SUMMARY OF MATERIAL MODIFICATIONS
TO THE
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
OF THE
I.B.E.W. 292 HEALTH CARE PLAN
(2015 Restatement)

IMPORTANT NOTICE TO PLAN PARTICIPANTS AND BENEFICIARIES

The Board of Trustees has amended the Plan. This notice summarizes the change and its effective date.

Amendment No. 11, Effective Date December 5, 2017.

The Plan Document was amended so participants who work in Prohibited Employment and then re-enter the Plan will forfeit Premium Credits based on the number of months he or she worked in Prohibited Employment.

Amendment No. 12, Effective Date December 5, 2017.

The Plan Document was amended to clarify which parent's plan is treated as primary coverage for dependents when the participant is cohabitating with their dependent child's other biological parent to whom the participant is not married.

Amendment No. 13, Effective Date January 1, 2018.

The Plan Document was amended to implement the Working Spouse Rule. The Working Spouse Rules states that 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.

Qualifying Employer Health Care Coverage will mean any 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.

All spousal coverage under the Plan will terminate as of 11:59PM as of each December 31, beginning December 31, 2017. This creates a COBRA qualifying life event for all covered spouses, and allows each spouse to enroll in any available outside Qualifying Employer Health Care Coverage as of January 1 each calendar year, regardless of such outside employer's annual re-enrollment date.

If a non-working spouse (as of January 1, 2018) later becomes eligible for Qualifying Employer Health Care Coverage during the calendar year, they are subject to the Rule as of his or her first available enrollment effective date with such outside employer.

If a new spouse (marriage after January 1, 2018) becomes eligible for Qualifying Employer Health Care Coverage during the calendar year, they are subject to the Rule as of his or her first available enrollment effective date with such outside employer.

All spouses will be required to complete and submit an annual enrollment form **on or before December 15, 2017**, confirming their employment status for coverage on and after January 1, 2018, The Plan will conduct annual spouse re-enrollments beginning October, 2017, affecting spousal coverage on and after January 1, 2018. This process will include a working spouse affidavit (to be completed by the spouse's employer, as applicable) confirming the availability and cost of the spouse's outside coverage.

Working spouses will be responsible for updating the Fund Office when their outside employment coverage changes (for example, the spouse's employer changes). The Fund Office may request updated employer coverage affidavits at any time during the year to re-substantiate a spouse's lack of outside Qualifying Employer Health Care Coverage.

A timely submitter will have submitted all necessary paperwork **prior to December 15, 2017.** Non-working spouses need only sign the annual enrollment paperwork and the accompanying affidavit confirming they have no outside employment. If a working spouse's timely enrollment paperwork confirms they <u>are not eligible</u> for qualifying employer coverage as of January 1, the Plan will continue to pay primary for that spouse as of January 1. If a working spouse's timely enrollment paperwork confirms they <u>are eligible</u> for outside qualifying employer coverage and enrolls Time as of January 1, the Plan will pay secondary to the working spouse's primary coverage effective January 1.

Non-timely submitters will have submitted all necessary paperwork **after December 15, 2017**. Spouses who do not submit timely paperwork will have their coverage **terminated** from the Plan as of January 1. Such spouses will receive a notice of creditable coverage reflecting their coverage terminated December 31. A non-working spouse's primary coverage will be reinstated the first day of the month following the date their completed paperwork was received by the Fund Office. A working spouse whose late enrollment paperwork confirms they were not eligible for qualifying employer coverage as of January 1, the Plan's primary coverage would be reinstated the first day of the month following the date their completed paperwork was received by the Fund Office. When a working spouse's timely enrollment paperwork confirms they are eligible for outside qualifying employer coverage and enroll in such outside coverage after January 1, the Plan will pay secondary as of the date such outside qualifying employer coverage is effective for such spouse.

<u>Amendment No. 14, Effective Date October 1, 2017</u>.

The Plan Document has been amended to reduce the maximum weekly disability period from 144 weeks to 104 weeks for new claims after the amendment's effective date.

<u>Amendment No. 15, Effective Date October 1, 2017</u>.

The Plan Document has been amended to include certain prescription drugs in the Plan's prior authorization and step therapy programs.

Please retain this notice with your current copy of the Plan Document and Summary Plan Description and insert the attached slip pages 2, 12, 13, 19, 28, 29, 29A, 56, 57, 77, 100, 102, 102A, 139, 139A, 147, and 147A to replace the current page of the same number. If you have any questions about the Plan, contact the Fund Office at (763) 493-8830 or 1-800-368-9045.

- **Delta Preferred Network**. The Delta Preferred Network is a subset of the Premier network in which over 800 dentists have given greater discounts on services. If you see a Delta Preferred dentist, you will have lower out-of-pocket expenses.

Non-Participating Providers. If you have access to Delta dentists and choose to use another dentist instead, your benefit may be significantly different than if services were provided by a Delta dentist. This may result in higher out-of-pocket expenses for you.

Vision Care

Vision care is offered through Vision Service Plan (VSP). You may choose to see any Doctor you wish under this Plan. Again, if you choose non-participating providers, your benefits may differ substantially.

- **VSP Doctors**. A network of participating Doctors through which eye exams, lenses and frames can be obtained.

- **Non-Participating Providers**. All out-of-network providers.

- **Safety Eyewear**. All commercial, residential, inside construction, maintenance, and Limited Energy Agreement Bargaining Unit Employees are eligible for safety eyewear benefits. Contact the Fund Office for the current covered provider. Call the Fund Office for claim forms before scheduling an appointment with the provider.

Loss of Time Benefits

Loss of time benefits are also called "weekly income" or "disability" benefits. These benefits are provided to you when you become Totally Disabled and meet other criteria for this benefit. These benefits are payable for up to fifty-two (52) weeks per occurrence of Total Disability and subject to a one hundred four (104) week lifetime maximum. Your Plan premiums are credited during a period of Total Disability, subject to a fifty-two (52) week cap per occurrence of Total Disability and a lifetime maximum of one hundred four (104) weeks.

Accidental Dismemberment Benefits

Accidental dismemberment benefits are provided to you through the Plan. These benefits are provided to protect you in the event of the loss of your limbs or eyes.

Life Insurance Benefits

- **Employee Life Insurance Benefit.** Eligible Employees participating in the Plan are eligible for life insurance coverage, although the amount of coverage begins to decrease at age 65.

- **Dependent Life Insurance Benefit**. If you are an Employee participating in the Plan, your Spouse is also eligible for life insurance coverage. So is each of your Dependent children, but only up to the Eligible Child's 26th birthday.

or employer contributions can be from accumulated Premium Credits or employer contributions under the Continuing Eligibility provisions or from credited disability hours in the Eligibility Month in which you become Totally Disabled, or from a combination of accumulated Premium Credits or employer contributions from working and credited disability Premium Credits or employer contributions during the Eligibility Month in which you become Totally Disabled.

- ► You must provide the Trustees with medical proof acceptable to the Trustees of your Total Disability.
- ► You will be credited with disability credits for each day that you are Totally Disabled that falls on a normal work day of the week, including Saturdays and Sundays.
- ► The disability credits granted to you will be used as regular Premium Credits in determining your eligibility.
- ► The maximum period that your eligibility may be continued under this provision is fifty-two (52) weeks for any single period of Total Disability (one hundred four (104) week lifetime maximum) following the last Benefit Month for which you were eligible due to accumulated Premium Credits under the Continuing Eligibility provisions of the Plan.
- ► If you recover from your Total Disability after having been covered under this provision and you do not return to employment for a Contributing Employer, your benefits will terminate on the date you are no longer Disabled or the date your eligibility terminates according to Plan's other eligibility rules, whichever occurs first.
- ► If you continue to be Totally Disabled and unable to return to work after having been covered under this Eligibility During Disability provision for the maximum allowable period, you may continue to make Self-Contributions for Continuation Coverage under the COBRA Continuation Coverage provisions of the Plan.
- ► If you recover from your Total Disability after having been covered under this provision but there is no work available in the jurisdiction in which you are located, you may be entitled to make Self-Contributions for Continuation Coverage under the COBRA Continuation Coverage provisions of the Plan.
- ► You will be credited with a maximum of forty (40) Pension Credits per week under the I.B.E.W. Local No. 292 Pension Plan for a maximum of one hundred four (104) weeks of disability.
- ► You may elect to be paid a gross benefit of two hundred fifty dollars ($250) per week under the Electrical Workers Local No. 292 Supplemental Unemployment Benefit Plan after six weeks of Total Disability.

- Occupational Disability. If you are a Bargaining Unit Employee and become Totally Disabled as the result of an occupational Injury or Sickness that occurs while working for a Contributing Employer under a Collective Bargaining Agreement, these Eligibility During Disability provisions will apply to you as though the disability occurred as a result of non-occupational Injury or Sickness. This benefit is paid for a maximum period of fifty-two (52) weeks for any single period of Total Disability and a total of one hundred four (104) weeks lifetime maximum. You may also elect to be paid a gross benefit of two hundred fifty dollars ($250) per week from your account under the Electrical Workers Local No. 292 Supplemental Unemployment Benefit Plan after six (6) weeks of the Total Disability after any single period of Total Disability. In any event, you will not be eligible for this benefit unless you first provide the Fund Office a copy of the first report of injury as well as a copy of each check stub that is attached to each of your monthly worker's compensation payments.

♦ Non-Bargaining Unit Employees

- If you are a Non-Bargaining Unit Employee covered under this Plan, you will be provided with Plan coverage in the absence of premium payment during a period of Total Disability for which disability benefits are paid under this Plan. This benefit is for a maximum of fifty-two (52) weeks for any single period of Total Disability and a total of one hundred four (104) weeks lifetime maximum.

- If you become Totally Disabled and unable to work as a result of occupational or non-occupational Injury or Sickness, you will continue to be eligible for benefits only as long as you continue to meet the Continuing Eligibility requirements of the Plan unless you elect to maintain eligibility under the COBRA Continuation Coverage provisions of the Plan.

Survivor Benefits

Surviving Dependents of Eligible Employees Covered Under the Plan

♦ If you are an Eligible Employee who has accrued at least twenty-four (24) months of eligibility and you die while eligible under this Plan, your Eligible Dependents will maintain coverage for six (6) calendar months following the month in which your death occurs.

♦ After the six (6) months, your Eligible Dependents will maintain eligibility under the Plan by using your Premium Credit Account until it is exhausted.

♦ After your Premium Credit Account is exhausted, your Eligible Dependents may elect, as an alternative to and lieu of COBRA, to continue coverage by making Self-Contributions until the first of the following occurs:

- The date your surviving Spouse remarries;

- The date your surviving Spouse or other Dependent become eligible for coverage under any other group health plan;

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.

Prescription Drugs: To obt*ain a current list of these prescriptions, please call the Plan Administrator at 800-247-0401.*	Certain drugs will be subject to a prior authorization and some will also be subject to "Step Therapy", split fills (i.e. a 30-day prescription will be filled in two 15-day increments to determine whether the drug is tolerated by participant to reduce waste) and quantity level limits (dispensing only quantities that will actually be used). The Step Therapy program is a "step" approach to providing the medications that treat your condition. This means that you may first need to try a more clinically appropriate or cost-effective medication before certain higher-cost medications will be approved. Step Therapy programs can help both you and the Plan save money. A medication meets the Plan's Step Therapy requirements if it is the most cost-effective medication available to treat a disease or condition. This means that if your doctor prescribes you a new medication that is subject to the Plan's Step Therapy program, the Plan will initially only cover the least expensive "step" in that drug class, typically a generic drug. If the first step medication does not safely and effectively treat your condition, the Plan will cover the next "step", typically a formulary brand medication. If your doctor recommends prescription drugs or quantities that do not comply with the prior authorization and/or Step Therapy protocols, your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Prime Therapeutics. Your doctor can visit MyPrime.com to download the PA form.
Pharmacy Specialty Prescriptions Program: *For more information on the Pharmacy Specialty Prescriptions Program, please contact Prime Therapeutics at 877-357-7463* *To obtain a current list of the specialty drugs on the Specialty Copay Solutions Program list, call the Plan Administrator at 800-368-9045.*	**Specialty Coupon Assistance Program** – Beginning April 1, 2017, Eligible Individuals will be enrolled in the Prime Therapeutics' Specialty Coupon Assistance Program if they obtain a drug on the Specialty Copay Solutions Program from the Prime Specialty Drug Pharmacy. This Program offers a combination of pharmaceutical coupons, rebates, and/or other financial assistance to reduce copayment amounts for certain specialty drugs purchased through the Prime Specialty Pharmacy. An Eligible Individual's net copayment for a specialty drug on the then current Specialty Copay Solutions Program list and purchased through the Prime Specialty Pharmacy (based upon the Eligible Individual's out-of-pocket cost for copayments) will not be greater than the specialty drug copayment amount would have been if the Specialty Coupon Assistance Program were not in place. Any coupon, rebate, and/or other financial assistance applied directly towards an Eligible Individual's copayment at the time of purchase under Prime's "Specialty Coupon Assistance Program" will not be applied towards satisfying such Eligible

	Individual's maximum copayment or annual Out-of-Pocket costs. Eligible Individuals should refer to the current list of the specialty drugs eligible for Prime Therapeutics' Specialty Coupon Assistance Program and the applicable copayments. **Specialty Drug Copayments** - The copayment a Eligible Individual will be responsible for a specialty drug not covered under the Prime Therapeutics' Specialty Coupon Assistance Program is as follows: Retail Brand Name Drugs - $9.00 minimum co-pay or 20% of the cost over $9.00 up to a maximum of $50.00 total per prescription for up to a 90-day maximum supply (subject to the Pharmacy's ability to fill a 90-day maximum supply). Retail Generic Drugs - $5.00 minimum co-pay or 20% of the cost over $5.00 up to a maximum of $25.00 total per prescription for up to a 90-day maximum supply (subject to the Pharmacy's ability to fill a 90-day maximum supply). Mail Order Brand Name Drugs - $18.00 minimum co-pay or 20% of the cost over $18.00 up to a maximum of $100.00 total per prescription for up to a 90-day maximum supply . Mail Order Generic Drugs - $10.00 minimum co-pay or 20% of the cost over $10.00 up to a maximum of $50.00 total per prescription for up to a 90-day maximum supply.

<table>
<tr><td>Compound Drug Control Program:

For more information on the Compound Drug Control Program, please contact Prime Therapeutics at 877-357-7463</td><td>Compound drug prescriptions will be subject to prior authorization and rejection if they contain components of the following high priced compounds:

Baclofen powder;
Cyclobenzaprine powder;
Diclofenac powder;
Flurbiprofen powder;
Fluticasone propionate powder;
Gabapentin powder;
Ketamine powder;
Ketoprofen powder;
Ketorolac powder;
Lansoprazole powder;
Meloxicam powder;
Mometasone powder;
Omeprazole powder;
Testosterone powder;
Testosterone propionate powder; and
Testosterone micronized powder.</td></tr>
<tr><td colspan="2">NOTE: Diabetic supplies such as glucose monitors, insulin, insulin hypodermic needles and syringes which can be purchased either directly and reimbursed by the Plan, or through the prescription drug program are subject to the prescription drug benefit limitations.</td></tr>
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- ► For the surviving Spouse, the date the surviving Spouse remarries or dies, whichever occurs first; or

- ► The date on which Dependent's eligibility for the Plan terminated under the Plan for any other reason.

3. For the dependent Child in the event of the surviving Spouse's death, the end of the last day of the benefit month in which the Spouse's death occurs unless Self-Contributions are made by or on behalf of the Child.

- When Dependent benefits are continued and there is no surviving Spouse, benefits end:

  1. When the Fund Office does not timely receive the correct Self-Contribution on behalf of the Child;

  2. The date the child ceases to meet the Plan's definition of a Dependent;

  3. At the end of the last day of the last month of the 18-month period for which the child was entitled to continue coverage and for which correct and timely Self-Contributions have been made; or

  4. The date on which the Dependent's eligibility Plan coverage would terminate under the Plan for any other reason.

Suspension of Retiree Coverage

Prohibited Employment. Retiree coverage for you and your Dependents under this Plan will be suspended if you perform more than thirty-nine and one-half (39½) hours per month of work:

- ♦ That is subject to a Collective Bargaining Agreement negotiated by, signed by, or otherwise involving the International Brotherhood of Electrical Workers (the "I.B.E.W.") or any of its affiliated local unions or any similar type of work (regardless of whether your particular work is the subject of any collective bargaining agreement);

- ♦ That is considered Covered Employment or that does or would entitle you to contributions to or benefits under this Plan or that is the kind of work performed by an individual who is covered by (or is entitled to be covered by) this Plan or any similar type of work;

- ♦ As an electrician for any federal, state, or local or other subdivision of government;

- ♦ For an employer that is signatory to a Collective Bargaining Agreement with the I.B.E.W. (or with any of its affiliated local unions) or for an employer that is not such a signatory but that is similar to the types of employers who are such signatories, if the work is in a supervisory, managerial, estimating, or other non-bargaining position.

Prohibited Employment does not include any amount of work as: (i) an instructor in an apprenticeship program recognized by NECA and I.B.E.W. where instructors are not

contributed upon; or (ii) an electrical inspector for a governmental authority where electrical inspectors are not contributed upon.

Geographic Limits. There are no geographic limits on these rules. They apply to work performed and to employers located in any geographical location whatsoever.

Scope of Suspension. Suspension of retiree coverage includes the following:

- Elimination of the entire balance in your Premium Credit Account;
- Elimination of any right to apply an account balance under the Electrical Workers Local No. 292 Supplemental Unemployment Plan towards payment of premiums for retiree coverage under this Plan;
- Termination of all coverage under this Plan for you and your Eligible Dependents; and
- Elimination of any discount on the cost of Self-Contributions for retiree coverage.

Reinstatement. Any suspension of retiree coverage is effective on the date you begin performing Prohibited Employment, regardless of when the Fund Office learns of the Prohibited Employment. The suspension is permanent. Even so, you may apply for reinstatement of the benefits suspended above, but only if the following two (2) conditions are satisfied:

1. You have permanently stopped performing any Prohibited Employment; and
2. The following number of months has passed since you last performed any Prohibited Employment:

   A number of months equal to: (a) one plus; (b) the number of months you performed Prohibited Employment.

Any reinstatement granted by the Trustees will be effective prospectively only. Reinstatement will not, for example, restore your retiree coverage back to the date it was suspended. You will lose Premium Credits under your Retiree Coverage Premium Credit Account for the number of months you worked in Prohibited Employment.

disability payments, you will be required to provide proof of application to Social Security at twenty-six (26) weeks and every six (6) months thereafter. If you do not provide this proof, disability payments will cease. This benefit is subject to a fifty-two (52) week cap per occurrence of Total Disability and a lifetime maximum of one hundred four (104) weeks. If you sustain an additional injury while collecting disability benefits the maximum benefit aggregate period for which you may receive loss of time benefits is fifty-two (52) weeks.

The amount of your weekly benefit is based on the cause of your Total Disability as shown below:

Work-Related Injury or Sickness

Disability Period	Maximum Rate
Second and Third Days of First Week	Reimbursed at the current Minnesota unemployment weekly rate provided the second and third days are not paid under Workers' Compensation

Non-Occupational Injury or Sickness

Disability Period	Waiting Period Before Benefits Will Be Paid	Maximum Rate
Weeks 1 Through 6	7 Days (If Confined to a Hospital Because of Illness – None)	Paid at the Lesser of: 65% of the Eligible Employee's actual weekly wage *or* 65% of current average journeyman wireman's weekly wage.
Weeks 7 Through 52	None	Paid at 100% of the current effective Minnesota unemployment compensation weekly rate for the Eligible Employee.

Social Security Offset

Loss of time benefits from the Plan will be reduced if the Eligible Employee receives disability benefits from the Social Security Administration while receiving loss of time benefits. That means if the award from Social Security is equal to or exceeds the benefits otherwise payable under the Plan, the Eligible Employee will not be entitled to weekly loss of time benefits under this Plan. In addition, if an Eligible Employee receives an award from the Social Security Administration for a period of time during which you had already received weekly loss of time benefits, the Eligible Employee will be required to refund to the Plan an amount equal to the lesser of:

- The amount of loss of time benefits you received under this Plan during that time; or
- The amount of Social Security disability benefits you received during that time.

For example, imagine Joe applies for Social Security disability benefits in January. He is already receiving loss of time benefits from the Plan in the amount of $325 a week. The Social Security Administration approves benefits for him in the amount of $100 a week on

- ♦ 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

- **Active Employee or Retired or Laid-Off Employee**. The Plan covering the Eligible Individual as an employee who is not retired or laid-off (or as that employee's dependent) is the primary Plan. The Plan covering that same person as a retired or laid-off employee (or the dependent of the retired or laid-off employee) is the secondary Plan;

- **Dependent Child Covered Under More Than One Plan**. Unless there is a Qualified **Medical** Child Support Order (QMSCO) (as defined below) stating otherwise, when a Dependent Child is covered under more than one Plan, the order of payment is determined as follows:

  - When The Parents Are Not Separated Or Divorced Or Are Living Together.

    1. The Plan covering the parent whose birthday comes first in the year will pay first, and the Plan covering the parent whose birthday comes later in the year will pay second (the year of birth does not count);

    2. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan; and

    3. If a parent's Plan does not have this "birthday rule," the provisions of that Plan will determine the order of benefit payments for Eligible Dependent Children claims.

  - When The Parents Are Separated, Divorced, Or Were Never Married To Each Other And Are Not Living Together.

    1. If there is no QMCSO establishing financial responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the child are as follows:

       a. The Plan covering the Custodial Parent;

       b. The Plan covering the spouse of the Custodial Parent;

       c. The Plan covering the non-Custodial Parent; and then

       d. The Plan covering the Spouse of the non-Custodial Parent.

    2. If the QMCSO establishes financial responsibility for the child's health care expenses or health care coverage, the Plan covering the Child as a dependent of the parent with that responsibility is the primary Plan. The Plan covering the Child as a dependent of the parent without that responsibility is the secondary Plan;

    3. If the QMSCO states that both parents are responsible for the dependent Child's health care expenses or health care coverage, the Plan covering a parent of the Child as an employee will pay first and This Plan will pay after any such Plan. If each parent of the

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