AMENDMENT NO. 13
TO THE
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
OF THE
I.B.E.W. 292 HEALTH CARE PLAN
(2015 Restatement)

WHEREAS, the Section entitled "Trustee Authority to Amend and Terminate the Plan" in the Plan Document and Summary Plan Description of the I.B.E.W. 292 Health Care Plan (Amended and Restated Effective January 1, 2015) (the "Plan") empowers the Board of Trustees to amend the Plan; and

WHEREAS, the Trustees believe it is in the best interests of participants to amend the Plan to implement the Working Spouse Rule.

NOW THEREFORE, BE IT RESOLVED, that the Plan Document is hereby amended to according to the attached replacement pages 19, 98, 98A, 102, 102A, 139, 139A, 147 and 147A.

The provisions of this Amendment will be effective as of January 1, 2018.

IN WITNESS WHEREOF, the duly authorized Trustees of the I.B.E.W. 292 Health Care Plan executed this Amendment on December 5, 2017.

Opt-Out for Health Savings Account (HSA) Coverage

A Dependent of an Eligible Individual may elect to opt-out of coverage under this Plan if the Dependent is eligible for a health plan offered by their employer that is a high deductible health plan with a Health Savings Account (HSA). The Dependent must complete a "Waiver of Coverage" form to opt-out of coverage under the Plan.

The Dependent and Eligible Individual understand that by electing to opt-out of coverage under the Plan, the Dependent will:

- Not be entitled to any benefits or other payments from the Plan, including, but not limited to, health care benefits, dental benefits, accidental death and disability benefits, extended coverage options under federal law, or retiree benefits.
- Have no right or claim to any contributions made to the Plan for the purposes of funding the Dependent's eligibility for coverage.
- Forfeit any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the plan offered by the Dependent's employer.
- Have no right to return to coverage under the Plan until such time as HSA and high-deductible health plan coverage is lost, or the Dependent otherwise meets the eligibility requirements of the Plan and provides written notice to the Trustees of the desire to once again become covered by the Plan.

The "Waiver of Coverage" form can be obtained from the Plan Administrator. The Dependent must indicate the date upon which the waiver of coverage will be effective.

Working Spouse Rule

Effective January 1, 2018, employed Spouses who are eligible to enroll in Qualifying Employer Health Care Coverage through their employer for a cost of less than $250 per month for the lowest cost employee-only coverage option are required to enroll in such coverage in order to be eligible for Medical Coverage under the Plan. Upon proof of enrollment in such employer's group coverage in a form acceptable to the Trustees, the Spouse would be eligible for Medical Coverage under the Plan on a secondary basis. Any optional/voluntary benefit buy ups, if any (like vision, dental, or spouse/child coverage additions), do not count towards the $250 threshold.

- Any coverage under federal or state or other governmental programs, except Medicare, and any coverage required or provided by statute;
- Coverage under a labor-management trusteed plan, union welfare plan, Employer organization plan or employee benefit organization plan;
- Medicare. For the purposes of this Section, the definition of Medicare includes both Part A and Part B of Medicare, whether or not the Eligible Individual is enrolled for both parts; and
- Qualifying Employer Health Care Coverage.

The term **"Other Plan"** or **"Another Plan"** will not mean:

- Hospital indemnity coverage or other fixed indemnity coverage;
- Accident only coverage, except no-fault coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined by state law;
- School accident type coverage that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;
- Benefits for non-medical components of long-term care policies, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or receipt of services;
- Medicare supplement policies; or
- A state plan under Medicaid.

The term **"Plan"** is construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not. Notwithstanding the foregoing, the term "Plan" includes any plan which is paid for entirely by an Employee, Retiree or Dependent only if such plan contains a provision coordinating its benefits with This Plan.

The term **"This Plan"** means that portion of the I.B.E.W. 292 Health Care Plan which provides the medical, dental, and vision benefits subject to these COB provisions.

The term **"Allowable Expense"** means any Medically Necessary, Reasonable and Customary item of expense at least a portion of which is covered under at least one of the Plans covering the Eligible Individual with respect to whom claim is made. When a Plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished will be both an Allowable Expense

and a benefit paid. The Trustees are not required to determine the existence of, benefits payable under any Plan except This Plan. The payment of benefits under This Plan

requirement applicable to the treatment for which the Allowable Expense was incurred; and

- The benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of these COB provisions, whether or not a claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses.

More Information on Coordination of Benefits

The following rules also apply to claims eligible for coordination of benefits:

- Benefits are coordinated on all Eligible Individual claims;
- The Fund Office may release or receive necessary information about Eligible Individual claims to or from other sources. All Eligible Individuals must furnish the Fund Office with any information it needs to process a claim;
- Benefits are paid for "Allowable Expenses," which means expenses that are eligible under This Plan to be considered for payment;
- All Eligible Individuals must file a claim for any benefits the Eligible Individual is entitled to from any other source. Your Plan benefits will be calculated as if the Eligible Individual received benefits from the other sources (whether or not the Eligible Individual files a claim with those sources);
- Benefits are coordinated with Other Plans, including other Blue Cross Blue Shield group plans and individual plans paid for by the Eligible Individual. Benefits are also coordinated with Medicare. If an Eligible Individual is covered under another health plan or policy, contact the Fund Office to find out whether that fits the definition of Other Plan; and
- If other insurance is lost or terminated, the Eligible Individual must notify the Fund Office and provide proof of the loss (such as a Certificate of Prior Health Coverage). Benefits will be delayed or denied until the required proof is provided.
- The "Working Spouse Rule" as described under the Benefit Eligibility section.

Facility of Benefit Payment

Whenever payments which should have been made under this Plan in accordance with this Section have been made under any other plans, the Trustees have the right, exercisable alone and in their sole discretion, to pay over to any organization making such payments any amounts the Trustees determine to be warranted in order to satisfy the intent of this Coordination of Benefits Section.

Whenever any Eligible Individual is physically, mentally, or otherwise incapable of giving a valid release for payment of benefits due, the Trustees have the right to pay Plan benefits to:

- Any person or institution that provided the services for which benefits are payable; or

Employees for hours worked by their Employees and also Employee payments to the Plan as required by such Agreements; and

- Self-Contributions as defined below.

COVERED OR COVERED UNDER THE PLAN. This term means a person is eligible to receive the Plan benefits which are applicable to his or her status as an Employee, a Retiree or a Dependent.

COVERED EMPLOYMENT. Work performed within the jurisdiction of the Union by an Employee for an Employer for which the Employer is required to make Contributions to the Fund on the Employee's behalf. Work performed within the jurisdiction of another I.B.E.W. local union for which Contributions may be transferred under reciprocal agreement.

COVERED EXPENSES; COVERED MEDICAL EXPENSES. The Reasonable, Customary and Medically Necessary Charges incurred by an Eligible Individual upon the recommendation and approval of the attending Physician for services and supplies required for treatment of the Eligible Individual as a result of a non-occupational Injury or Sickness and for which Plan benefits are payable, subject to the Schedule of Benefits and other Plan provisions.

DENTIST. A person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry.

DEPENDENT. For purposes of the Plan, a person who is:

- The Spouse of an Eligible Employee or Eligible Retiree while not legally separated from such Employee or Retiree. The Plan may require that an Employee or Retiree provide a certified copy of his or her marriage certificate before any benefits are paid for a Dependent Spouse.

  - Effective January 1, 2018, employed Spouses who are eligible to enroll in Qualifying Employer Health Care Coverage through their employer for a cost of less than $250 per month for the lowest cost employee-only coverage option are required to enroll in such coverage in order to be eligible for Medical Coverage under the Plan.

- An Eligible Employee's or Eligible Retiree's Child who is less than 26 years of age.

- Any grandchild of an Eligible Individual or Eligible Retiree, provided that:

  - The Eligible Employee or Eligible Retiree has been appointed the legal guardian of the grandchild; or a parent of the grandchild is: (i) a Dependent Child under this Plan; (ii) age 19 but less than age 26, and such Child is a registered full-time student in an accredited post-secondary school, college or university or in a vocational or technical trade school or institute and is dependent upon the Employee or Retiree for the major portion of the grandchild's support and maintenance, as defined above; and (iii) unmarried, and provided also that the Eligible Employee or Eligible Retiree, the parent of the grandchild, and the grandchild all reside in the same household;

  - The grandchild is not eligible for coverage through an employer of the grandchild or the grandchild's parents.

Eligibility for the grandchild will terminate immediately if any of the above requirements are no longer met

OUT-PATIENT SURGERY. Surgical procedures performed at a Hospital or an Ambulatory Surgical Center for which the patient does not stay overnight but has the surgical procedure done on the same day and released on the same day of admittance.

PALLIATIVE CARE. Treatment which is provided to a terminally-ill person for the purpose of relieving or alleviating symptoms without curing.

- Provide, either directly or under other arrangement, the "core services" listed in this handbook as covered expenses for the Hospice Care Program.

PARTIAL HOSPITALIZATION. An intensive ambulatory service provided in a licensed acute care setting by a multi-disciplinary team consisting of psychiatry, nursing, social work and psychology, with occupational and other supportive therapies available when indicated by patient need. The program will have available a minimum of six hours of therapeutic involvement daily, five days a week.

PARTICIPATION AGREEMENT. A written agreement between the Trustees and an employer in which the Trustees approve the employer's participation in the Plan and the employer agrees to make and the Trustees agree to accept contributions to the Fund on behalf of the employer's employees who are not members of the bargaining group. The Trustees will, by appropriate action, determine the employer's contribution rate.

PERIOD OF CRISIS. A period during which a terminally-ill person requires continuous care which is primarily provided by a licensed nurse. This care must be necessary to achieve palliation or management of acute medical services.

PHYSICIAN. A legally qualified physician or surgeon who is a Physician of Medicine (M.D.), a Physician of Osteopathy (D.O.), a Physician of Chiropractic (D.C.), a Physician of Dentistry (D.D.S .), or a Physician of Podiatry (D.P.M.). Any practitioner of the healing arts other than the Employee or Dependents of the Employee licensed to practice in his or her state and providing services within the scope of that licensing.

PLAN OR BENEFIT PLAN OR PLAN OF BENEFITS. The self-funded program of health and welfare benefits described in this handbook established and amended from time to time by the Board of Trustees pursuant to the Trust Agreement.

QUALIFYING EMPLOYER HEALTH CARE COVERAGE. Coverage that:

- Is insured, or self-insured, by the employer of a Spouse, and subject to regulation by state or federal agencies, such as the U.S. Department of Labor or Internal Revenue Service; and

- Provides standard benefits equal to the Bronze level plan of benefits for medically-necessary hospitalization, surgery, outpatient medical treatment and prescription drug coverage.

REASONABLE AND CUSTOMARY OR REASONABLE AND CUSTOMARY CHARGE.

- With respect to medical expenses incurred by an Eligible Individual as a result of a non-occupational Injury or Sickness, the Plan's maximum allowable expense for a charge by a Physician or any other provider of medical services or supplies is the applicable

percentage as specified under the "Schedule of Benefits", provided that the Plan may review and compare the charge with the charges made by other Physicians and providers of medical services or supplies for similar services or supplies in the locality concerned to individuals of similar age, sex, circumstances and medical condition.

- With respect to dental expenses incurred by an Eligible Individual, the Plan's maximum allowable expense for a charge by a Dentist for services and supplies rendered for the treatment of a dental condition is the applicable percentage as specified under the