involves medical judgment (excluding those that involved only contractual or legal interpretation without any use of legal judgment) or rescission of coverage. External review will also be available to dispute determinations that involve whether the Plan complied with the surprise billing and cost-sharing protections under the No Surprises Act. For external appeal reviews, the following standards apply:

- **Request For External Review.** Claimants will be allowed to file a request for an external review, provided that the request is filed within four months of the date of the Notice of the Adverse Benefit Determination.
- **Preliminary Review.** Within five business days of receipt of the request for an external review, the Plan will complete a preliminary review of the request to determine whether the claimant was a participant in the Plan at the time of the service, whether the participant had exhausted all of the Plan's internal appeal processes, and whether the claimant has provided all information and forms necessary to proceed with an external review.

  Within one business day after the completion of the preliminary review, the Plan will issue a notification in writing to the participant identifying any deficiencies with regard to the ability to proceed to the external review process. The participant will then be entitled to supply information and materials needed to make the request complete. Note that for an urgent care issue, the preliminary review must be done immediately, and the claimant must be then immediately notified.
- **Referral to Independent Review Organization (IRO).** The Plan must contract with at least three IROs. Within five business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO; for an urgent care issue, the information must be sent electronically, by fax or other expeditious means. The IRO must provide written notice of its decision within 45 days of assignment; for urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.
- **Implementation of Reversal.** Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

Claims Appeal Procedure for Dental Benefits

Informal Appeal With Delta Dental

If you receive a Notice of the Adverse Dental Benefit Determination, and if you think that Delta Dental incorrectly denied all or part of your claim, you or your dentist should contact Delta Dental's customer service department at their toll-free number, **800-524-0149**, and ask them to check the claim to make sure it was processed correctly.

You may also mail your inquiry to the customer service department at P.O. Box 9089, Farmington Hills, MI 48333-9089. When writing, please enclose:

- A copy of your Explanation of Benefits and description of the problem;
- Your name;
- Your telephone number;
- The date; and
- Any information you would like considered about your claim.

Note: This type of inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this informal opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Formal Appeal With Delta Dental

Whether or not you have asked Delta Dental informally, as described previously, to recheck its initial determination, you can submit your claim to a formal review through the claims appeal procedure described here. To request a formal appeal of your claim, you must send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, MI 48909-7916

With your request for a formal appeal of your claim, you must include:

- Your name and address;
- Your Member ID number;
- The reason for your appeal; and
- Any other information you believe supports your claim.

You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it via certified mail, return receipt requested.

You have 180 days from the date you receive your notice of the adverse determination to submit your appeal.

You or your authorized representative should seek a formal review as soon as possible. You have **180 days from the date you receive your Notice of the Adverse Benefit Determination.** Note: If your appeal is for a concurrent care claim, you may have to submit your appeal as soon as possible so that you may receive a decision before the *course of treatment* you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, he or she will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time.

The Dental Director will make his or her decision within 30 days of receiving your request for the review of pre-service claims and within 60 days for post-service claims. If your claim is denied on the review (in whole or in part), you will be notified in writing. The Notice of the Adverse Benefit Determination by the Dental Director will:

- Inform you of the specific reason(s) for the denial;
- List the pertinent Plan provision(s) on which the denial is based;
- Contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed;
- Reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge;
- Contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part); and
- Contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

If your claim is denied in whole or in part after you complete this formal claims appeal procedure, or Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described previously. If you wish to file your claim in court, you must do so within the timelines established by the Plan.

Informal Review With the Board of Trustees

Following the conclusion of the formal process through Delta Dental, you have the option to request an informal review by the Board of Trustees. The appeal to the Trustees is strictly voluntary and available only once you have pursued the formal appeal with Delta Dental. The request for review must be in writing and submitted to the Trustees **within 180 days of the final decision on appeal from Delta Dental.** The request should state your name, address, Social Security number, and a copy of any documents you would like the Trustees to consider. The material should be sent to:

Board of Trustees
4th District IBEW Health Fund
9200 U.S. Route 60
Ona, WV 25545

The Trustees will consider your informal review at the next regularly scheduled quarterly meeting. You will be notified of the decision of the Trustees as soon as possible, generally within five days after a decision is made. You are under no obligation to pursue an informal review before filing a civil action, and the Plan waives any defense relating to your failure to exercise this option. Additionally, any defense the Plan may have based on timeliness is tolled while you are pursuing the voluntary level of appeal.

Claims Appeal Procedure for Weekly Disability Benefits

If you receive a Notice of the Adverse Benefit Determination for Weekly Disability Benefits, see the "Notice of the Adverse Benefit Determination for Weekly Disability Benefits" subsection in this section for information on how you can appeal.

You have **180 days from the date of the denial of your claim** to file an appeal. With your appeal, you have the right and opportunity to:

- Submit written comments, documents, records, and other information relating to your claim for benefits.
- Receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
- Receive any new or additional evidence or rationale considered or relied upon in connection with your claim automatically and free of charge.
- Receive a review that does not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual.

The review on appeal shall take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In deciding an adverse benefit determination that is based in whole or in part on medical judgment including determinations regarding whether a treatment or drug is experimental, investigational, or not medically necessary, the Plan will consult a health care professional who has the appropriate training and experience in the medical field involved in the judgment, and the medical or vocational expert will be identified. The health care professional engaged for consultation will not be an individual who was consulted in making the adverse benefit determination that is the subject of the appeal, nor their subordinate.

The Plan Administrator shall provide you with a written or electronic notification of the Plan's benefit determination on review. In the case of an adverse benefit determination, you'll receive a Notice of the Adverse Benefit Determination. See the "Notice of the Adverse Benefit Determination for Weekly Disability Benefits" subsection in this section.

Timing of the Appeal Procedure

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

The Trustees shall make a benefit determination no later than the date of the meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting.

In such case a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review.

If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify you of the benefit determination as soon as possible but no later than five days after the benefit determination is made.

Statute of Limitations

No action at law or equity shall be brought by you or your beneficiary after the expiration of three years from the date the Trustees provide written notice of a decision on appeal of an adverse benefit determination. Failure to bring an action within this three-year period shall forever bar such action.

De Minimis Violations

If the Plan fails to strictly adhere to all the requirements of the claims and appeals section of the Plan with respect to the claim, you are deemed to have exhausted the administrative remedies available under the Plan, except for de minimis violations explained below. As such, you are entitled to pursue any remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you chose to pursue remedies under Section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

The administrative remedies available under the Plan with respect to claims for disability benefits will not be deemed exhausted based on de minimis violations that do not cause and are not likely to cause prejudice or harm to you so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. You may request a written explanation of the violation from the Plan, and the Plan must provide such explanation

within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review under this section on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered refiled on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide you with notice of the resubmission.

Legal Action

No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeal procedures set forth in this SPD. Additionally, any legal action must be brought within three years from the expiration of the time in which the proof of claim is required. A participant or beneficiary shall only bring an action in connection with the Plan in the United States District Court for the Southern District of West Virginia.

Fraudulent Claims

The filing of false claims will be deemed as fraud, and the Trustees will pursue reimbursement to the fullest extent of the law. Additionally, if payments are made under this Plan based upon fraudulent misrepresentations, the Plan may refuse to honor future claims until the amount paid due to fraudulent misrepresentations has been recouped as an offset against such claims.

Release of Information

If you file a claim for benefits, you are required to authorize any physician, hospital, Employer, government agency, or any other person, corporation, or organization having information which may be required for a proper determination of the claim to release such information to the Trustees.

Right of Recovery

The Plan reserves the right to recover any monies paid in error to or on behalf of an individual, or to providers of health care. To the extent that payments are made by the Plan which are either in excess of the maximum amount necessary to satisfy the obligations of the Plan or are subsequently determined to have been incorrectly made, regardless of the party to whom such payments have been made, the Plan shall have the right to recover such excess or incorrect payments from any person or other entity to whom or for whom such payments were made (including the individual), any insurance companies, or any other person or entity for whom repayment is appropriate as the Plan shall determine. Any individual may be required by the Plan to furnish information, to execute and deliver such documents, and otherwise to cooperate in whatever manner may reasonably be required to secure the Plan's rights to recover such payments.

OTHER INFORMATION YOU SHOULD KNOW

Coordination of Benefits (COB)

The Plan's Coordination of Benefits (COB) provision applies if you are covered under another group plan. If your spouse is also eligible as a member under this Plan, the total amount payable for all medical, prescription drug, and dental benefits will not exceed the lesser of the reasonable and customary charges for eligible expenses incurred or the total benefits payable under the Plan on behalf of you and your spouse.

If your spouse is also eligible as a member under this Plan, the total amount payable for benefits will not exceed the lesser of the reasonable and customary charges for eligible expenses incurred or the total benefits payable under the Plan on behalf of you and your spouse.

These definitions are provided so that you will have a better understanding of this COB provision.

- "Coordination of Benefits" means if you or your eligible dependent(s) are covered under more than one group plan or insurance policy, the total benefits payable under such plans for care, services, or supplies will not exceed 100% of the total allowable expenses.
- A "plan" means any plan that provides benefits or services for or by reason of medical or dental care or treatment if such benefits or services are provided by:
  - Group or blanket coverage;
  - Group hospital service prepayment plans, group medical service prepayment plans, or group practice;
  - Any coverage under labor-management trusteed plans, Union welfare plans, Employer organization plans, or employee benefit organization plans; and
  - Any coverage under governmental programs (including Medicare), and any coverage required or provided by any statute.

  The term "Plan" means all benefits under this Plan, except weekly disability benefits and vision benefits.

  The term "plan" is considered separately with respect to:

  - Each policy, contract or other arrangement for benefits or services; and
  - Any portion of the policy, contract, or other arrangement which reserves the right to consider benefits or services of other plans in order to determine its benefits (and that portion which does not reserve that right).
- "Allowable Expense" means any necessary, reasonable, and customary charge, which is covered at least partially under one or more of the plans covering the person for whom a claim is made.

  When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.
- "Claim Determination Period" means a Calendar Year (January 1 through December 31).

The rules for determining which plan is the primary plan are (in order of their application) as follows:

- A plan without a COB clause always pays first.
- The plan covering the patient as an employee (rather than as dependent) pays first.
- The plan covering a child as dependent of the parent whose birthday occurs first during the Calendar Year pays first.
- The plan covering the patient as an active member or dependent (rather than as a retiree or laid-off employee) pays first.
- The plan not covering the patient under a COBRA continuation of coverage pays before the plan covering the patient under COBRA.

In the case of divorced parents, the following line of benefit determination applies:

- The plan of the (natural) mother, if the mother has custody, pays first; then
- The plan of the stepfather, if the mother has custody; then
- The plan of the (natural) father.

In the case of a child who is entitled to group health coverage as the result of his or her employment, the following line of benefits determination applies:

- The plan covering the child as an employee pays first; then
- The plan covering the child as the dependent of the parent whose birthday occurs first each Calendar Year.

In the case of a married child who is entitled to group health coverage as a result of his or her spouse's employment, the plan covering the child for the longest continuous period of time pays first.

Medicare benefits provide secondary coverage for an eligible active participant who is entitled to Medicare and for the Medicare-eligible spouse of an eligible active participant.

Except insofar as the above may apply first, if you are covered as an employee under two plans, or as a dependent under two plans, the plan under which you are covered for the longer period of time pays first. When determining the length of time for which you are covered under a given plan, this Plan considers two successive plans covering you to be one continuous plan, provided you are eligible for coverage within 24 hours after the prior plan's coverage terminates.

If there is a court decree which otherwise establishes financial responsibility for your child's health care expenses, the benefits of the plan that covers your child as a dependent of the parent with such financial responsibility is determined before the benefits of any other plan that covers your child as a dependent.

When applying the rules for determining which plan is primary, a plan's provisions are not considered if it:

- Attempts to shift the status of this Plan from secondary to primary by excluding you or your dependent from coverage under such other plan; or
- Limits the amount or type of coverage that is available to you or your dependent as a result of your or your dependent's eligibility for coverage under this Plan.

Any other provision of this section notwithstanding, an automobile, homeowners, event, or premises policy of insurance which provides for the payment of medical benefits (such as no-fault, personal injury protection, or medical payments coverage) shall always pay on a primary basis before the Plan.

If another plan is determined to be primary and such other plan is either not financially able or refuses to discharge its responsibility, such action will not cause this Plan to assume primary status.

If you or your dependent fail or refuse to comply with the terms and conditions of another plan or insurance policy, and it results in the other plan or insurer either reducing or denying benefits, this Plan will pay benefits only under the COB provision based on the benefit that the other plan or insurer would have provided if you or your dependent had fully and properly complied with the terms and conditions of the other plan or policy.

The Fund may exchange benefit information with other insurance companies, organizations, and individuals. It also has the right to recover any overpayment it may make to you if you neglect to report coverage under any plan.

Be sure to file claims with each plan to obtain all benefits that are available to you.

Third-Party Recovery Reimbursement (Subrogation)

Subrogation and reimbursement allows the Fund to recoup the value of any benefits (medical, disability, prescription drug, etc.) paid on behalf of a covered participant/dependent ("claimant") who is injured or who suffers an illness through the actions or omissions of a person or entity accountable for the injury or illness (hereinafter called "accountable person"). The subrogation and reimbursement process helps the overall financial stability of the Fund by ensuring that the Fund is not the only entity paying for illness and injuries caused by accountable persons.

Right to Subrogate

The Fund is subrogated to any and all rights of recovery and causes of action that the claimant may have against any accountable person, an accountable person's insurer, or a claimant's first-party insurer—whether by suit, settlement, or otherwise—that may be liable for a claimant's injury or illness for which the Fund has paid or is obligated to pay benefits on the claimant's behalf.

Payment of benefits is conditional upon the claimant's written agreement to fully cooperate and reimburse the Fund for any benefits paid should the claimant recover monies or damages, or be compensated for the illness or injury from the accountable person or any other source. The claimant must sign forms that assign subrogation and reimbursement rights to the Fund. The Claims Administrator may withhold payment of any benefits due under the Fund until it receives the signed forms. Payment of Fund benefits before the signed forms are received does not modify or invalidate the Fund's subrogation and reimbursement rights.

Rights to Reimbursement With Source of Funds Specifically Identified

In situations where an accountable person is liable, the claimant must reimburse the Fund the full value of the claims paid in connection with the illness or injury but only to the extent that he or she recovers settlement, judgment, or insurance proceeds (from any source) connected with the illness or injury. A source includes, but is not limited to:

- An accountable person and/or an accountable person's insurer (or self-funded protection);
- No-fault protection;
- Personal injury protection;
- Medical payments coverage;
- Uninsured or underinsured insurance coverage;
- An Employer under the provisions of a workers' compensation law; or
- An individual policy of insurance maintained by a claimant and an organization, corporation, or government agency.

The Fund's subrogation and reimbursement rights will apply on a priority first-dollar basis to any recovery—whether by suit, settlement, or otherwise—even though the claimant may not have been fully compensated or "made whole" for all physical, psychological, and/or financial damages. This provision rejects any "make-whole" doctrine which would require a claimant to be "made whole" before the Fund is entitled to assert its subrogation rights. Moreover, the Fund is a self-funded ERISA benefit plan, and therefore its rights of subrogation and reimbursement may not be eliminated or reduced by any provision of state law. Even though the subrogation rights of the Fund are specifically unequivocally due from the first dollar received by the claimant or beneficiary, the Fund reserves the right to exercise judgment as to the facts of each case. When determining each individual case—even though the Fund has the right to recover from the first dollar received—the Trustees (in their sole discretion) may consider and allow for the cost of collection from the accountable person, including reasonable attorney's fees incurred by the claimant.

The Fund's rights also apply to any recovery made by a claimant, regardless of whether the amounts are characterized or described as medical expenses (or as amounts other than for medical expenses).

Equitable Lien by Agreement

Once the Fund makes or is obligated to make payments on behalf of a claimant, the Fund is granted (and the claimant consents to) an equitable lien by an agreement or a constructive trust on the proceeds of any payment, settlement, or judgment that is received by the claimant or beneficiary from any source—to the extent that payments are made or will be made by the Fund on the claimant's behalf.

Claimant Must Set Aside Funds

The claimant shall 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 claimant shall reimburse the Fund immediately upon recovery.

Claimant's Duty to Reimburse

The claimant shall immediately notify the Fund if he or she is involved in or suffers an accident or injury for which an accountable person may be liable. The claimant shall again notify the Fund if he or she pursues a claim to recover damages or other relief relating to an injury or illness for which the Fund may make payments on the claimant's behalf. The claimant shall do nothing to impair, release, discharge, or prejudice the Fund's rights to subrogation and/or reimbursement.

Reduction of Future Benefits

The claimant has the responsibility to seek damages for future accident-related benefit expenses. The Fund has the discretion to take into consideration future accident-related medical expenses when negotiating a settlement. The Fund may settle all accident-related claims (past, present, and future) in full (meaning that upon settlement, the Fund shall not be responsible for any further accident-related benefit expenses). The Fund reserves the right to deny future accident-related benefit expenses. The Fund reserves the right to deny future accident-related care with the understanding that the claimant shall be responsible for any future accident-related claims, as those benefits should be paid directly from the claimant's settlement proceeds.

Disavowal of "Common Fund" Doctrine

The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, sickness, accident, or condition. In addition, the Fund's recovery shall not be reduced by such legal fees or expenses.

The Fund further asserts that the "Common Fund" doctrine does not apply to any proceeds recovered by an attorney the claimant or the claimant's dependents may hire, regardless of whether funds recovered are used to repay the benefits paid by the Fund.

The Fund specifically disavows any claims that a claimant may make under any federal or state common-law defense including, but not limited to, the make-whole doctrine and/or the Common Fund doctrine.

Cooperation

The claimant and legal representatives must do whatever is necessary to enable the Fund Administrator to exercise the Fund's rights. They also must not do anything to prejudice the Fund's rights. The Fund Administrator may require the claimant to complete and/or execute certain documentation to assist the Fund in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment agreement.

The claimant shall assist and cooperate with representatives the Fund designates. The claimant shall do everything necessary to enable the Fund to enforce its subrogation and reimbursement rights. The claimant shall immediately notify the Fund upon receiving a judgment, settlement offer, or compromise offer and will not settle or compromise any claims without the Fund's consent.

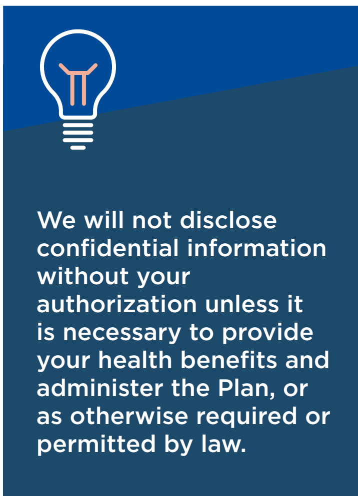
In the event a claimant fails to reimburse the Fund the full value of its subrogated interest, or otherwise fails to cooperate, the Fund shall be entitled to:

- Retroactively deny payment of related claims, to the extent permitted by provider contract;
- Suspend all benefit payments due to a claimant;
- Deduct the amount of the subrogated interest from the claimant's future benefit payments; or
- Apply Employer contributions made on the claimant's behalf against the amount owed to the Fund.

Confidentiality of Health Care Information

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully and share it with your family.

This notice has been drafted to comply with the "HIPAA Privacy Rule" under federal law. Any terms that are not defined in this notice are specified in the HIPAA Privacy Rule.



How We Protect Your Privacy

We are required by law to protect the privacy of your *protected health information* (PHI) and to provide you with this notice of our privacy practices. We will not disclose confidential information without your authorization unless it is necessary to provide your health benefits and administer the Plan, or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this notice to protect your confidentiality.

We maintain confidential information and have procedures for accessing and storing confidential records. We restrict internal access to your confidential information to employees who need that information to provide your benefits. We train those individuals on policies and procedures designed to protect your privacy. Our Privacy Officer monitors how we follow those policies and procedures and educates our organization on this important topic.

How We May Use and Disclose Your Protected Health Information

We will not use your confidential information or disclose it to others without your written authorization, except for the purposes listed below. When required by law, we will restrict disclosures to the *limited data set,* or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

Treatment. We may disclose your PHI to your health care provider for its provision, coordination, or management of your health care and related services. For example, we may disclose your PHI to a health care provider when the provider needs that information to provide treatment to you. We may also disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing, or credentialing.

Payment. We may use or disclose your PHI to provide payment for the treatment you receive under the Plan. For example, we may use and disclose your PHI to pay and manage your claims, coordinate your benefits, and review health care services provided to you. We may use and disclose your PHI to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges.

In addition, we may use and disclose your PHI as necessary to preauthorize services to you and review the services provided to you. We may also use and disclose your PHI to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your PHI to adjudicate your claims. Also, we may disclose your PHI to other health care providers or entities who need your PHI to obtain or provide payment for your treatment.

Health care operations. We may use or disclose your PHI for our health care operations. We may use or disclose your PHI to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your PHI to provide you with customer service activities or develop programs. We may also provide your PHI to our attorneys, accountants, and other consultants who assist us in performing our functions. We may disclose your PHI to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will disclose your PHI to these entities only if they have or have had a relationship with you and your PHI pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

Disclosures to the *Plan Sponsor.* The Trustees are the Plan Sponsor. We may disclose your PHI to the Plan Sponsor. The Plan Sponsor is not permitted to use PHI for any purpose other than the administration of the Plan. The Plan Sponsor must certify, among other things, that it will use and disclose your PHI only as permitted by the Plan, it will restrict access to your PHI to those individuals whose job it is to administer the Plan, and it will not use PHI for any employment-related actions or decisions. The Plan may also disclose enrollment information to the Plan Sponsor. The Plan may also disclose summary health information to the Plan Sponsor for purposes of obtaining bids for health insurance or lending or modifying the Plan.

Disclosures to business associates. We contract with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use, or disclose PHI. We require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your PHI to a business associate to administer claims or provide service support, utilization management, subrogation, or pharmacy benefit management.

Disclosures to family members or others. Unless you object, we may provide relevant portions of your PHI to a family member, friend, or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose PHI (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

Other uses and disclosures. The law allows us to disclose PHI without your prior authorization in the following circumstances:

- **Required by law.** We may use and disclose your PHI to comply with the law.
- **Public health activities.** We will disclose PHI when we report to a public health authority for purposes such as public health surveillance, public health investigations, or suspected child abuse.
- **Reports about victims of abuse, neglect or domestic violence.** We will disclose your PHI in these reports only if we are required or authorized by law to do so, or if you otherwise agree.
- **To health oversight agencies.** We will provide PHI as requested to government agencies that have the authority to audit or investigate our operations.

- **Lawsuits and disputes.** If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the PHI requested.
- **Law enforcement.** We may release PHI if asked to do so by a law enforcement official in the following circumstances:
  - To respond to a court order, subpoena, warrant, summons, or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - To assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - To investigate a death we believe may be due to criminal conduct;
  - To investigate criminal conduct; and
  - To report a crime, its location, or victims, or the identity, description, or location of the person who committed the crime (in emergency circumstances).
- **Coroners, medical examiners, and funeral directors.** We may disclose PHI to facilitate the duties of these individuals.
- **Organ procurement.** We may disclose PHI to facilitate organ donation and transplantation.
- **Medical research.** We may disclose PHI for medical research projects, subject to strict legal restrictions.
- **Serious threat to health or safety**. We may disclose your PHI to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.
- **Special government functions.** We may disclose PHI to various departments of the government such as the U.S. military or U.S. Department of State.
- **Workers' compensation or similar programs.** We may disclose your PHI when necessary to comply with workers' compensation laws.

Uses and Disclosures With Your Written Authorization

We will not use or disclose your confidential information without your written authorization for any purpose other than the purposes described in this notice. For example, we will not:

- Supply confidential information to another company for its marketing purposes (unless it is for certain limited health care operations);
- Sell your confidential information (unless under strict legal restrictions); or
- Provide your confidential information to a potential Employer with whom you are seeking employment without your signed authorization.

You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer but not with respect to any actions we already have taken.

Your Individual Rights

You have the following rights:

Right to inspect and copy your protected health information (PHI). Except for limited circumstances, you may review and copy your PHI. Your request must be addressed to the Privacy Officer. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

If you request copies of your PHI, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your PHI, upon your request, if you agree to the rules and cost (if any) in advance.

Right to correct or update your PHI. If you believe that the PHI we have is incomplete or incorrect, you may ask us to amend it. Your request must be made in writing and must be addressed to the Privacy Officer. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.

We may deny your request if you ask the Fund to amend information that:

- Was not created by the Fund;
- Is not part of the PHI we keep about you;
- Is not part of the PHI that you would be allowed to see or copy; or
- Is determined by us to be accurate and complete.

If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your PHI.

Right to obtain a list of the disclosures. You have the right to get a list of PHI disclosures, which is also referred to as an "accounting." You must make a written request to the Privacy Officer to obtain this information.

The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment, and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include other disclosures, including incidental disclosures, disclosures we have made for national security purposes, or disclosures to law enforcement personnel. The list we provide will include disclosures made within the last six years unless you specify a shorter period.

You may also request and receive an accounting of disclosures of electronic health records made for payment, treatment, or health care operations during the prior three years.

The first list you request within a 12-month period will be free. You may be charged for any additional lists within a 12-month period.

Right to choose how we communicate with you. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

Right to request additional restrictions on health information. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment, and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket.

Questions and Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Fund or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Fund, put your complaint in writing and address it to the Privacy Officer listed in the "Future Changes to Our Practices and This Notice" below. The Plan will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

Future Changes to Our Practices and This Notice

We are required to follow the terms of the privacy notice currently in effect. However, we reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this notice to reflect the change. We will send or provide a copy of the revised notice. You may also obtain a copy of any revised notice by contacting the Privacy Officer:

Ryan Jones, Privacy Officer
4th District IBEW Health Fund
9200 U.S. Route 60
Ona, WV 25545
304-525-0331

Non-Discrimination

Any provision of the Plan notwithstanding, the Plan shall at all times be interpreted, applied, and administered so as to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan will not discriminate with respect to rules for eligibility or benefits based upon a health factor including:

- Health status
- Medical condition
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability or
- Disability

Important Disclosure

The 4th District IBEW Health Fund complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The 4th District IBEW Health Fund does not exclude people or treat them differently due to race, color, national origin, age, disability, or sex.

The 4th District IBEW Health Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact American Benefit Corporation, 9200 U.S. Route 60, Ona, WV 25545; 304-781-3912 or 888-466-9094 (press "3" after the greeting).

If you believe that the 4th District IBEW Health Fund has failed to provide these services or discriminated in any other way on the basis of race, color, national origin, disability, or sex, you can file a grievance with American Benefit Corporation, 9200 U.S. Route 60, Ona, WV 25545; 304-781-3912 or 888-466-9094 (press "3" after the greeting).

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, the Plan Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201; 800-868-1019, 800-537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Language Access Services and Non-Discrimination

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 304-781-3192.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 304-781-3192 .

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 304-781-3192.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 304-781-3192.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 304-781-3192

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 304-781-3192.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로
이용하실 수 있습니다. 304-781-3192 번으로 전화해 주십시오.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。304-781-3192 まで、
お電話にて ご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 304-781-3192.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 304-781-3192.

เรียน: ถ้ าคุณพูดภาษาไทยคุณสามารถใช้ บริการช่ วยเหลือทางภาษาได้ ฟรี โทร 304-781-3192.

न दिनुहोस्: तपाइ्ले नेपाली बोल्‍ नुहुन्छ भने तपाइ्को निम्ति भाषा सहायता सेवाह निःशुल्‍ कपमा उपलब्‍ छ । फोन गनु्होस्‍ 304-781-3192.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 304-781-3192.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 304-781-3192

The Women's Health and Cancer Rights Act of 1998

Under federal law, group health plans that provide medical and surgical benefits in connection with mastectomy must provide benefits for certain reconstructive surgeries. This covers reconstruction of the breast to produce symmetrical appearance and prostheses and physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the Plan's annual deductible and copayment provisions.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans 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 does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother of her newborn earlier than 48 or 96 hours, as applicable. In any case, plans and insurers may not require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of 48 or 96 hours, as applicable.

Rights and Protections Under ERISA

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts, Collective Bargaining Agreements and Participation Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan. These include insurance contracts, Collective Bargaining Agreements, and copies of the latest report (Form 5500 Series) and updated Summary Plan Description. The Plan may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Office is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, your 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 SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of 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 these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at a nearby regional office or at the national office:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
866-444-3272

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact EBSA by visiting **www.dol.gov/ebsa**.

Assignment

Any individual or custodial parent over 18 years of age may authorize the Plan to pay benefits applicable to expenses for care and treatment directly to the provider of service(s) on whose charge a claim is based.

Procedure to Appoint an Authorized Representative

Federal regulations allow a health plan to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a participant. The Plan will require a participant to complete a form that includes details about the covered participant, the designated authorized representative, and the scope of the appointment. In addition, because in virtually all cases an authorized representative would need access to the participant's PHI to effectively act on their behalf, a form allowing for disclosure of the PHI must also be completed.

Any participant who would like an individual to act on his or her behalf with respect to the Plan must complete an Appointment of Authorized Representative Form. In addition, an Authorization Form for PHI Disclosure must be completed if the appointed authorized representative will be allowed access to the individual's PHI.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage

Under COBRA, you may elect to continue certain benefits provided by the Plan in the event your coverage, or that of your dependents, would otherwise terminate. You may continue your medical, prescription drug, dental, vision, and life insurance benefits. The length of the time for which the benefits elected may be continued is based upon the qualifying event which would have caused the loss of benefit eligibility.

- You may elect to continue benefits for yourself and your eligible dependents (or your dependents may make the election) for up to 18 months from the date your eligibility ends as the result of:
  - Termination of employment (other than due to gross misconduct) or
  - You do not earn sufficient credits to qualify for benefits.
- You may elect to continue benefits for an additional 11-month period beyond the basic 18 months if you are awarded Social Security disability benefits as the result of a disability which commenced prior to the qualifying event or within 60 days of the commencement of the COBRA continuation coverage. Proof of the total disability must be provided to the Fund Office prior to the end of the basic 18-month period.

- Your eligible spouse and/or any eligible dependents may elect to continue benefits for as long as 36 months from the date their eligibility ends because:
  - You die,
  - You become eligible for Medicare benefits and elect that coverage as primary,
  - You and your spouse are legally separated or divorced, or
  - A child is no longer eligible as a dependent.

When the qualifying event is the end of employment or reduction of the participant's hours of employment and the participant becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement. For example, if a covered participant becomes entitled to Medicare eight months before the date on which his eligibility lapses, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

You are responsible for notifying the Fund Office in writing when medical benefits end due to the following reasons. This notice must be received by the Fund Office within 60 days after the divorce, legal separation, or dependent's loss of eligibility. You will need to provide a copy of any court order, birth certificate, or other information the Plan may deem relevant. Additionally, if you are already receiving COBRA continuation coverage, you must notify the Fund Office in writing of any qualifying event that may extend your COBRA eligibility period.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Upon recognition of the occurrence of a qualifying event, the Fund Office will send you and your spouse a notice describing your right to purchase continued benefits. (The notice will be sent to a former dependent if the qualifying event resulted in the loss of dependent eligibility.) You or your dependents have 60 days to return the written application for COBRA continuation coverage. This 60-day period begins on the latter of:

- The date benefits would otherwise end (the last day of the Benefit Month) or
- The date the notice is received (if the notice is sent after the last day of the Benefit Month).

The required contribution for purchase of the continued coverage must be paid to the Fund within 45 days from the date the COBRA continuation coverage is elected. The notice of your rights to COBRA will provide the costs associated with the options available. This initial payment must include the current month's premium plus any premium due for the months which have elapsed since the end of the last quarter for which you or your dependents were eligible. Subsequent payments are due monthly on the first day of the month. A 30-day grace period is granted for payment of the amount due.

The COBRA continuation coverage will end on the earliest of the following:

- The date the Fund ceases to provide any group health plan;
- The last day of the month through which you or your dependent has paid the required premium;

- The date you again become eligible for benefits as the result of contributions credited;
- The date the individual becomes covered for benefits under Medicare; or
- The end of the maximum periods described previously.

More About COBRA

- Continued coverage begins after the expiration of previously earned eligibility. You cannot purchase double coverage for the same period of time.
- You or your dependents are not permitted to continue COBRA if you and/or they become eligible for other group coverage on or after the date the COBRA coverage becomes effective.
- In the event that more than one continuation provision applies, the periods of continued coverage will run concurrently.
- The continuation of eligibility through self-contribution will be counted to reduce the maximum 30-month continuation period.
- The continuation of eligibility at no cost for the surviving dependents of an active participant who dies while eligible for benefits will be counted to reduce the maximum 36-month continuation period.
- You or your dependents will not receive monthly reminder notices concerning payment of the required premium to keep coverage in effect. It is the responsibility of the covered individuals to pay the premium when due.
- The COBRA premium amount due to purchase continued coverage will not be affected by contributions made to the Fund by your Employer.
- It is important all addresses for participants and dependents be kept up-to-date. In the event the Fund Office does not have a valid address on file, you may jeopardize your right, or a dependent's right, to elect continuation coverage.
- This is not a complete description of your COBRA rights. For more information contact the Fund Office at 888-466-9094, or consult the Department of Labor website at **www.dol.gov/ebsa**.

Coverage Through the Health Insurance Marketplace

Coverage through the Public Health Exchange Marketplace may be an alternative option if you lose your health care coverage. Generally, you can enroll yourself and your dependents in the Public Health Exchange Marketplace outside of the annual enrollment period if you lose coverage.

Federal Family and Medical Leave Act

Under the Family and Medical Leave Act of 1993 *(FMLA),* you may qualify to take up to 12 weeks of unpaid leave for a serious illness, to care for your newborn child or newly adopted child, to care for your seriously ill spouse, parent, or child, or because of a qualifying exigency arising out of the fact that a family member is in the military on active duty.

FMLA also allows a qualifying person to take up to six months of unpaid leave to care for a service member who is recovering from a serious illness or injury sustained in the line of duty. You may be required to provide:

- 30-day advance notice of the leave, if possible,
- Medical certifications supporting the need for a leave, and
- Second or third medical opinions and periodic recertification (at your Employer's expense) and periodic reports during the leave regarding your status and intent to return to work.

If FMLA applies to your Employer, it requires your Employer to maintain your health coverage for the length of your leave for up to 12 weeks (or longer if the leave is to care for a service member who is recovering from a serious illness or injury sustained in the line of duty), as if you were actively at work. The Act also states that if you take a family or medical leave, you cannot lose any benefits accrued before the leave.

The Fund will grant eligibility for a family or medical leave and maintain your current eligibility status for the duration of the leave, provided your Employer properly grants the leave of absence under federal law and makes the required contributions to the Fund on your behalf.

The Fund will maintain your prior eligibility until the end of the leave, provided your Employer properly grants leave under federal law, makes the required notification to the Fund, and makes contributions to the Fund for each month based on the average monthly contributions made on your behalf over the last five years.

Your leave will end on the earlier of your return to work, the date your Employer ceases to make contributions to the Fund, or the end of your maximum allowable leave period. If you do not return to work before the end of your maximum leave period, you may qualify for COBRA continuation coverage. Your FMLA leave period will run concurrently with your COBRA continuation coverage period and, if applicable, any period during which your eligibility is extended due to disability.

Military Leave of Absence

If you leave covered employment to serve in the U.S. military (active duty or inactive duty training), your eligibility may either be frozen during your military service or used to continue eligibility for your dependents. The eligibility freeze is the default option. Under a freeze, your eligibility will be frozen until you return to work in covered employment. During the freeze period, neither you nor your dependents will be eligible for Plan benefits. After you return to covered employment, and if your Employer reports your return to the Fund Office during the federally required time period, your eligibility and your dependents' eligibility will be reinstated on the day you return to work.

If your U.S. military duty is for 30 days or less, you will not lose eligibility for benefits provided you return to covered employment in conformity with governing federal law.

You need to notify the Fund Office in writing when you enter the military. For more information about your coverage rights during a military leave, contact the Fund Office.

Reemployment

Following your discharge from military service, you may be eligible to apply for reemployment with your former Employer in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Such reemployment includes your right to elect reinstatement of any existing health care coverage provided by your Employer.

If a Dependent Enters the Military

If your eligible dependent is called into duty in the uniformed services, he or she may be able to continue coverage under the Plan. If the military service (active duty or inactive duty training) is for 30 days or less, health care coverage will continue if the required coverage payment is made.

If the military service is for 31 or more days, coverage can continue, if the required coverage payment is made, for up to 24 months. You or your dependent needs to notify the Fund Office in writing about the dependent's military call-up. For more information, contact the Fund Office. Following discharge from the uniformed services, your dependent's coverage may be reinstated if he or she meets the definition of a dependent under the Plan.

PLAN ADMINISTRATION

Case Management

The Plan reserves the right to contract with any appropriate firm for case management review services. Individuals are required to cooperate with the firm providing the case management review with regard to providing authorization to receive medical records and other reports as requested. Failure to cooperate with the case management review firm may result in the Plan's denial of normal benefits.

Change of Address

If you change your address, you must notify the Fund Office. If you fail to do so, your Self-Contribution Notice may be delayed or lost, and you will lose your eligibility.

Your Social Security Number

Your hours are processed by computer, and you are classified by your Social Security number. It is very important your Social Security number is correctly reported to your Employer and shown on the reporting forms.

Physical Examination

The Plan, at its own expense, shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Plan when and so often as the Trustees may reasonably require while a claim is pending. The Trustees have the right to ask for an autopsy in the case of death, provided this is not forbidden by law.

Compliance With Federal Law

Governing Law

All questions pertaining to the validity or interpretation of the Agreement, the Plan, or any questions concerning the acts and transactions of the Trustees or any other matter that affects the Plan will be determined under federal law, where applicable federal law exists. If there is no applicable federal law, the laws of the state of Ohio will apply in all matters.

Fraud

The Plan does not rescind health coverage once you are covered under the Plan, unless you (or persons seeking coverage on your behalf) perform an act, practice, or omission that constitutes fraud or you make an intentional misrepresentation of material fact (as prohibited by the terms of the Plan) and in other instances that may be prescribed in the Treasury Regulations. See the "Rescission of Coverage" subsection of the "When Coverage Ends" section for more information.

FUTURE OF THE PLAN

Change of Eligibility Rules

The Trustees may, in their discretion, amend the eligibility provisions at any time; however, the Trustees shall make no change which, in their sole opinion, would render the Fund actuarially unsound.

Trustees of the 4th District IBEW Health Fund

Union Trustees

William Hamilton
IBEW Local 1105
5805 Frazeysburg Rd.
Nashport, OH 43830

Chris Samples
IBEW Local 466
800 Indiana Avenue
Charleston, WV 25302

Dan Shirey
IBEW Local 575
110 Offnere St.
Portsmouth, OH 45662

Shane Wolfe
IBEW Local 317
1848 Madison Ave.
Huntington, WV 25704

Employer Trustees

James Bane
Mon Valley Electric
P.O. Box 338
Kingmont, WV 26578

Ted Brady
Progressive Electric
P.O. Box 3695
Charleston, WV 25336

Mike Dishon
IBEW Local 688
67 S. Walnut St.
Mansfield, OH 44903

John Frantz
Sidney Electric Company
840 South Vandemark Rd.
Sidney, OH 45365

Authority of Trustees

The Trustees, except to the extent delegated to the Claims Administrator, shall have the sole authority and discretion to determine eligibility for participation in the Plan, determine eligibility for the payment of benefits under the Plan, determine the amount of any benefits payable under the Plan and authorize and direct payment of such benefits, make and apply such rules and regulations and prescribe the use of such forms as shall be necessary to carry out the provisions of the Plan, contract with certain organizations, do such other acts reasonably required to administer the Plan, rule on all appeals, interpret and construe terms of the Trust Agreement, Plan Rules and Regulations, and all other documents coming before them. All decisions of the Trustees shall be final and binding.

Trustee Right to Modify

Any provision in this document notwithstanding, due to the exigencies inherent in any health and welfare fund and the duty of the Trustees to provide benefits for all of the participants in amounts and kinds which may vary from time to time, no participant shall be deemed to have any vested interest in any benefit provided by the Fund, and the Trustees expressly reserve the right to modify, add to, subtract from, or eliminate any benefit to any participant or group or class of participants as may be required under the circumstances.

The Trustees reserve the right to modify the terms of this program at any time as necessary or to terminate this program without prior notice. The Trustees may also use and/or modify this program to facilitate the addition of any Union that wishes to have its members participate in the Fund.

ADMINISTRATIVE INFORMATION

Summary Plan Description

This is your Summary Plan Description; it is prepared by the Trustees of the 4th District IBEW Health Fund.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each eligible participant in an employee benefit plan. Contributions to this Plan are made by the participating Employers and under certain circumstances by the participant only. Contributions are based on negotiated contribution rates as set forth in the Collective Bargaining Agreement.

Plan Information

E.I.N.	31-6068797
Plan Number	501
Plan Year	October 1 – September 30
4th District IBEW Health Fund Administrative Office (American Benefit Corporation)	4th District IBEW Health Fund Administrative Office 9200 U.S. Route 60 Ona, WV 25545 304-525-0331 888-466-9094
Agent for Service of Legal Process	Trustees of the 4th District IBEW Health Fund 9200 U.S. Route 60 Ona, WV 25545
Plan Administrator	American Benefit Corporation 9200 U.S. Route 60 Ona, WV 25545 304-525-0331 888-466-9094
Fund Attorney	Michael A. Ledbetter, Esq. Ledbetter Parisi LLC 5078 Wooster Road, Suite 400 Cincinnati, OH 45226 937-619-0900
Fund Auditor	J. Ryan Lindsay, CPA Gray Griffith and Mays 707 Virginia St. E., Suite 400 Charleston, WV 25301
Actuary	Segal Consulting 101 N. Upper Wacker Dr., Suite 500 Chicago, IL 60606

Relevant provisions of the Collective Bargaining Agreements, the names of the parties, and their expiration dates may be reviewed at the Administrative Office. The Collective Bargaining Agreements are between the NECA and Local Unions 32, 141, 306, 317, 466, 575, 596, 688, 968, 972, and 1105 of the International Brotherhood of Electrical Workers (AFL-CIO), who are participants of the Health Fund.

List of Local Unions

- LU. 32 Lima, Ohio
- LU. 141 Wheeling, West Virginia
- LU. 306 Akron, Ohio
- LU. 317 Huntington, West Virginia
- LU. 466 Charleston, West Virginia
- LU. 575 Portsmouth, Ohio
- LU. 596 Clarksburg, West Virginia
- LU. 688 Mansfield, Ohio
- LU. 968 Parkersburg, West Virginia
- LU. 972 Marietta, Ohio
- LU. 1105 Newark, Ohio

GLOSSARY

This Glossary is provided to help you understand the Plan by summarizing several of its key terms. However, any questions about Plan coverage that concern these terms will be answered by the Fund Office. The Fund Office is not limited to the summary definitions provided in this Glossary.

AD&D means accidental death and dismemberment insurance.

Administrator means an entity appointed by the Board of Trustees to carry out administration of the Plan.

Air Ambulance Service means medical transport by helicopter or airplane for patients.

Annual physical is a once yearly examination by your family physician (or a “well-woman exam” by an OB-GYN physician). The physician’s exam usually will include a medical history review, a physical examination, and basic lab tests (for example, for cholesterol or diabetes). An annual physical is designed to assess overall health and screen for possible chronic conditions and generally is not performed solely for the purpose of addressing an already diagnosed medical condition.

Benefit Month is any month you and any applicable dependents are eligible for coverage under the Plan.

Benefits means the reimbursement of benefits for covered expenses described in this SPD.

Board of Trustees (Trustees) means the individuals appointed and designated according to the terms of the Trust Agreement of the 4th District IBEW Health Fund to administer this Plan of benefits together with such individuals’ successors.

Brand name drugs are prescription drugs sold under the registered or trademarked name given to them by the drug manufacturer that holds the manufacturing and marketing rights to that drug or as defined by the national pricing standards used by the Pharmacy Benefit Manager.

Calendar Year is the 12-month period from January through December.

Claimant means a covered person (or authorized representative) who files a claim.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance is the percentage of an eligible expense you pay after you meet the Plan’s annual deductible. It applies to eligible in-network and out-of-network expenses.

Collective Bargaining Agreement means the negotiated labor agreement(s) between the Union and an Employer or an Employer association requiring the Employer or association to contribute to the Fund on behalf of its bargaining unit employees.

Complication of pregnancy is the non-obstetrical treatment of a definable medical condition or disability occurring to the mother during the pregnancy, delivery, or after termination of pregnancy that is related to the pregnancy, and that is classified as a medical condition under the following ICD-9 codes: V23, V28, 630-649.6, 651-677. Complications of pregnancy does not include common symptoms/discomforts associated with pregnancy such as spotting, false labor, morning sickness, skin changes, backache, headache, leg cramps, indigestion, constipation, hemorrhoids, or the usual lab/ultrasound tests to monitor status and progression of the pregnancy.

Copayment is the fee or amount you pay for certain covered services when you use in-network providers. The Plan then pays 100% of remaining covered expenses.

Course of treatment is a planned program of services or supplies furnished by a health care provider in connection with the diagnosis and treatment of an injury or disease of a definite duration.

Coverage Period begins each "Calendar Year"—see the definition for Calendar Year for more information.

Covered employment is work covered by a Collective Bargaining Agreement between your Employer and the Union. The Collective Bargaining Agreement requires your Employer to contribute to the Plan on your behalf.

Covered services are the services for which the Plan provides benefits in accordance with this document.

Custodial care is services and supplies furnished to a person mainly to help him or her in the activities of daily life. Services include room and board and other institutional care. To receive custodial services, a covered person does not have to be disabled. Services and supplies are considered custodial care regardless of:

- Who prescribes the care;
- Who recommends the care; or
- The person or institution that provides the care.

Deductible is the amount you pay each Calendar Year before the Plan pays all or a portion of your eligible expenses.

Dependent means a participant's spouse or other dependent who satisfies the dependent eligibility requirements listed in the "Eligibility and Participation" section or the policy of insurance.

Dollar Bank is the accumulation of all Employer contributions made on your behalf to the Fund. Once you reach the minimum amount, as determined by the Trustees, you can purchase coverage for yourself and your dependents with the credits in your Dollar Bank.

Durable medical equipment is equipment that is made to withstand prolonged use, made for and mainly used in the treatment of a disease or injury, suited for use in the home, not normally of use to persons who do not have a disease or injury, not for use in altering air quality or temperature, and not for exercise or training.

Effective date means January 1, 2024. The Plan has been amended several times since its origination.

Eligibility Determination Date is the first day of the month where the Trustees look to see if your Dollar Bank balance has reached the minimum required amount, set by the Trustees.

Eligible participant means an active participant who is eligible to receive coverage through the 4th District IBEW Health Fund and is otherwise deemed eligible by the IRS to participate in a tax-favored health reimbursement arrangement.

Eligible provider means a provider who is considered "in-network"—see the definition for in-network for details.

Eligible retiree means a retiree who is eligible to receive coverage through the Fund.

Emergency or Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Emergency Services, with respect to an Emergency Medical Condition, means:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition
- Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department
- Further services that are furnished by a non-network provider or non-network emergency facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the hospital in which such further examination or treatment is furnished).

Employer means an Employer who is bound by a Collective Bargaining Agreement or Participation Agreement providing for the making of contributions to the Agreement and Declaration of Trust or who has signed an assent agreeing to participate and be bound by the Agreement and Declaration of Trust, as stated in the Plan Document.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Essential health benefits are a set of 10 categories of services that health insurance plans must cover under the Affordable Care Act. These include doctors services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and others. For more information, visit **www.healthcare.gov**.

Experimental or investigative treatment, as used here, is a procedure, service, drug, or other supply that falls into any of the following categories:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- If required by the FDA, approval has not been granted for marketing;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
- The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

FMLA means the Family and Medical Leave Act of 1993.

Fund means the 4th District IBEW Health Fund.

Generic refers to prescription drugs that are the lower-cost equivalents of brand name drugs. They are approved by the U.S. Food and Drug Administration (FDA) and have the same active ingredients, dosage, safety, effectiveness, strength, stability, and quality as their brand name equivalents.

Handicapped child is a dependent child who depends chiefly on you for support and maintenance and is not able to earn his or her own living because of a mental or a physical condition which began prior to age 26. Proof of the child's handicap must be submitted to the Fund Office within 60 days after the child's 26th birthday. The Fund Office has the right to require proof of the continuation of the handicap, including examining the child as often as needed while the handicap continues, at the Fund Office's own expense. Please note, however, that an exam will not be required more often than once each year after two years following the child's 26th birthday. Coverage for a handicapped dependent child will end when the child is no longer handicapped, when you fail to provide proof of the continued handicap, when you fail to submit to any required exam, or if the Fund stops offering the Plan to dependents, whichever happens first.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Hospice facility is a facility, or distinct part of one, that:

- Mainly provides inpatient hospice care to the terminally ill;
- Charges for its services;
- Meets the licensing or certification standards of its jurisdiction;
- Keeps a medical record on each patient;
- Provides an ongoing quality assurance program that includes reviews by physicians other than those who own or direct the facility;
- Is run by a staff of physicians and has at least one of them on call at all times;
- Provides 24-hour nursing services under the direction of an RN;
- Has a full-time administrator.

Hospital (including a birthing center) is defined as an institution that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of the injured and sick;
- Is supervised by a staff of physicians;
- Provides 24-hour RN service;
- Is not mainly a place for rest or a nursing home for the aged, drug addicts, or alcoholics;
- Charges for its services.

In-network refers to a health care service or supply furnished by:

- A Highmark Blue Cross Blue Shield Association Preferred Provider Organization network provider;
- A Lyra Health provider for mental health treatment;
- An out-of-network provider approved by the Fund Office;
- Any health care provider in an emergency.

Independent Freestanding Emergency Department means a health care facility that (i) is geographically separate and distinct and licensed separately from a hospital under applicable state law and (ii) provides any Emergency Services as defined in this document.

Limited data set is a limited set of identifiable patient information as defined in the privacy regulations issued under the Health Insurance Portability and Accountability Act. A "limited data set" of information may be disclosed to an outside party without a patient's authorization if certain conditions are met. Visit **www.hhs.gov** for more information.

Local Union is the Union to which you belong and which has contracted with the 4th District IBEW Health Fund under a Collective Bargaining Agreement or Participation Agreement.

Maintenance drugs are medications taken on a regular basis (more than 30 days) for chronic conditions such as high blood pressure, arthritis, diabetes, and asthma.

Medicaid is a state program of medical aid for needy individuals, established under Title XIX of the Social Security Act of 1965, as amended.

Medically necessary means the extent of services required to diagnose or treat a bodily injury or sickness which is known to be safe and effective by the majority of qualified practitioners who are licensed to diagnose or treat that bodily injury or sickness. Such services must be:

- Performed in the least costly setting required by your condition;
- Not provided primarily for the convenience of yourself or a qualified practitioner;

- Appropriate and consistent with your symptoms or diagnosis of the sickness or bodily injury under treatment;
- Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for your symptoms, diagnosis, sickness, or bodily injury; and
- Substantiated by records and documentation maintained by the provider of the service.

Medicare is the Health Insurance for the Aged and Disabled Program under Title XVIII of the Social Security Act as such program is currently constituted and as it may later be amended.

Negotiated fee amount is the cost of a service or treatment when it is received in-network. In-network providers are contracted with Highmark BCBS and Lyra Health to charge the "negotiated fee amount," which is generally lower than what they would otherwise charge.

Network provider refers to a health care provider who has contracted to furnish services or supplies for a negotiated charge but only if the provider is, with Highmark Blue Cross Blue Shield's or Lyra Health's consent, included in its directory as an in-network care provider for the service or supply involved.

Network Health Care Facility means, in the context of non-Emergency Services, a network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center (as defined in the Social Security Act).

Nonparticipating/Out-of-Network Emergency Facility means an emergency department of a hospital or an Independent Freestanding Emergency Department (or a hospital, with respect to Emergency Services as defined) that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service.

Non-occupational sickness or injury is an illness or disease that does not arise out of (or in the course of) any work for pay or profit, or result in any way from a disease that does.

- A disease is considered non-occupational regardless of its cause if proof is furnished that the person is covered under any type of workers' compensation law and not covered for that disease under such law.
- Non-occupational injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit or result in any way from an injury that does.

Non-preferred brand name refers to brand name prescription drugs that are not listed on the 4th District IBEW Health Fund Pharmacy Benefit Manager's formulary.

Notice of the Adverse Benefit Determination is a communication from the Plan or Highmark Blue Cross Blue Shield that reduces or denies benefits in whole or part.

Out-of-network refers to care received from providers not affiliated with the Highmark Blue Cross Blue Shield Association Preferred Provider Organization (PPO) network or the Lyra Health network of mental health practitioners.

Out-of-Network Rate will be determined in the following order:

- the amount that the state approves under an All-Payer Model Agreement, if applicable
- the amount determined by a state law, if applicable;
- the payment amount agreed to by the Plan and provider or facility, if applicable;
- the amount approved under the independent dispute resolution (IDR) process.

Out-of-pocket maximum is the most you pay during a Plan Year in cost sharing before your Plan begins to pay 100% for covered services. The out-of-pocket maximum does not include amounts over the reasonable and customary charge or charges for services that your Plan does not cover. The out-of-pocket maximum may consist of deductibles, coinsurance, and/or copayments.

Over-the-counter (OTC) drugs are medicines sold directly to consumers without a prescription, for example, regular strength Advil or ibuprofen.

Participant means an individual who satisfies the eligibility requirements listed in the "Eligibility and Participation" section or policy of insurance.

Participation Agreement is the negotiated contract between your Employer (if you are not a member of the Bargaining Unit) and the Fund requiring contributions to be made on your behalf to the Fund.

Payroll Month is the month the Fund must receive contributions, paid by your Employer on your behalf, in order for you to be eligible for coverage the following month.

Pharmacy Benefit Manager (PBM) is the third-party administrator of the prescription drug program for the 4th District IBEW Health Fund.

Plan refers to the 4th District IBEW Health Fund.

Plan Administrator means the Board of Trustees, except to the extent fiduciary authority and control for claims administration has been delegated to another entity. Day-to-day operation of the Plan has been delegated by the Board to the Fund Office.

Plan Sponsor means the Board of Trustees.

Plan Year is the 12-month period from October 1 through September 30 during which the Plan is administered.

Preferred brand name refers to the brand name prescription drugs that are listed on the 4th District IBEW Health Fund Pharmacy Benefit Manager's formulary.

Protected health information ("PHI") is individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in 45 CFR §160.103.

Qualified expenses means any expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease, eligible for reimbursement under the HRA. The expense is one of the participant, the participant's spouse, or a dependent and not otherwise used by the participant as a deduction in determining the participant's tax liability or reimbursed under any other health coverage, including a health Flexible Spending Account (FSA). Qualified medical expenses covered by this Plan are limited as elected by the Board of Trustees and explained in this document.

Qualifying Payment Amount (QPA) generally means the median amount the Plan has contractually agreed to pay network providers, facilities, or providers of Air Ambulance Services for a particular covered service. This amount is updated annually to account for inflation.

Reasonable and customary charge (or "recognized charge") is the recognized amount charged for a service or supply that is the lower of the provider's charge for furnishing the service or supply, or:

- For professional services: the 80th percentile of the prevailing charge rate for the service or supply in the geographic area where it is furnished, as reported by FAIR Health, a nonprofit company, in its database
- For hospitals and other facilities: the facility charge review rate, which is the amount Highmark Blue Cross Blue Shield determines is enough to cover the provider's estimated costs for the service and leave the provider with a reasonable profit, based on Centers for Medicare and Medicaid Services reporting and/or statewide averages as adjusted by Highmark where Highmark determines it is reasonable to do so.

In some circumstances, Highmark may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate Highmark will pay for a service. In these instances, the reasonable and customary charge is the rate established in the agreement.

Highmark also may reduce the reasonable and customary charge by applying Highmark reimbursement policies. In doing so, Highmark may take into account:

- The duration and complexity of the service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow-up care is included;
- Whether there are any other characteristics that may modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided; and
- The educational level, licenses, or length of training of the provider.

Recognized Amount, for items and services furnished by an Out-of-Network provider or Out-of-Network emergency facility, will be determined in the following order:

- An amount determined by an All-Payer Model Agreement, if applicable
- An amount determined by a specified state law, if applicable;
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

Special enrollment period occurs when you or your dependent loses eligibility under another group health plan (or if an Employer stops contributing toward your or your dependent's other coverage), or if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption.

Specialty drugs are generally high-cost medications used to treat chronic or long-term conditions.

Substance abuse is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders [DSM] published by the American Psychiatric Association that is current as of the date services are rendered to you or your covered dependents.)

Urgent care is medical care given to treat an injury or disease that, while not an emergency, is severe enough to require immediate care. Examples of situations that require urgent (but not emergency) care are broken limbs, acute bronchitis, first-degree burns, and chronic earache.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994.

WHCRA means the Women's Health and Cancer Rights Act of 1998.

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