EFFECTIVE February 1, 2021

A GUIDE FOR YOUR FAMILY

Health Benefits & Summary Plan Description (SPD)

ELECTRICAL WELFARE TRUST FUND
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The Board of Trustees is made up of an equal number of Trustees appointed by IBEW Local 26 and the Washington D.C. Chapter of the National Electrical Contractors' Association.

Important Contact Information

Organization	For Information Regarding	Contact Information
Electrical Welfare Trust Fund (EWTF) Office	■ Claims ■ Eligibility ■ Names of Participating Health Care Providers ■ Hearing Benefits ■ Death Benefits	(301) 731-1050 1 (800) 929-EWTF (3983) Fax (301) 731-1065 If you have to dial a one (1) for long distance and are calling from surrounding states, call 1-800-929-EWTF or e-mail at info@ewtf.org
UnitedHealthcare (UHC) Choice Plus Preferred Network	■ Referrals to Doctors, Hospitals, and Specialists ■ All Claims other than Dental and Medicare ■ Prior Authorization ■ Healthy Pregnancy Program Note: Providers of services must contact the UHC Choice Plus provider service unit for information about your benefits and claims status. If a provider contacts the Fund Office, they will be referred to UHC Choice Plus.	1-800-850-1418 http://directory.uhis.com
UnitedHealthcare Bariatric Resource Service (BRS)	■ Bariatric Surgery Benefits ■ Authorizations for Bariatric Surgery ■ Enrollment for Bariatric Surgery	1-888-936-7246
CIGNA Dental Network	Referrals to In-Network Dental Providers	800-797-3381 www.cigna.com
Vision Service Plan (VSP)	Referrals to Participating Vision Providers	1-800-877-7195 **www.vsp.com**

Organization	For Information Regarding	Contact Information
Business Health Services Employee Assistance Program (EAP)	■ Mental Health and Substance Misuse Benefits ■ Referrals ■ Counseling	1-800-765-3277 www.bhssolutions.com **www.bhsonline.com**
CVS Caremark	■ Prescription Drug Prior Authorizations ■ Specialty Pharmacy	1-800-386-0329 www.caremark.com 1-800-237-2767 www.cvscaremarkspecialtyrx.com
Telligen	Case Management	1-888-234-4090 www.telligen.com
Virta	Disease Management	**www.virtahealth.com/join/ewtf**
Teladoc	■ Remote Medical Diagnosis ■ Remote Mental Health Assistance	1-800-TELADOC www.teladoc.com

TO ALL PARTICIPANTS

We are pleased to provide you with this up-to-date booklet describing your health and welfare benefits. This booklet, the Summary Plan Description (SPD) of the Electrical Welfare Trust Fund (the "Fund"), reflects all changes made to the benefits offered under the Fund's Health Plan through January 1, 2020. Read this information carefully and keep it handy for future reference. Note: The terms "Plan" and "Fund" are used interchangeably throughout this SPD. Both terms refer to the Electrical Welfare Trust Fund.

The Electrical Welfare Trust Fund ("EWTF") is a self-insured private health plan regulated by the Employee Retirement Income Security Act ("ERISA") and governed by a Board of Trustees. The Plan has contracted with different healthcare networks to provide a broad array of healthcare services to Plan Participants.

Your health benefits are provided by the Fund, using the UnitedHealthcare Choice Plus Network (UHC) that offers a wide choice of providers as well as deep discounts on provider services which saves valuable health benefit dollars for both you and your Plan. With the exception of dental coverage, when this SPD refers to your "network," it is referring to UnitedHealthcare Choice Plus Network. Your dental benefits are offered through the CIGNA Dental PPO Network.

Your Plan continues to offer other programs to help keep you and your family healthy. Take advantage of the physical exam benefit, the coverage for well-woman exams and coverage for well-child healthcare. The Employee Assistance Program (EAP) can privately and confidentially help you and your family members cope with the pressures of daily life, both at work and at home.

We trust that efficient utilization of these programs will help the Plan continue to provide important protection for you and your family for many years to come, while keeping your out-of-pocket expenses to a minimum. To help control costs for yourself, your eligible family members, and the Plan, remember:

- Visit network Providers for medical, dental, and vision coverage.
- Use toll free numbers or the Internet to find a network Provider near you.
- Do not use the Emergency Room if your medical problem is not an emergency.
- Take advantage of the EAP benefit—you and your family are entitled to up to eight free visits with an EAP counselor.

We will keep you informed of any changes to the benefits described in this SPD in the form of Summaries of Material Modifications. You may always contact the Fund Office either by telephone or by connecting via the web (www.ewtf.org) to make sure you have the latest information regarding Plan benefits.

Also note that, as the Trustees of the Fund, we have the discretion to determine eligibility for benefits and the level of benefits available. We also have the power to interpret, apply and construe the terms of the Plan and make factual determinations regarding the Plan's construction, interpretation and application. Further, as Trustees, we may amend the rules and benefit levels at any time and may terminate the Plan. If we terminate the Plan, your rights and the distribution of assets will be determined

under the terms of the Trust and applicable law. Participants and beneficiaries have no vested rights to the benefits described in this book. Our decision is final and binding on all parties, including participants and their beneficiaries, employers, unions, providers and any other claimant or Business Associate. As Trustees, we administer the Fund and serve without compensation.

Please note that information obtained from any source other than this SPD document is not binding, including but not limited to information posted on social media such as Facebook and Twitter, or from any other sources. If there is a conflict between the rules of the Plan and other sources, the Plan rules always govern.

If you have questions concerning the benefits provided or how the Plan operates, contact the Fund Office at 301-731-1050 or at 1-800-929-3983 or at www.ewtf.org. The Fund Office staff are happy to assist you.

Sincerely,

BOARD OF TRUSTEES

GRANDFATHERED STATUS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

The Trustees of the Electrical Welfare Trust Fund believe that the Plan is a *"grandfathered health plan"* under the PPACA.

The Electrical Welfare Trust Fund uses collectively bargained employer contributions to the Plan, and income from the investment of Plan assets, to provide the most generous health benefits that are prudently possible, and as supported by the assets of the Plan. To avoid the financial and administrative burdens on the Plan that would be associated with full implementation of the PPACA, the Trustees have decided to operate the Plan as a "grandfathered health plan" as permitted under the PPACA. A "grandfathered plan" is a health plan that was in existence on March 23, 2010, the enactment date of the PPACA. As permitted by the PPACA, a grandfathered health plan can preserve certain basic health benefits that were already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the PPACA that apply to non-grandfathered health plans. *For example, the requirement that the health plan offer coverage for "preventive" health services without any cost sharing would apply to a non-grandfathered plan, but under a "grandfathered" plan any such services would be covered pursuant to the terms of the Plan in effect on March 23, 2010.* However, grandfathered plans must comply with certain other consumer protections in the PPACA such as coverage of health benefits for dependent children (biological and adopted or placed for adoption) up to age 26 (the end of the month in which the child reaches age 26).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from a grandfathered health plan status to non-grandfathered status can be directed to:

Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
(301) 731-1050
info@ewtf.org

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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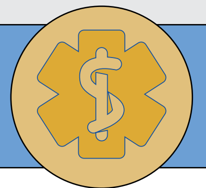
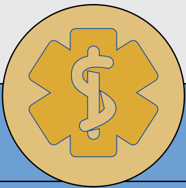
Schedule of Benefits

The following schedule shows the percentage of the **"allowance"** the Plan will pay for covered expenses. Your allowance is the Plan's pre-determined amount for a particular service. **For most medical services, the Plan pays 80% of expenses after you've met your annual deductible. You are responsible for the other 20% (the Patient's Responsibility).**

If you visit a provider in the UnitedHealthcare (UHC) network, the allowance is accepted as payment in full for a particular service. In those cases, you will generally owe only the Patient's Responsibility to the participating provider. If your provider is not in the UHC network, you are responsible for paying any amount your provider charges above the allowance in addition to the Patient's Responsibility.

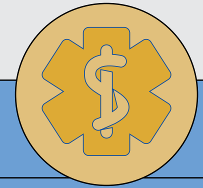


MEDICAL DEDUCTIBLES, OUT-OF-POCKET MAXIMUM, IN/OUT OF NETWORK, & LIFETIME BENEFIT COVERAGE Both Standard (full) and "H" Plan Members (limited)	
Annual Deductible	$150 per individual
	$300 per family
Annual Out-of-Pocket Maximum	All Standard Plan Members--$8,000 per family, after meeting the annual deductible "H" Plan Members—No Annual Out-of-Pocket Maximum
Network Access	All Standard Plan Members—In and Out of Network Coverage; "H" Plan Members—Only In-Network Coverage
Lifetime Benefit Coverage	All Standard Plan Members--$1,000,000 (essential and non-essential health benefits) then coverage level reduces from 80% of allowance to 50% of allowance for essential health benefits and non-essential health benefits are no longer covered "H" Plan Members--$100,000 (essential and non-essential health benefits) then coverage level reduces from 80% of allowance to 50% of allowance for essential health benefits and non-essential health benefits are no longer covered

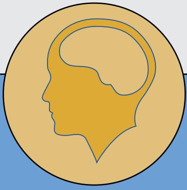


MEDICAL BENEFITS
Both Standard and "H" Plan Members

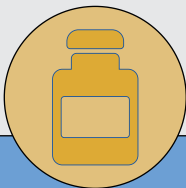
Covered Service	Plan Pays
Doctor's Office Visits	80% of allowance, after annual deductible
Chiropractic Care	80% of allowance, after annual deductible prior authorization required after first 20 visits)
Emergency Medical Care	80% of allowance, after annual deductible
Diagnostic Laboratory Pathology Tests and X-Ray Examination (Outpatient)	80% of allowance, after annual deductible
Emergency Room Treatment, if Not Hospitalized	80% of allowance, after annual deductible
Charges by Physicians and Surgeons (Inpatient or Outpatient)	80% of allowance, after annual deductible
Durable Medical Equipment	80% of allowance, after annual deductible
Hospitalization	Prior Authorization Required
Expenses up to $7,000 for each spell of illness	100% of allowance, no deductible applies
Expenses in excess of $7,000	80% of allowance, no deductible applies
Home Health Care	Prior Authorization Required
Covered home health care visits by a registered or licensed practical nurse	80% of allowance, after annual deductible
Covered home health care visits by a home health care aide	100% of allowance, after annual deductible
Convalescent Nursing Home Care	
Semi-private accommodations rate charged by discharging hospital	50% of allowance, no deductible applies
Maximum days per spell of illness	60 days
Maximum benefit when combined with covered charges made by discharging hospital	$7,000
Covered charges that exceed the maximum	80% of allowance, no deductible applies
Hospice Care (Approved Facility)	100% of allowance, no deductible applies
Surgery (Including Organ Transplants)	
Charges by physicians and surgeons in or out of the hospital	80% of allowance, after annual deductible
Assistant or co-surgeon	25% of allowance for surgeon, at 80%, after an-nual deductible
Anesthesiologist's charges	80% of allowance
Second Surgical Opinion	100% of allowance, no deductible applies
Facility fee charged by an approved facility for outpatient surgery (up to first $7,000 per spell of illness)	100% of allowance, no deductible applies
Expenses after $7,000	80% of allowance, no deductible applies



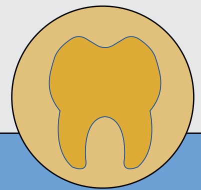
MEDICAL BENEFITS Both Standard and "H" Plan Members	
Covered Service	**Plan Pays**
Wellness	
Child Wellness Visits and Examinations of eligible dependent children by a physician including required immunizations according to the following maximum number of visits:	
Birth through age 23 months; maximum of seven visits	80% of allowance, after annual deductible
Age 2 through age 26; one visit per year	80% of allowance, after annual deductible
Physical Exams for participants and spouses	80% of allowance, after annual deductible (including tests and immunizations)
Well-woman office visit	80% of allowance, after annual deductible
Bariatric surgery — Only one surgical procedure is covered and prior authorization is required by Bariatric Resource Services.	80% of allowance up to maximum lifetime benefit of $100,000. After maximum reached, eligible expenses covered at 50%.
Mammogram	One per year for women age 35 or over
Zostavax - Physical Examination includes coverage (including administration) for Zostavax, a vaccine for the prevention of herpes zoster (shingles). NOTE: The Zostavax vaccine benefit is also available to Medicare-eligible retirees and their spouses, provided such retirees or spouses are not enrolled in a separate Medicare Part "D" prescription plan.	80% of allowance, no deductible applies
Gardasil – for all eligible members through age 26 and dependents through the end of the month they reach age 26	80% of allowance, subject to deductible
Gynecological Care and Maternity Expenses	
Hospital bills, including maternity and nursery expenses up to $7,000 per spell of illness.	100% of allowance, no deductible applies
Expenses in excess of $7,000	80% of allowance, no deductible applies
Maternity and Gynecological Care expenses including charges by physicians and surgeons in or out of the hospital	80% of allowance, after annual deductible
Initial routine physical examination for newborn	100% of allowance, no deductible applies
Assistant or co-surgeon	25% of allowance for surgeon, at 80% after annual deductible
Pap Test	One routine exam per year



MENTAL HEALTH BENEFITS Both Standard (full) and "H" Plan Members (limited) Substance Misuse and Mental Health Treatment Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members	
Covered Service	**Plan Pays**
Outpatient treatment	80% of allowance, after annual deductible
Inpatient treatment for the first $7,000 of expenses for each spell of illness	100% of allowance, no deductible applies
Inpatient expenses in excess of $7,000 for each spell of illness	80% of allowance, no deductible applies
Employee Assistance Program (EAP) —Both Standard and "H" Plan Members	
Counseling Sessions	8 Free Sessions per Year



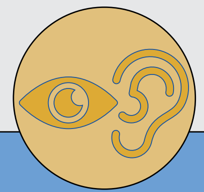
PRESCRIPTION DRUG BENEFITS— Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members		
Prescription Drug	**Participating Pharmacy Participant Pays**	**Non-Participating Pharmacy Participant Pays**
Retail (34-Day Supply)		
Generic Drugs	$10 copayment	$10 copayment plus difference between the allowance and retail price
Preferred Brand Name Drugs	$25 copayment	$25 copayment plus difference between the allowance and retail price
Non-Preferred Brand Name Drugs	$35 copayment	$35 copayment plus difference between the allowance and retail price
Mail Order or CVS (90-Day Supply)		
Generic Drugs	$20 copayment	Not covered
Preferred Brand Name Drugs	$50 copayment	Not covered
Non-Preferred Brand Name Drugs	$70 copayment	Not covered



DENTAL BENEFITS Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members		
Dental Services	**PPO Provider Plan Pays**	**Non-PPO Provider Plan Pays**
Dental Care (Preventive Services)		
Visits and Examinations	100% of the allowance	80% of the allowance
Examinations (limited to once every six months)	100% of the allowance	80% of the allowance
Prophylaxis, including scaling and polishing (limited to once every six months)	100% of the allowance	80% of the allowance
Topical applications of fluorides limited to one course of treatment per 12-month period	100% of the allowance	80% of the allowance
X-Rays and Pathology		
Single films (up to 13)	100% of the allowance	80% of the allowance
Panorex (limited to once every year)	100% of the allowance	80% of the allowance
Entire denture series (14 or more films; limited to once every year)	100% of the allowance	80% of the allowance
Bitewings	100% of the allowance	80% of the allowance
Biopsy and examination of oral tissue	100% of the allowance	80% of the allowance
Dental Care (Basic Services)		
Problem visits	80% of the allowance	80% of the allowance
Consultation by specialist when diagnosis has been made by a general dentist	80% of the allowance	80% of the allowance
Restoration (fillings)	80% of the allowance	80% of the allowance
Oral Surgery (Including Local Anesthesia)	80% of the allowance	80% of the allowance
Extractions	80% of the allowance	80% of the allowance
Incision and drainage of abscess	80% of the allowance	80% of the allowance
Removal of cyst or tumor	80% of the allowance	80% of the allowance
Alveoplasty with ridge extension	80% of the allowance	80% of the allowance
Suture, soft tissue injury	80% of the allowance	80% of the allowance
Periodontics	80% of the allowance	80% of the allowance
Subgingival curettage	80% of the allowance	80% of the allowance
Root planning	80% of the allowance	80% of the allowance

DENTAL BENEFITS Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members		
Dental Services	**PPO Provider Plan Pays**	**Non-PPO Provider Plan Pays**
Dental Care (Basic Services)		
Provisional splinting	80% of the allowance	80% of the allowance
Gingivectomy	80% of the allowance	80% of the allowance
Endodontics	80% of the allowance	80% of the allowance
Pulp capping	80% of the allowance	80% of the allowance
Root canals	80% of the allowance	80% of the allowance
Apicoectomy	80% of the allowance	80% of the allowance
Denture repairs	80% of the allowance	80% of the allowance
Space maintainer, fixed (bank type) and removable	80% of the allowance	80% of the allowance
Dental Care (Major Services)		
Inlays and Crowns (not covered if teeth can be restored with a filling material)	80% of the allowance	50% of the allowance
Pontics (artificial teeth)	80% of the allowance	50% of the allowance
Removable bridge (one piece casting clasp attachment)	80% of the allowance	50% of the allowance
Dentures (complete upper or lower; specialized techniques not eligible)	80% of the allowance	50% of the allowance
Orthodontia (Dependent Children Only)		
Orthodontia	50% of the allowance	50% of the allowance

Maximum For All Covered, non-Orthodontia Dental Services	**Children Under Age 18: No Limit** **Members, Spouses and Children Age 18 and Older: $3,000 per calendar year**
Maximum For Orthodontia Dental Services (Dependent Children Only)	**$3,000 per lifetime**



VISION BENEFITS Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members		
Vision Services	**VSP Provider Plan Pays**	**Non-VSP Provider Plan Pays**
Vision survey once per every two calendar years, unless prescription changes and meets specified criteria	100% of allowance	You pay the difference between the actual charge and the allowance
Vision analysis, if indicated, once per every two calendar years, unless prescription changes and meets specified criteria	100% of allowance	You pay the difference between the actual charge and the allowance
Eyeglass lenses, if necessary, once per every two calendar years, unless prescription changes and meets specified criteria	100% of allowance	You pay the difference between the actual charge and the allowance
Frames, once every two calendar years, unless prescription changes and meets specified criteria	100% of allowance, up to $150 per person	You pay the difference between the actual charge and the allowance
Contact lenses once every two calendar years, unless prescription changes and meets specified criteria	100% of allowance, up to $100 per person	You pay the difference between the actual charge and the allowance
Safety Glasses (actively working eligible members only) once per calendar year	100% of allowance for lenses. Safety frames at 100% of allow-ance up to $65 plus 20% of out of pocket costs	You pay the difference between the actual charge and the allowance
Computer Glasses (actively working eligible members only) once every two calendar years	100% of allowance for lenses. Frames at 100% of allowance up to $40 plus 20% of out of pocket costs	You pay the difference between the actual charge and the allowance

HEARING BENEFITS Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members	
Audiologist Exam	80% of allowance, up to $100 maximum
First Hearing Aid	$3,000
Second Hearing Aid	$1,000

ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT BENEFITS Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members	
Loss of One Hand	$5,000
Loss of One Foot	$5,000
Loss of Sight of One Eye	$5,000
Loss of Two or more of the above	$10,000

WEEKLY ACCIDENT AND SICKNESS BENEFITS Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members	
Benefit based on a percentage of regular gross compensation and a normally scheduled work week of 40 hours or less	
First 13 weeks of disability	50%; $350 per week maximum
Next 13-weeks of disability (after Trustee approval)	40%; $210 maximum per week

DEATH BENEFITS Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members	
Eligible Active Electrical Worker or Non-Bargaining Unit Employee	$25,000
Eligible Retired Employee	$6,000

SUPPLEMENTAL OCCUPATIONAL ACCIDENT BENEFITS Coverage for Standard Plan Members Only; NO Coverage for "H" Plan Members	
Loss of life	$100,000 maximum benefit payable
Loss of one hand	$50,000 maximum benefit payable
Loss of one foot	$50,000 maximum benefit payable
Loss of sight in one eye	$50,000 maximum benefit payable
Loss of hearing in one ear	$50,000 maximum benefit payable
Two or more of the above	$100,000 maximum benefit payable
Loss of speech	$100,000 maximum benefit payable
Thumb and index finger of same hand	$25,000 maximum benefit payable
First 52 weeks of disability	$150 per week maximum
Next 52 weeks of disability	$150 per week maximum
The maximum amount payable for Supplemental Occupational Accident Benefits is $100,000 including $50,000 for disability.	

Understanding the EWTF Plan

Understanding the EWTF Plan

The Electrical Welfare Trust Fund Plan is a comprehensive package of **health and welfare benefits** sponsored by the Board of Trustees. Your EWTF Plan is a private health plan provided under a Collective Bargaining Agreement (or other agreement) between the IBEW Local 26 and the D.C. Chapter of the National Electrical Contractors Association (NECA). The Electrical Welfare Trust Fund is NOT an insurance company.

Plan Basics

The EWTF Plan provides eligible participants and their eligible family members with a wide range of health and welfare benefits. However, it is important for you to realize that not all charges are covered in full or in part under this Plan. As one example, optional or elective treatments generally are not covered under this Plan. (See page 19 for Plan General Exclusion and sections titled 'What's Not Covered" within each benefit description.)

Payment for Coverage

There is no cost to you to participate in the Plan while you are working. Participating employers contribute to a trust fund from which your benefits are paid. However, you are responsible for deductibles and the Patient's Responsibility when you receive services.

The Annual Deductible

The annual deductible is the amount you and/or your family must pay each calendar year before the Plan will pay benefits. The annual deductible for each individual is $150. The annual deductible for each family is $300. The Plan's annual deductible does not apply to Medicare-eligible retirees.

The annual deductible for each family is $300.

Coverage for Participants Covered Twice

If a person is covered twice under this Plan—either as an eligible employee married to another eligible employee, as the dependent of two eligible employees, or as an eligible employee who is also an adult dependent of an eligible employee—the Plan will pay up to a maximum of the lesser of (a) 100% of the Plan's allowance, or (b) the actual charges after the annual deductible has been met. This applies to medical, mental health/substance abuse, and dental coverage ONLY. No additional benefit is provided for prescription, vision, or hearing benefits.

Out-of-Pocket Maximum

The annual out-of-pocket maximum per family is $8,000 per calendar year. You are required to provide proof of payment of the annual out-of-pocket maximum to receive full payment of charges, up to the allowance, for covered services obtained for the balance of the calendar year.

What the Out-of-Pocket Maximum Does Not Include

- Your annual deductible;
- Services that are not covered under the Plan (e.g., cosmetic surgery, TMJ treatment, fertility/infertility treatments, etc.);
- Dental and vision expenses;
- Charges above the Plan's allowance.

Prior Authorization

Prior authorization under the Plan is required in only a limited set of circumstances, but if you fail to obtain prior authorization in those circumstances your benefits may be denied.

Prior authorization is required in the following circumstances:

- Home Health and Hospice Care;
- Hospitalization and other in-patient care;
- Speech Therapy and Occupational Therapy;
- Physical Therapy, including Aqua Therapy, after the first 20 visits;
- Chiropractic Care, after the first 20 visits; and
- Major Dental Care over $600.

For benefits not listed above you do not need to obtain a prior authorization before you seek treatment.

Plan Features

The Health Care Cost Containment Corporation

The Electrical Welfare Trust Fund, along with many other union plans, participates in the Health Care Cost Containment Corporation of the Mid-Atlantic Region, Inc. (HC-CCC). It is designed to reduce health care costs for union funds and their participants.

UnitedHealth Premium® Physician Designation Program

The UnitedHealth Premium® Physician Designation Program uses clinical practice information to assist consumers in making more informed and personally appropriate choices for their medical care. The program uses national industry, evidence-based and medical society standards with a transparent methodology and robust data sources to evaluate physicians across 20 specialties to advance safe, timely, effective, efficient, equitable and patient-centered care. The program supports practice improvement and provides physicians with access to information on how their clinical practice compares with national and specialty-specific standards for quality and local cost efficiency benchmarks.

Plan General Exclusions

The following is a list of general exclusions under the Plan. **Please refer to the specific benefit sections of this SPD for additional exclusions relating to specific benefits.**

1. Any injury or illness resulting from, or arising out of, any employment or occupation for compensation or profit;
2. Any injury or illness for which benefits are payable under any workers' compensation law, occupational disease law, or similar legislation;
3. Any care, treatment or supplies to the extent obtained from any federal, state or local government agency or program, or from a government-owned hospital or institution unless otherwise required by law;
4. Any injury or illness for which medical care, treatment and supplies are available without cost or are not required to be paid;
5. Care provided to you or your eligible dependent(s) to the extent that the cost of the professional care or hospitalization may be recoverable by, or on behalf of, you or your eligible dependent in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you, your dependent, or you or your dependent's attorney may receive as a result of the accident or Injury, no matter how these amounts are characterized or who pays these amounts.
6. Any service, care or treatment that is experimental in nature, as defined in this SPD, or which is not considered a generally accepted medical practice;
7. Any injury or illness resulting from, or occurring during, an attempt to commit or in the commission of a crime; Any prosthetic device or supportive appliance, or its repair, unless specifically covered under this Plan;

8. Expenses for treatment of learning deficiencies or behavioral problems (except as specifically covered under this Plan) or for special education;
9. Orthopedic shoes or supportive devices for the feet, such as arch supports, heel lifts, etc., except for orthotics when medically necessary and used in lieu of surgery, following surgery, or after an accidental injury to support, align, prevent or correct deformities or to improve the function of moveable parts of the body;
10. In-vitro fertilization, artificial insemination, or other treatment of male or female infertility, or services to reverse tubal ligation, vasectomy, or other voluntary, surgically induced infertility. The Plan will cover the diagnostic procedures for determining impotence or infertility;
11. Callus or corn paring; toenail trimming or excision for toenail trimming; treatment of local chronic conditions of the foot, such as weak or fallen arches, flat or pronated foot metatarsalgia, or foot strain;
12. Humidifiers, air conditioners, exercise equipment or whirlpools; and other non-essential durable medical equipment such as supplies or equipment for personal hygiene, comfort or convenience such as telephone, television or similar items not required for medical care;
13. Benefits for claims not filed within one year of service date;
14. Charges incurred prior to the individual becoming covered under this Plan or after termination of eligibility, except as provided under any extension or continuation of benefits provisions of this Plan;
15. Private-duty nursing care, medical care or treatment, or performance of surgical procedures, dental care or physical therapy when those services are rendered by a nurse, physician, dentist, or physiotherapist that ordinarily resides in the patient's home or who is a member of the patient's immediate family;
16. Travel and non-patient living expenses, whether or not recommended by a physician;

17. Medical, dental and vision services or supplies determined by the Board of Trustees as not medically appropriate or clinically eligible for the care or treatment of any injury or illness;
18. Cosmetic, plastic or reconstructive surgery, including surgery to correct developmental malformations, or as a result of earlier cosmetic, plastic or reconstructive surgery are generally excluded from coverage for all Plan participants unless the surgery is appropriate for the repair of damage caused by an accidental injury or congenital defect, or unless otherwise required to be covered under applicable law 1998 shall not be considered "cosmetic" and, thus, shall not be excluded under this provision;
19. Treatment by any method of jaw joint problems including temporomandibular joint (TMJ) syndrome, craniomandibular disorders, and/or other jaw joint conditions, except for surgery specifically determined in advance to meet clinical guidelines for medical appropriateness and up to specified limits set by the Trustees in consultation with the Fund's dental and/or medical consultant;
20. Treatment of obesity, or weight reduction or physical fitness programs, including surgical treatment unless specifically provided elsewhere under the terms of the Plan;
21. Surgery, implants or other treatment or devices or drugs to enhance sexual performance;
22. Confinement for more than one day preceding the date of surgery, unless justified as medically appropriate by the attending physician;
23. Any charges in excess of actual expenses, such as may be provided under a diagnostic related group (DRG) program;
24. Hospital charges in connection with extraction of teeth or other dental process, unless justified as medically appropriate by the attending physician;
25. Charges for any individual not covered by this Plan.

Prior authorization under the Plan is required in only a limited set of circumstances.

If You Have Questions

Once you have read this Summary Plan Description, if you have any questions about your coverage, call the Fund Office. By calling the Fund Office in advance, you may avoid incurring expenses for which you may not be reimbursed. Representatives of the Fund Office cannot change the terms of this plan but may be able to help you with your questions. Help us to help you!

Plan Participation

Plan Participation

Your Work Category determines when you are eligible to participate in this Plan, how you maintain coverage and when your coverage may end. If you qualify in more than one category, the category that provides the higher level of benefits will apply. You will not be entitled to receive benefits under more than one category.

You and your Eligible Dependents are eligible to participate in this Plan if you meet the requirements under one of the following Work Categories:

- Active Electrical Worker (see page 26)
- Active Non-Bargaining Unit Employee (see page 32)
- Pre-Medicare Retired Employee (see page 35)
- Medicare Eligible Retired Employee (see page 36)

The chart below shows the Work Categories and the benefits available to employees, and their Eligible Dependents, that meet the Plan's eligibility requirements for each category.

	Active Electrical Worker—Standard Plan	Active Electrical Worker—"H" Plan	Active Non-Bargaining Unit Employee (Office Worker)	Retired Employee NOT Eligible for Medicare	Retired Employee Eligible for Medicare
Requirements	**135 hours/ payroll month**	**135 hours/ payroll month**	**You work 80 or more hours in a month**	**Must make self-payments for coverage**	**Must make self-payments for coverage**
Medical (office visits, lab and x-ray, physicals, chiropractic care)	✔	✔	✔	✔	Benefits Supplement Medicare Coverage Only (reimbursement of Medicare annual deductible and Medicare coinsurance)
Hospitalization and Surgery	✔	✔	✔	✔	
Maternity and Gynecological Care	✔	✔	✔	✔	
Emergency Room	✔	✔	✔	✔	
Employee Assistance Plan	✔	✔	✔	✔	
Substance Misuse and Mental Health	✔	No Coverage	✔	✔	
Prescription Drugs	✔	No Coverage	✔	✔	✔
Dental	✔	No Coverage	✔	✔	✔
Vision	✔	No Coverage	✔	✔	✔
Hearing	✔	No Coverage	✔	✔	✔
Death Benefit	✔	No Coverage	✔	✔	✔
Accidental Dismemberment and Loss of Sight	✔	No Coverage	✔	No Coverage	No Coverage
Weekly Accident and Sickness	✔	No Coverage	✔	No Coverage	No Coverage

Termination of Coverage for Participants in All Categories

Generally, once your coverage terminates, benefits will not be paid for expenses you incur after your coverage terminates. However, if you are totally disabled when your coverage terminates, you will continue to be eligible for benefits for Covered Medical Expenses relating to the illness or injury causing the disability for a period of one year or, if sooner, until you recover from the disability. There are other circumstances when you may be allowed to continue Plan coverage for a specific amount of time. These circumstances are described in more detail in the section "Continuing Your Coverage", on page 42.

You will not be entitled to receive benefits under more than one category.

Eligibility

Eligibility

Eligibility for Active Electrical Workers

You are an Active Electrical Worker if you work in covered employment for an employer who is required by a collective bargaining agreement with the Union to contribute to the Fund on your behalf.

Initial Eligibility Requirements

Once your employer has reported and paid contributions for at least 135 hours of covered employment in one payroll month, you will be eligible for coverage under this Plan. The payroll month in which the work was performed and contributed for is called the *Qualifying Month*.

Your actual coverage starts on the first day of the third calendar month after the Qualifying Month. The calendar month in which you are entitled to receive benefits is called the *Benefit Month*. Eligibility is determined on a monthly basis.

The delay between the time you work and the time you are eligible for benefits is due to the delay in reporting and contributing for the time you worked. This also delays the date your benefits end when you are no longer working for a contributing employer.

Remaining a Plan Participant

After you become a Plan "*participant*," you remain a participant by working at least 135 hours (for which your employer has contributed and reported) in your Employer's payroll month. For each Qualifying Month during which you work at least 135 hours, you have Plan coverage for the month that begins three months later, as shown in the chart below:

If You Complete At Least 135 Hours of Work in Covered Employment During the Qualifying Month of:	You Have Plan Coverage During the Benefit Month Of:
October	January
November	February
December	March
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December

Hours Bank

There may be times that you work more than 135 hours a month and other times that you work less than 135 hours.

If you work more than the required 135 hours in a month, all hours in excess of 135 are credited to your hours bank the following month. If you work less than 135 hours in a month, all hours worked for that month are credited to your hours bank the following month. You may draw on the hours in your bank to prevent a lapse in coverage in subsequent months in which you lack the minimum required hours; however, you may not apply the hours from your bank to a month that happened in the past. The maximum number of hours you can bank is 810. (Active Electrical Worker Employees who become Retired Employees are eligible to use a maximum bank of 405 hours.)

If you die while you are an active participant, any of your dependents that are eligible under this Plan at the time of your death may use any remaining hours in your hours bank.

The following example illustrates typical eligibility bank account activity:

Month	Hours Worked	Excess Over 135	Bank of Hours
1	204	69	69
2	160	25	94
3	144	9	103
4	198.50	63.50	166.50
5	152	17	183.50
6	135	0	183.50
7	155	20	203.50
8	160	25	228.50
9	200	65	293.50
10	160	25	318.50
11	166.50	31.50	350
12	188	53	403
13	201	66	469
14	164	29	498
15	96	-39	459
16	80	-55	404
17	40	-95	309
18	0	-135	174

If you leave covered employment, and cease to be covered, your remaining banked hours are held for a maximum of 24 months.

You may donate up to a maximum of 270 Hours (two months of coverage) from your personal Hours Bank.

Hours Bank Donation Program

Effective July 1, 2020, the Board of Trustees of the Fund has established an Hours Bank Donation Program ("Program") pursuant to which Fund participants may donate hours currently held in their own individual Hours Banks under the Fund's Plan of benefits to the Fund's newly created Hours Bank Donation Pool Account ("Pool Account"). The Pool Account will be used to provide donated Hours to participant applicants who would otherwise lose eligibility for coverage under the Fund due to reasons specifically designated by the Trustees from time to time as being subject to the Program.

Participants will be able to donate Hours, and apply to receive donated Hours, only during the time periods specifically designated by the Trustees. *For example, Hours may be donated, and applications for donated Hours may submitted, through December 31, 2020 for the specific purpose of extending the eligibility of participants who otherwise would lose such eligibility because:*

1. *The participant has been advised by a physician to self-quarantine due to COVID-19, including if a physician advises that the participant has a pre-existing condition that presents undue risk if s/he were not subject to self-quarantine; or*
2. *The participant is providing necessary care for an individual who has been advised by a physician to self-quarantine due to COVID-19, including if a physician advises that the individual under the participant's care has a pre-existing condition that presents undue risk if the individual were not subject to self-quarantine.*

Donating Hours: In order to donate hours to the Pool Account from your personal Hours Bank, you must meet the following criteria, which are designed to help your fellow participants while protecting the long-term financial health of the Fund:

- You must currently have a full personal Hours Bank (810 Hours);
- You may donate up to a maximum of 270 Hours (two months of coverage) from your personal Hours Bank;
- You may donate Hours in one month (135 Hours) or two month (270 Hours) increments; and
- Once you have made a donation of Hours, you may not make another donation until your personal Hours Bank is full again.

Any participant who would like to donate Hours from his/her personal Hours Bank under the Fund to the Pool Account should contact the Fund office at *eligibility@ewtf.org*.

Applying to Receive Donated Hours: Any participant who would like to apply for continued eligibility through use of Hours held in the Pool Account must contact the Fund office at *info@ewtf.org* In order to be eligible to receive Hours from the Pool Account, a participant applicant must:

- Have been eligible for coverage in the month before the extended eligibility period would begin *(for example, a participant applying for extended eligibility effective July 1, 2020 must have been eligible for coverage under the Plan as of June 30, 2020)*;
- Complete the necessary application form; and
- Provide any documentation required by the Fund in support of the participant's application for donated Hours.

If a participant is determined to be eligible, the participant and his eligible dependents, if any, will receive a one-time eligibility extension of up to two months of Plan coverage, subject to the availability of Hours in the Pool Account. Applications for continued eligibility through use of the Pool Account will be processed on a first come first serve basis in the event that the Pool Account does not contain sufficient Hours to cover all eligible participant applications.

All applications must email to *eligibility@ewtf.org* for inclusion in the Program. Submission of an application under the Program is not a guarantee that extended cover age will be provided. Further, in the event that extended coverage is provided and the Fund later determines that the participant did not meet the requirements for coverage, the

participant will be obligated to refund the amount of any claims paid by the Fund on his behalf or on behalf of his dependent(s) during the extended coverage period.

Once you have received two months of extended eligibility through use of the Pool Account, you may not receive any further extension of eligibility through this Program. The Program is intended as a temporary measure to assist participants for a limited time period while they locate a more permanent source of health coverage.

Making Payments to Maintain Your Eligibility

If you were eligible for Plan coverage as an Active Electrical Worker and you no longer have 135 hours in your bank of hours, you may be able to self-pay to continue your coverage under the Plan for a limited time if your coverage otherwise would lapse. You may make self-payments to continue your coverage if you have at least one hour in your hours bank or you worked at least one hour of covered employment in the preceding month.

Self-Payment Rates

Self-payment rates are set by the Board of Trustees and may be changed from time to time based on Plan benefit levels and costs. Contact the Fund Office for the current self-payment rates. Self-payment amounts are due in the Fund Office at dates specified by the Board of Trustees.

Delinquent Contributions from Employers

If your employer does not make the required contributions on your behalf, you and your family will lose your right to benefits once any accumulated banked hours drop below 135, unless you choose to self-pay for coverage in accordance with the rules described above. Only hours that are paid for at the proper rate are credited to your eligibility. If your employer is delinquent (that is, not paying contributions), *and the Plan is aware that you were working for that employer based on their last paid report*, you will be notified that your employer is delinquent.

If you continue to work for a delinquent employer, benefits for you and your family will be in jeopardy. While the Plan will take action—including legal action—to collect the

contributions, if the contributions are not paid, you will not be eligible for coverage during the related time periods unless you use the hours in your hours bank or self-pay for coverage. If your employer later pays the contributions owed on your behalf, your hours bank will be restored and/or the amounts you self-paid will be refunded to you. If you did not use your hours bank or self-pay during the relevant period, your eligibility will be retroactively reinstated but your family's benefit claims and prescriptions may be delayed, and the Fund Office may be unable to verify your coverage with UnitedHealthcare and the dental PPO providers.

All applications must email to eligibility@ewtf.org for inclusion in the Hours Bank Program.

When Your Coverage Ends

As an Active Electrical Worker, your coverage will terminate upon the occurrence of any one or more of the following events, unless you are able to use the hours in your hours bank, or self-pay, to temporarily continue coverage:

- Your employer does not make the required contributions to the Fund on your behalf;
- You do not work the required number of hours to maintain your eligibility;
- You stop working as an Active Electrical Worker for a participating employer for any reason; or
- The Plan is terminated by the Board of Trustees.

Re-Qualification Requirements

Once you have lost eligibility as an Active Electrical Worker for any reason and have not selected one of the options to continue your coverage (through Self-Payments or through COBRA, as described on page 42) the only way to regain eligibility is by returning to work in covered employment and meeting the initial eligibility requirements.

Eligibility for Active Non-Bargaining Unit Employees

You are considered an Active Non-Bargaining Unit Employee and eligible for benefits under this Plan if you work both:

- In a job category that is not subject to a collective bargaining agreement; and
- For: (a) an employer who has a collective bargaining agreement with IBEW Local 26, as well as a special written participation agreement with the Fund for Active Non-Bargaining Unit Employees that covers your participation; (b) Local No. 26 International Brotherhood of Electrical Workers ("Union"), within the scope of its participation agreement with the Fund; (c) IBEW 26 Federal Credit Union ("Credit Union"), within the scope of its participation agreement with the Fund; or (d) the National Electrical Contractors Association, Washington D.C. Chapter ("NECA"), within the scope of its participation agreement with the Fund.

Notwithstanding the foregoing, you are not considered an Active Non-Bargaining Unit Employee and are not eligible to participate if:

- You are a part-time or temporary employee who has never worked more than 80 hours in a payroll month;
- You are hired and work only during the months of May through September of any year regardless of the number of hours worked;
- You are not actively employed for wages; or
- Your employer does not employ at least as many Active Electrical Workers as it does Active Non-Bargaining Unit Employees, unless your employer is the Union, the Credit Union or NECA.

When Your Coverage Starts

If you are an Active Non-Bargaining Unit Employee, your employer must make contributions to the Plan on your behalf for two months before your coverage will begin. The Plan and the participation agreement with your employer require that contributions on your behalf begin for the payroll month following the first month in which you work 80 or more hours (or 100 hours in a five pay period month).

Your coverage starts on the first day of the second month following the month in which your employer first makes contributions on your behalf. *For example, if you first work 80 or more hours (100 hours in a five pay period month) in January and your employer begins to contribute in February, then you become covered beginning April 1st.*

Your coverage will continue as long as you are employed, and your employer makes timely payments to the Plan on your behalf.

Maintaining Your Coverage

Your coverage will continue as long as you are employed, and your employer makes timely payments to the Plan on your behalf. For each month that your employer makes payments, you will maintain coverage for the month that begins two months later.

When Your Coverage Ends

Your coverage as an Active Non-Bargaining Unit Employee terminates at the end of the second month following the earliest of any of the following events:

- Your employer ceases to contribute to the Fund on your behalf;
- Your employer no longer has employees in a category subject to a collective bargaining agreement with the union (unless your employer is the Union, the Credit Union or NECA);
- Your employer is no longer a party to a collective bargaining agreement with the Union (unless your employer is the Union, the Credit Union or NECA);
- Your employer terminates its participation agreement with the Board of Trustees;
- You terminate employment with your employer;
- Your employer employs fewer Active Electrical Workers than Active Non-Bargaining Unit Employees (unless your employer is the Union, the Credit Union or NECA); or
- The Board of Trustees terminates coverage for Active Non-Bargaining Unit Employees.

Continuing Your Coverage

If you leave employment while you have coverage as an Active Non-Bargaining Unit Employee, you may continue limited coverage in this Plan through COBRA Continuation Coverage (refer to page 42), or if you are an eligible retiree, you may make self-payments through the Retiree Plan (see page 34).

Eligibility for Retired Employees

If you are a retiree and you meet the requirements for participation, you may pay for coverage to participate in this Plan. If you are receiving benefits through Medicare, your benefits in this Plan will supplement your Medicare benefits provided you pay the required amount to the Plan that is established by the Trustees, which may be changed from time to time.

You are considered eligible for retiree coverage if:

- You have been covered under this Plan as an Active Electrical Worker or Active Non-Bargaining Unit Employee for 10 consecutive years immediately prior to your retirement (coverage under the H Plan does not satisfy this requirement); and
- You are eligible Medicare; or
- You are receiving a pension under the Electrical Workers Local No. 26 Pension Plan (the "Pension Plan"); or
- You are receiving Social Security retirement benefits (if you are not eligible to receive benefits under the Pension Plan); or
- You are receiving a pension under the National Electrical Benefit Fund's Plan.

If you fail to meet the 10-consecutive year requirement, you still may be eligible to qualify by self-paying under one of the following alternatives:

- If you were covered under the Plan for 20 or more (not necessarily consecutive) years, you may self-pay "back" to fulfill the 10-consecutive year requirement;
- If you were covered under the Plan for 10 or more (not necessarily consecutive) years and you are age 62 or older, you may self-pay "ahead" to fulfill the 10-consecutive year requirement; or
- If you are retired on a Disability Pension or Social Security, you have the choice of self-paying "ahead" or "back," whichever is most favorable to you, to fulfill the 10-consecutive year requirement, regardless of your age or the number of years you were covered.

If you meet one of the above conditions, please contact the Fund Office for specific details.

Note: If you are a former member of Local 637, and were eligible under the District 4 Plan, your eligibility with the District 4 Plan will be considered in applying the 10-consecutive year requirement.

Relief For Retirees Unemployed Between October 1, 2008 and December 31, 2013

If you meet all of the other eligibility requirements for retiree coverage set forth above, except for failure to fulfill the 10-year requirement based upon unemployment between **October 1, 2008 and December 31, 2013**, this period of unemployment may be disregarded for purposes of meeting the 10-consecutive year requirement, provided you meet all of the following:

- The last employment in which you engaged prior to or during your period of unemployment was for a contributing employer;
- You were available to work for a contributing employer throughout the period of unemployment;
- You were actively seeking work for a contributing employer throughout the period of unemployment;
- You complete and submit to the Fund Office the "Application to Avoid or Postpone a Break-in-Coverage"; and
- If applicable, you provide all supporting documentation to the Fund Office.

Retired Employee Monthly Payment Rates

The Trustees establish the monthly payment rates for Retired Employees, and the monthly payment may be changed by the Trustees at any time. If the rates are changed, you will be notified before the new rates go into effect. The current Retiree rates are as follows:

Pre-Medicare Retirees (Age at Retirement)	Current Monthly Rates
Ages Under 60	$200.29
Age 60-64	$145.16
Age 65 and Older	$73.50

Note: If you are the survivor of a deceased Retiree and are receiving EWTF benefits, your premium rate at any age under age 65 is $200.29. The premium cap per family per month is $400.58. These premiums are subject to re-examination by the Trustees at any time.

Pre-Medicare Retirees

If you are a retiree and are not yet eligible for Medicare, you may pay a premium for retiree health care coverage under the Plan. However, your coverage will not include accidental dismemberment and loss of sight, weekly accident and sickness or supplemental occupational accident benefits.

Retirees Eligible for Medicare

To be eligible for retiree coverage under the Plan, you, and your dependents, must enroll in Medicare — the federally-sponsored health care program consisting of hospital insurance (Part A) and supplementary medical insurance (Part B) -- once you, and/or your dependents, become eligible to do so (e.g. due to age or disability). At that time, you and/or your dependents, as applicable, will no longer be eligible for most of this Plan's regular benefits unless you are still working and covered as an Active Employee. Instead, you, and/or your dependents, will be eligible for this Plan's Medicare Supplemental Benefits program. Note that you, and/or your dependents will continue your entitlement to dental and vision benefits as before, since these benefits are not covered by Medicare.

If you are Medicare-eligible and your spouse and/or dependent child(ren) are not eligible for Medicare, your dependents will remain eligible for pre-Medicare retiree dependent coverage (see page 35) under this Plan.

If you are retired and are eligible for Medicare due to age or disability, the Plan assumes you are enrolled for Medicare Parts A and B and will consider your claims as if you are covered under Medicare even if you are not enrolled. That is why it is essential that you apply for Medicare as soon as possible (e.g. at least three months before you reach age 65) to assure continued coverage. This Plan does not pay the Medicare Part B premium for participants.

Medicare Part D

The EWTF Plan provides prescription benefits to Retirees. The Plan's actuary has determined that the benefits provided under the Plan exceed the Medicare Part D prescription coverage for Medicare eligible participants. The Plan therefore receives a subsidy from the Centers for Medicare and Medicaid Services for providing these benefits. If you or a covered dependent enrolls in a separate Medicare Part D program, you or your dependent will permanently lose your prescription benefits with EWTF.

When Retiree Coverage Ends

Your Retiree coverage will end when the first of the following events occurs:

- You return to covered employment;
- You fail to make any required payment in a timely manner;
- The Board of Trustees terminates retiree coverage; or
- You die.

Eligibility for Dependents (including Spouses)

If you are eligible to participate in this Plan, your dependents may also be covered for most of the benefits that are available to participants in your work category. Exceptions are noted in each section.

Your "dependents" are:

- Your legally married spouse who resides with you; and
- Your children under age 26.

"Children" includes biological children, stepchildren, adopted children, children placed with you for adoption, foster children, and those children for whom you are the legally appointed guardian, provided you can show proof of parental responsibility.

Disabled Children

If your child is totally disabled (that is, completely unable to perform the normal activities of a person of the same age), the age 26 limit for eligibility for coverage under the medical plan does not apply. You are required to provide proof of the disability before your child reaches age 26 and show that he or she is unmarried and dependent on you for support. From time to time, the Board of Trustees may require proof that your child remains disabled and financially dependent upon you.

When Dependent Coverage Starts

Generally, coverage for your dependent begins on the date you become eligible for coverage under the Plan (either as an Active Electrical Worker, Active Non-Bargaining Unit or Retired Employee), or if later, the date on which the individual becomes your dependent for purpose of coverage under this Plan. Your new spouse will be eligible as of the date of marriage. Your newborn child will be eligible from birth. Coverage for your adopted children will begin when the child is officially placed with you for adoption, not when the adoption becomes final.

Your dependents may also be covered for most of the benefits that are available to participants in your work category.

When Coverage Ends for a Dependent Child

Generally, your dependent child continues to be covered while you are covered. However, if a dependent child reaches the age limit, his or her coverage will end on the last day of the Benefit Month in which he or she reaches age 26. In addition, coverage will end on the last day of the Benefit Month in which one of the following events occurs:

- The individual no longer qualifies as a dependent;
- Your coverage terminates or you cease to be eligible for coverage;
- The dependent enters the military; or
- The Board of Trustees terminates dependent child coverage under the Plan.

When Coverage Ends for a Dependent Spouse

Generally, your dependent spouse continues to be covered while you are covered. However, the coverage of a dependent spouse will end on the last day of the Benefit Month in which one of the following events occurs:

- You and your spouse are separated and living apart;
- You and your spouse are legally separated or divorced;
- Your spouse enters the military;
- Your coverage terminates or you cease to be eligible for coverage; or
- The Board of Trustees terminates dependent spouse coverage under the Plan.

Special Enrollment Events

Generally, eligible members may enroll their dependents in the Plan at any time. In the event you initially decline enrollment for your dependents (including your spouse), for example because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this Plan if your dependents lose eligibility for that other coverage or if the employer stops contributing toward your or your dependents' other coverage. However, you must request enrollment in the Plan within 30 days after your dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your dependents within 30 days after the marriage, birth, adoption, or placement for adoption.

You and your dependents may enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and lose eligibility for that coverage. However, you must request enrollment within sixty (60) days after the Medicaid or CHIP coverage ends.

You and your dependents also may enroll in this Plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within sixty (60) days after being determined to be eligible for such assistance.

For Special Enrollment events involving birth or adoption, Plan coverage will be effective as of the date of birth or placement for adoption. For Special Enrollment events involving marriage or the loss of other coverage, Plan coverage will be effective on the first of the month after you request enrollment.

To request special enrollment or obtain more information, contact the Fund Office.

Generally, eligible members may enroll their dependents in the Plan at any time.

Qualified Medical Child Support Orders (QMCSOs)

The Fund will provide dependent coverage to a child if it is required to do so under the terms of a Qualified Medical Child Support Order ("QMCSO"). The Fund will provide coverage to a child under a QMCSO even if the participant does not have legal custody of the child, the child is not dependent upon the participant for support, and regardless of enrollment season restrictions which otherwise may exist for dependent coverage. If the Fund receives a QMCSO and the participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. You can request a copy of the Fund's procedures for determining whether an order is a QMCSO by calling or writing to the Fund Office.

A QMCSO may require that weekly accident and sickness benefits payable by the Fund be paid to satisfy child support obligations with respect to a child of a participant. If the Fund receives such an order/notice, the order/notice meets the requirements of a QMCSO, and benefits are currently payable or become payable in the future while the order/notice is in effect, the Fund will make payments either to the Child Support Agency or to the recipient listed in the order/notice.

Surviving Spouse Coverage

Coverage for Surviving Spouse and Other Dependents of Deceased Active Employees

Health benefits will be extended to your eligible dependents for a limited period of time at no cost if you die while you are an active participant. Your dependents can use all of the hours in your hours bank (see page 27) to maintain coverage. Beginning the first of the month after those hours are exhausted, coverage is extended for twelve months at no cost. At the end of the extension period, your dependents may apply, and pay, for COBRA continuation coverage under the rules set forth on page 42.

Coverage for Surviving Spouse and Other Dependents of a Deceased Retired Employee

If you die while you're retired, your eligible dependents are covered under this Plan until the last day of the third month following the date of your death. After the three-month extension, your surviving spouse may self-pay for continuation coverage for the remainder of his/her life, provided your spouse is not eligible for coverage under any other group health plan other than Medicare. Your dependent children may self-pay as long as they qualify as dependent children. Coverage is subject to the special rules for coverage of a surviving spouse of a deceased participant, as explained below.

The Fund will contact all Participants on an annual basis to confirm that the information the Fund relies on to process benefits for each Participant and his/her Dependents is accurate and up-to-date.

Termination of Surviving Spouse and Other Dependent Coverage

Surviving spouse and other dependent coverage under this provision terminates on the last day of the month in which the earliest of the following events occurs:

- The surviving dependent becomes covered as an employee or dependent under this or another group health plan that is not a "limited term plan," as defined below (provided, however, that surviving spouse coverage will resume if the spouse loses coverage under this Plan due to a termination of covered employment);
- The surviving dependent dies;

The Board of Trustees terminates surviving dependent coverage under the Plan;

- For a dependent child, the date dependent coverage terminates, as described on page 38; or
- The dependent fails to make any required payment for continued coverage.

When Surviving Dependent Coverage ends, your dependents are eligible to obtain coverage through COBRA for up to 36 months (see page 43).

Continuing Surviving Spouse Coverage

Your surviving spouse may apply for continuing Surviving Spouse Coverage if he or she becomes covered under another group health plan that the Board of Trustees considers a limited term plan. A "limited term plan" is a group health plan that the Board of Trustees determines:

- Is temporary;
- Does not provide adequate and similar coverage to that which is available under this Plan; and
- Does not have continuation rights that are substantially similar to the rights under this Plan

If the Trustees approve the application, your surviving spouse must continue to self-pay under the terms of this Plan at the rates that are in effect at that time.

In accordance with the requirements of the Patient Protection and Affordable Care Act, the Fund will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

Annual Enrollment Verification Process

The Fund will contact all Participants on an annual basis to confirm that the information the Fund relies on to process benefits for each Participant and his/her Dependents is accurate and up-to-date. For example, you will be required to confirm your contact information so that the Fund can provide you with Explanations of Benefit relating to your claims and other important information regarding your coverage. You also will be required to confirm other information relevant to your Fund coverage, such as whether you also have health coverage through another source. Failure to respond to the Fund's annual enrollment verification request could result in the suspension of your and your dependents' coverage under the Plan, so please respond promptly to any information requests you receive from the Fund.

COBRA Continuation Coverage

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and your eligible dependents to **continue health care coverage at your own expense, under certain circumstances, when health care coverage would otherwise end.** Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes your rights will change accordingly.

Certain "Qualifying Events," may cause your Plan coverage to terminate. If these circumstances apply to you, you and your dependents may have an opportunity to continue coverage for a limited time through the Plan's self-pay program, if you are an active employee (see page 30), or through COBRA. The following are "Qualifying Events" under the Plan:

Qualifying Event	Who May Purchase Continuation Coverage	For How Long
Employee loses eligibility due to termination or a reduction in hours of employment (including retirement)	Employee, spouse and/or dependent children	18 months
Termination or reduction in hours while you or your Dependent is disabled (The disability must be determined by the Social Security Administration.)	Employee, spouse and/or dependent children	29 months (18 months plus an additional 11)
Employee becomes entitled to Medicare and voluntarily drops coverage	Spouse and/or dependent children	36 months
Employee dies	Spouse and/or dependent children	36 months
Employee is divorced or is legally separated from spouse	Spouse and/or dependent children	36 months
Child is no longer considered an eligible Dependent under this Plan's definition	Dependent child	36 months

Under COBRA, you and/or your covered dependents may continue ONLY the same coverage in which you and/or your dependents were enrolled immediately before the COBRA Qualifying Event. The coverage includes:

- Medical coverage (including hospitalization and surgery);
- Prescription drug coverage;
- Employee assistance program benefits;
- Dental coverage;
- Vision coverage; and
- Hearing coverage.

You are **not** eligible to continue:

- Accidental dismemberment and loss of sight benefits;
- Weekly accident and sickness benefits;
- Supplemental occupational accident benefits; or
- Death benefits.

COBRA for Yourself

COBRA coverage is available to you if coverage would otherwise end because:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Plan;
- Your employment ends for any reason other than gross misconduct; or
- You are an Active Non-Bargaining Unit Employee and your employer no longer participates in the Plan because he or she no longer has employees covered under the collective bargaining agreement with the union.

COBRA for Your Dependents

COBRA coverage is available to your eligible dependents if dependent coverage would otherwise end because:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Plan;
- Your employment ends for any reason other than gross misconduct;
- You die, are divorced or legally separated, or become entitled to Medicare; or
- Your dependent ceases to be eligible for coverage under the terms of the Plan (see page 38).

Even if the participant rejects COBRA continuation coverage, each eligible dependent has the **independent** right to elect or reject COBRA continuation coverage. An election on behalf of a minor dependent child can be made by the child's parent or legal guardian.

You must notify the Fund Office in writing within 60 days of certain Qualifying Events, such as divorce, legal separation, or a child losing dependent eligibility due to age, in order for you and/or your dependents to be eligible for COBRA. **If notice is not received by the end of that 60-day period, the affected spouse or dependent will not be entitled to elect COBRA continuation coverage.**

In case of your death, termination of employment, reduction in hours or entitlement to Medicare, your Employer must notify the Fund Office within 30 days of the event.

Notice of a Qualifying Event should be sent to:

Fund Administrator
10003 Derekwood Lane
Suite 130
Lanham, MD 20706

The Notice must include the following information: name and address of affected participant and/or beneficiary, date of occurrence of the qualifying event, and the nature of the qualifying event. In addition, you should enclose evidence of the occurrence of the qualifying event (for example: a copy of the divorce decree, separation agreement or death certificate).

Financial Responsibility for Failure to Give Notice

If a participant or dependent does not give written notice within 60 days of the date of the qualifying event, or a Participating Employer within thirty days of the qualifying event, and as a result, the Plan pays a claim for a person whose coverage terminated due to a qualifying event, then that person or the Participating Employer, as applicable, must reimburse the Plan for any claims that should not have been paid. If the person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the person was his or her dependent.

How to Elect COBRA Continuation Coverage

Once the Fund Office receives notice of your or your dependent's Qualifying Event, it will send you and/or your covered dependents notice of the date your or your dependent's coverage ends and the information and forms you and/or your dependent will need to elect COBRA Continuation Coverage.

If you and/or any of your covered dependents do not elect COBRA continuation coverage within the later of the date coverage would otherwise end or 60 days after receiving notice from the Fund office of your and/or your dependents' right to elect COBRA coverage, you and/or they will not have any group health coverage from this Plan after coverage ends. The only way for you to regain eligibility under the Plan is by meeting the initial eligibility requirements as set forth in this SPD.

Cost of COBRA Coverage

Individuals who continue coverage under COBRA pay, on an after-tax basis, 102% of the Plan's cost of providing the benefits, except in cases of extended COBRA coverage due to disability where you can pay up to 150% of the Plan's cost for the 11-month extension (see page 47 for details). The amount you, your covered spouse, and/or your covered dependent child(ren) must pay for COBRA coverage is due monthly (first of the month with a maximum grace period of 30 days).

The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect. However, generally your premiums will remain in effect for at least a 12-month period before an increase.

You have up to 45 days from the date you elect COBRA to pay all initial amounts due. If you elect COBRA coverage within the election period but after the date your coverage ends, you will have to pay the initial required COBRA premiums retroactively to cover the elapsed period. The full monthly amount must be paid before coverage starts. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of the coverage month with a 30-day grace period. *For example, if you are paying for January coverage, your payment is due on January 1, but you have until January 31 to make the payment.*

If full payment of the amount due is not made by the end of the applicable grace period, your COBRA coverage will terminate and cannot be reinstated.

Duration of COBRA Coverage

Your COBRA coverage can continue for up to 18, 29, or 36 months depending on the COBRA Qualifying Event. The COBRA Continuation Coverage period begins on the date of loss of coverage (rather than on the date of the Qualifying Event).

18 Months

COBRA health coverage can continue for up to 18 months if you would otherwise lose health coverage because of:

- Your reduction in hours; or
- Your change from active to inactive work status due to your:
  - Resignation;
  - Discharge (except for discharge for gross misconduct);
  - Disability;
  - Strike;
  - Layoff;
  - Leave of absence, except for leave under the Family and Medical Leave Act (FMLA); or
  - Retirement.

29 Months

COBRA coverage can continue for up to a total of 29 months if you or an eligible dependent becomes permanently disabled (as determined by the Social Security Administration), within the first 60 days of COBRA coverage. You or your dependent must notify the Fund Office of the determination no later than 60 days after it was received and before the end of the initial 18-month COBRA period in order to be eligible for this extended coverage. It is important that you apply for Social Security disability benefits as soon as you become disabled because it can take time to receive an award determination from the Social Security Administration. Remember to notify the Fund office immediately upon receipt of the Social Security Administration's determination if you want to take advantage of the COBRA disability extension.

This extended period of COBRA coverage will end at the earlier of:

- The first day of the month that begins more than 30 days after the Social Security Administration has determined that you and/or your dependent(s) are no longer disabled;
- The end of 29 months from the date of the COBRA Qualifying Event; or
- The date the disabled individual becomes entitled to Medicare.

36 Months

Your dependents may extend their coverage to 36 months from the date of the first Qualifying Event, if, during an 18-month or 29-month period of COBRA Continuation Coverage, a second Qualifying Event occurs due to:

- Your divorce or separation;
- Your death; or
- Your dependent ceasing to be a dependent child under the Plan.

Your COBRA coverage can continue for up to 18, 29, or 36 months depending on the COBRA Qualifying Event.

Your dependents must notify the Fund Office in writing and in accordance with the notification procedures described in this Section in order to extend their period of COBRA Continuation Coverage upon the occurrence of a second qualifying event.

For example, assume Jack loses his job (the first COBRA Qualifying Event), and enrolls himself and his covered eligible dependents in COBRA coverage. Three months after his COBRA coverage begins, his child turns 26 years old and is no longer eligible for Plan coverage. This is a second Qualifying Event. Although Jack's coverage is limited to 18 months, Jack's child can continue COBRA coverage for 33 months, for a total of 36 months of COBRA coverage.

After your spouse or dependent loses coverage under another health plan you must enroll the spouse or dependent within 31 days.

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of your employment or reduction in your hours. However, the extended period of COBRA is available to any child(ren) born to, adopted by or placed for adoption with you (the active employee) during the 18-month period of COBRA Continuation Coverage.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of disability). As a result, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

Cost of COBRA Coverage in Cases of Disability

If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may charge employees and their families up to 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month period following the 18th month of COBRA Continuation Coverage.

Acquiring a New Dependent(s) while Covered by COBRA

If you acquire a new dependent through marriage, birth or placement for adoption while you are enrolled in COBRA Continuation Coverage, you may add that dependent to your coverage for the balance of your COBRA coverage period at an additional cost.

For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage. To enroll your new dependent for COBRA coverage, you must notify the Fund Office within 31 days. There may be a change in your COBRA premium amount in order to cover the new dependent.

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36 month COBRA coverage period, COBRA coverage also will end for your newly added spouse. However, COBRA coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the applicable COBRA period. The spouse or dependent must have been eligible for, but not enrolled in, coverage under the terms of the Plan, and when enrollment was previously offered under the Plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

After your spouse or dependent loses coverage under another health plan you must enroll the spouse or dependent within 31 days. Adding a spouse or dependent child may increase the amount you must pay for COBRA Continuation Coverage. The loss of coverage must be due to:

- Exhaustion of COBRA Continuation Coverage under another plan;
- Termination as a result of loss of eligibility for the coverage; or
- Termination as a result of employer contributions toward the other coverage being terminated.

Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

When COBRA Coverage Ends

COBRA coverage will be terminated upon the occurrence of any of the following events:

- The first day of the time period for which you don't timely pay the required COBRA premiums;
- The date all health care coverage offered by the Electrical Welfare Trust Fund terminates;
- The date on which the Fund is terminated;

- The date on which you or your eligible dependent(s) first become covered by another group health plan;
- The date on which you or your eligible dependent(s) first become entitled to Medicare (usually age 65);
- If you fail to follow the Fund's policies and procedures and take actions that would result in termination of coverage for an active employee for cause *(for example, if you submit false claims to the Fund)*;
- When the employer that employed you prior to the Qualifying Event has stopped contributing to the Plan and either: (i) establishes one or more group health plans covering a class of the employer's employees formerly covered under this Plan; or (ii) starts contributing to another multiemployer plan that is a group health plan;
- The applicable COBRA period (18, 29, or 36 months) ends.

Confirmation of Coverage to Health Care Providers

Under certain circumstances, federal rules require the Fund to inform your health care providers (through UHC) as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances:

- If a health care provider requests confirmation of coverage during the COBRA election period, and you, your spouse or your dependent child(ren) have not yet elected COBRA continuation coverage, UHC and/or the Fund will give a complete response to the health care provider about you and your dependents' COBRA continuation rights during the election period; and

- If, after you have elected COBRA continuation coverage, a health care provider requests confirmation of coverage for a period for which the Fund Office has not yet received payment, UHC and/or the Fund will give a complete response to the health care provider about you and your dependents' COBRA continuation rights during that period.

Coverage under the Plan is cancelled for you and your dependents as of the first day of a period of coverage (i.e., the applicable month) if the Fund does not receive the payment due. However, the Fund retroactively reinstates your coverage once the COBRA payment is made if paid during the 30-day grace period. If you and/or your dependents have not paid the applicable COBRA payment including during the applicable 30-day grace period, during this time UHC will inform the health care provider that you do not currently have coverage, but that you and your dependents would have coverage retroactively to the first day of the applicable coverage period if payment is made before the expiration of the grace period. Charges for services that are obtained during this grace period will not be paid by the Plan if payment is not received before the expiration of the grace period.

Interaction of COBRA, the Affordable Care Act and Medicare – Other Options

If you lose group health coverage under the Plan and become eligible for COBRA Coverage, you may also become eligible for other coverage options that may cost less than COBRA Coverage. For example, you and/or your family may be eligible to buy an individual plan through the Health Insurance Marketplace (the "exchange"), Medicaid, Medicare, the Children's Health Insurance Program ("CHIP") or other group health plan coverage (such as a spouse's plan) through a 30-day "special enrollment period", even if the other plan generally does not accept late enrollees. If you enroll in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about many of these options and about your rights under the Affordable Care Act at ***www.healthcare.gov***.

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. For more information visit ***https://www.medicare.gov/medicare-and-you.***

If you lose group health coverage under the Plan and become eligible for COBRA Coverage, you may also become eligible for other coverage options that may cost less than COBRA Coverage.

Medicare and Second Qualifying Events

If you become entitled to Medicare and you later have a termination of employment or reduction in hours, your eligible dependents would be entitled to COBRA Continuation Coverage either for: (a) a period for 18 months (29 months if the 11-month Social Security Disability extension applies) from your termination of employment or reduction in hours; or (b) 36 months from the date you became entitled to Medicare, whichever is longer.

If You Have Questions

Questions concerning your Plan or your COBRA Coverage rights should be addressed to the Plan at the address and telephone number listed at the beginning of this booklet. For more information about your rights under ERISA, COBRA, the Affordable Care Act, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about health insurance options available through the Health Insurance Marketplace, and to locate a representative in your area to whom you can talk about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Fund Office informed of any changes in your address and the addresses of family members. You also should keep a copy, for your records, of any notices you send to the Fund Office.

Life Events

Life Events

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected **when different changes occur**.

The following Life Events can affect your coverage or the coverage of your dependents. Contact the Fund Office as soon as possible when you experience, or expect to experience, any of the following:

- Marriage;
- Change in your address;
- Legal separation or divorce;
- Birth, adoption or legal guardianship of a child;
- Loss of your child's eligibility;
- Loss of your eligibility;
- Taking a leave of absence (including FMLA);
- Entering military service;
- Disability;
- Retirement;
- Medicare eligibility (due to age or disability); or
- Death.

What You Need To Do

- In general, you should notify the Fund Office at 301-731-1050 or at 1-800-929-3983 as soon as possible when you experience a life event.
- If you move, call or write to the Fund Office with your new address. Only you as the participant can make this change.
- If you're adding a dependent, if you or your dependent become covered under another plan, or if there is any change to your other insurance coverage, call or e-mail the Fund Office at info@ewtf.org to request the proper form you must complete and submit to the Fund. If more information is required after you submit the completed form, the Fund Office will contact you in writing.

If You Take a Leave of Absence (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave from employment during any 12-month period (26 weeks if the reason is to care for a spouse, child or parent who is a covered service member with a serious injury or illness) due to:

- The birth, adoption, or placement of a child with you for adoption;
- The need to provide care for a spouse, child, or parent who is seriously ill;
- Your own serious illness;
- Any "qualifying exigency" arising out of the fact that you, as a covered military member, are on active duty or call to active duty status, in support of a contingency operation (e.g., attending certain military events and related activities, making appropriate financial and legal arrangements, certain child care and related activities, attending counseling, certain post-deployment activities and issues arising from short notice deployment); or
- The need to care for a spouse, child or parent who is a covered service member with a serious injury or illness.

During your leave, you may arrange for your employer to continue all of your medical coverage and other benefits offered through the Plan. You are generally eligible for leave under the FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within 75 miles.

The Fund will maintain your eligibility status until the end of your leave, provided the contributing employer properly grants the leave under the FMLA and the contributing employer makes the required notification and payment to the Fund.

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave from employment during any 12-month period.

If You Enter Active Military Service

This Plan complies with the Uniformed Service Employment and Reemployment Rights Act (USERRA). Therefore, if you, as an eligible employee, go into active military service, including Reserve and National Guard Duty, the Fund provides you with the right to elect continuous health coverage for you and your eligible dependent(s) for up to 24 months, beginning on the date your absence begins from employment due to military service.

After 31 days, you must pay the cost of the coverage unless your employer elects to pay for your coverage in accordance with its military leave policy. The cost that you must pay to continue benefits will be determined in accordance with the provisions of USERRA by the same method that the Fund uses to determine the cost of COBRA continuation coverage.

You must notify your employer or the Fund office that you will be absent from employment due to military service unless you cannot give notice because of military necessity

or unless, under all relevant circumstances, notice is impossible or unreasonable. You also must contact the Fund office and elect continuation coverage for yourself or your eligible dependent(s) under the provisions of USERRA within 60 days after your military service begins. Payment of the USERRA premium, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the date of election of your USERRA coverage. Ongoing payments must be made by the last day of the month for which coverage is to be provided. You will not be billed; it is your responsibility to remit payments to the Fund Office. Late payments can result in termination of coverage.

Any period of leave of absence under the provisions of USERRA will not be counted as a break in coverage for purposes of determining your eligibility for benefits. Questions regarding your entitlement for leave under USERRA and Continuation Coverage should be referred to the Fund Office.

Reinstatement of Coverage after Completion of Military Service

In order to have coverage reinstated by the Plan after active military service, you must apply for reinstatement in accordance with USERRA. If your period of service in the uniformed services was less than 31 days, you must report to your employer for reemployment by the first day of the first full regularly scheduled work period after the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence.

If your period of service in the uniformed services was for 31 days or more but less than 181 days, you must submit an application for reemployment not later than 14 days after the completion of your period of service.

If your period of service was for more than 180 days, you must submit your application for reemployment with your employer within 90 days of release of service.

If you have been hospitalized, or are convalescing from an illness or injury incurred or aggravated during your tour of duty in the uniformed services, you have until your recovery from that illness or injury to submit an application for reemployment. However, that period of recovery may not exceed two years.

Please contact the Fund Office at 301-731-1050 or at 1-800-929-3983 for further questions regarding your entitlement to reinstatement of coverage after active military service.

If You Want to Dis-enroll

In general, the Plan's rules regarding eligibility govern whether you and your dependents have coverage under the Plan. However, if an otherwise eligible participant or dependent wants to dis-enroll from coverage, they may do so. **Once voluntarily dropped, an otherwise eligible dependent cannot be reenrolled unless s/he experiences a special enrollment event or the Fund otherwise is legally obligated to permit reenrollment**.

To dis-enroll from coverage, contact the Fund Office to request the Fund's disenrollment form, or download and print the form from the Plan's website at *www.ewtf.org*. Please note that no claims will be paid for any services received on or after the date on which the coverage terminates. This includes services received after the termination date for an injury or illness that occurred before the effective date of disenrollment.

Your Medical Benefits

Your Medical Benefits

Understanding Your Medical Benefits

Your Plan provides comprehensive medical coverage for you and your eligible dependents. The Plan participates in the UnitedHealthcare Choice Plus Network (UHC) to provide quality health care, convenience and savings to you, your dependents and to the Plan.

After you meet your annual deductible, most covered services are paid at 80% of the allowance. You're responsible for paying the other 20% of the allowance—your Patient's Responsibility. If you visit a non-UHC provider, you may be responsible for additional expenses as well, including any amount billed by the provider that exceeds the allowance. However, if you receive services from a non-UHC provider under circumstances in which you did not have an opportunity to determine, and were not aware of, the provider's status as a non-UHC provider prior to receiving the services (for example: emergency room services or anesthesiology services received at a UHC provider facility), then the Plan will treat the billed amount as the allowance and will pay 80% of such allowance. You will be responsible for the remaining 20%.

Advantages of Using the UHC Choice Plus Network

The Plan has contracted with the UnitedHealthcare Choice Plus Network (UHC). This organization works with thousands of the country's top medical providers, including doctors, medical labs and hospitals.

When you go to a UHC provider, the provider will:

- Agree to accept payment for services directly from the Plan;
- Ask members to pay their estimated Patient's Portion of the allowance at the time of service; and

The Power to Save

Although you are not required to use UHC network providers, you generally will save money by using UHC doctors, hospitals, labs and other providers.

For example: Let's say David has to go to the doctor to receive treatment. The Plan has determined that the allowance for this service is $200 per visit both in-network and out-of-network. The example below compares what the Plan pays and what David pays in and out-of-network.

UHC Doctor	Non-Participating Doctor
The UHC doctor's normal charge for this service is $250	The Non-Participating doctor charges $250 for this service
The allowed amount is $200 and UHC doctor accepts this as full payment.	The allowed amount is $200, but the Non-Participating doctor still requires $250 as full payment.
The Plan pays 80% of the allowance, or $160	The Plan pays 80% of the allowance, or $160
David's Patient's Portion is the remaining 20% or $40	David's co-payment is the remaining 20% of the allowance, or $40, plus the amount over the allowance, or $50.
David's out-of-pocket costs: $40	**David's out-of-pocket costs: $90**

Telemedicine Services

In addition to the in-person medical visit coverage described in this Section, Participants and Dependents also have unlimited, toll-free access or web-based video access to a licensed physician for medical and behavioral health consultations and health information services through Teladoc. Consultations are available on-demand 24 hours a day, 365 days per year and scheduled consultations are available between the hours of 7 a.m. to 9 p.m., seven days a week. To access such services by telephone, please contact Teladoc at 1-800-TELADOC or go to www.teladoc.com. You also may download Teladoc's secure video-based app on your smartphone, desktop or tablet. These telemedicine services are available at no cost to you.

Self-Funded Plan

UnitedHealthcare is not your insurance company. The EWTF Plan is "self-funded" private health plan. This means that your employer's contributions—and any income earned from investments of your employer's contributions—pay for the health care expenses that you and your fellow participants incur under the Plan. The EWTF Plan makes the final decisions about what is covered and what is paid and EWTF writes the checks to pay benefits.

Provider Directories

For the most up-to-date information about all participating providers call the Fund Office at (301) 731-1050 or 1-800-929-EWTF or visit the UHC website at ***http://directory.uhis.com*** or the UHC link on the EWTF website (www.ewtf.org). This is the best way to get a list of all network doctors, hospitals, labs, emergency centers, etc. Be sure to check with your providers before you make a UHC appointment to be certain that they still participate in the UHC network.

Find dental providers by visiting the CIGNA Dental website at ***www.cigna.com***.

EWTF Benefit Card

When you and your family first become eligible in the Plan, you will receive information and an EWTF Benefit Card that identifies you as a network member. You will need to use this card to receive network health care services, prescription drugs and dental care. Your UHC Group Number is 78-340001. The last six digits of the 12 digit number appearing on your card will be used when submitting dental claims or for filling prescriptions at your local pharmacy.

Always identify yourself as an EWTF participant covered by the UHC network by showing your EWTF Benefit Card to any doctor, pharmacy, dentist or other provider you visit. If the provider is a network member, you will start saving money right away.

Out-of-Pocket Maximum (Catastrophic Benefit)

Note: This benefit provided for Standard Plan (full) coverage only; no provision for “H” Plan (limited) coverage.

The Plan limits the amount of eligible expenses you have to pay each year. Once you have provided written proof to the Fund Office that you have paid the out-of-pocket maximum of $8,000 per family in a calendar year, EWTF will pay 100% up to the allowance of your eligible expenses for the rest of the calendar year. This benefit provides great protection in those situations where an individual or a family may suffer a financial hardship due to a very serious illness or accident.

What the Out-of-Pocket Maximum Does Not Include

Your annual deductible;

- Services that are not covered under the Plan (for example, cosmetic surgery, TMJ treatment, fertility/infertility treatments, etc.);
- Dental and vision expenses; and
- Charges above the Plan’s allowance.

Hospitalization and Surgery

The Plan provides coverage for hospitalization and surgery—including organ transplants—for you and your eligible dependents.

What You Need To Do

If you are going to be hospitalized, call UHC at 1-800-850-1418 to have your hospital stay pre-authorized to make sure your expenses are covered to the fullest extent possible.

- If your doctor recommends elective surgery, you may contact another physician to obtain a second opinion.

You will need to use the EWTF benefit card to receive network health care services, prescription drugs and dental care.

Hospitalization

Covered Hospital expenses are paid at 100% of the allowance for expenses up to the first $7,000 per spell of illness. A spell of illness is a period beginning when you are first confined in a hospital, nursing home, or other approved facility and ending when you are discharged and:

- You recover completely from the condition causing the confinement
- You go at least one year during which you are not confined again for the same condition.

After that, covered hospital expenses are paid at 80% of the allowance. No deductible applies.

Covered Hospital Expenses include charges made by a hospital for:

- Semi-private accommodations;
- Drugs;
- Use of the intensive care or coronary care unit;
- Use of the operating room or other specialized facilities;
- Diagnostic testing; and
- Other covered ancillary charges.

Pre-Admission Review and Approval through UHC

A part of the Fund's agreement with UHC is the "utilization" or "pre-admission" review program. When you are going into the hospital, call UHC case management and review services at 1-800-850-1418. Doing so will not only ensure the quality of the services you receive both in the hospital and from your attending physician, but it also can save you hundreds, if not thousands, of dollars in hospital and doctor charges.

When your doctor schedules a hospitalization for you, the doctor or the hospital will call UHC for information about benefits, eligibility and pre-authorization. Generally, UHC will review the clinical information necessary to determine eligibility for benefit coverage and will verify eligibility and basic benefits for services that meet clinical guidelines for medical appropriateness. The UHC case management service will, if they establish clinical eligibility for coverage, pre-authorize the hospital stay. **(Note: This pre-autho-**

rization is not a guarantee of coverage under the Plan.) They will then monitor your hospital stay and assist in discharge planning, equipment rental, home health care, and other appropriate services.

The UHC Case Management Program is designed to ensure that in-patient and post-hospital services are covered to the full extent allowed under the Plan. This will help minimize your out-of-pocket expenses and will allow you to take advantage of any discounts offered. The case management service is available nationwide, regardless of whether your doctor or hospital is a member of the UHC network.

EWTF will not cover hospitalization for a procedure if it is normally provided on an out-patient basis unless UHC approves the hospital stay in advance.

Surgery

The Plan will pay 80% of the allowance, after you've satisfied your annual deductible, for charges related to surgery such as:

- Charges by physicians and surgeons in or out of the hospital (including attending physician, consulting physician, and anesthesiologist);
- Services of a licensed speech therapist or physiotherapist (prior authorization by UHC is required before beginning any treatment or services);
- Anesthesia and its administration;
- Breast reconstructive surgery following mastectomies;
- Treatment of a fracture or dislocation of the jaw, oral surgery, or treatment of natural teeth, if medically appropriate as the result of, and within 12 months after, an accidental injury;
- 25% of surgeon's charges to cover an assistant or co-surgeon; and
- Emergency medical care expenses.

Outpatient Surgery

If you or your dependent receives outpatient surgery at an approved facility, the Plan will pay 100% of the allowance for the facility fee up to the first $7,000 in covered expenses. After that, the Plan will pay 80% of the allowance.

Second Surgical Opinion

To help eliminate unnecessary surgery, you may wish to obtain a second surgical opinion before undergoing elective (non-emergency) surgery. The second opinion must be performed by someone other than your surgeon and not affiliated with your surgeon.

The Plan pays the full cost of obtaining a second surgical opinion. If the first and second opinions differ, the cost of a third opinion is also covered, on the same terms as the second surgical opinion.

If the second opinion is the same as your surgeon's, you will have added peace of mind. If the consultant advises you against the operation, you may obtain a third opinion. Regardless of the outcome, if you still want to proceed with the surgery, you are free to do so. The choice is yours.

The Plan pays the full cost of obtaining a second surgical opinion.

What's Not Covered

No benefits are payable in connection with a second surgical opinion relating to the following:

- A consultation with anyone who is not certified to perform the proposed surgery;
- More than two consultations with a surgeon after the initial determination, in connection with the proposed surgery;
- Any consultation with a physician who performs the surgery or has a financial interest in the outcome of the recommendation;
- Any consultation in connection with a proposed surgery for which a surgical expense benefit would not be payable under this Plan; or
- Any consultation unless the patient is examined in person by the surgeon rendering the second opinion.

Please see page 19 for an in-depth listing of your Plan's exclusions.

You and your spouse are eligible for an annual physical exam. The Plan will pay 80% of the allowance, after you've met your annual deductible.

Organ Transplants

The cost of an organ transplant is covered the same as any other surgery, provided the following conditions are met:

- The transplant procedure is not considered experimental or investigational;
- Patient screening, including an opinion rendered by a qualified medical professional employed by the Trustees, confirms the appropriateness of the transplantation; and
- The patient is admitted to a transplant center program at a major medical center approved by the Board of Trustees.

In addition, the UHC network includes Transplant Resource Services, which provide network access to qualified transplant facilities that have high-quality, cost effective transplant care.

Charges for immunosuppressant drugs prescribed in connection with organ transplants are considered medical expenses.

What's Not Covered

- Charges for any individual not covered by this Plan; and
- Charges for a donor covered by this Plan if the charges are not directly related to the transplant procedure itself.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Disease Management Program

The Plan provides a Disease Management program to help you and your dependents better manage certain chronic conditions in order to live a healthier life. The Disease Management Program starts with an outreach from the Fund's disease management provider. Participating in the Disease Management program is completely free, voluntary and confidential. Please contact the Fund office for more information if you or your dependent have a chronic health condition and are interested in participating in the Fund's Disease Management Program but have not yet been contacted by the Fund or its provider.

Routine Physical Exam for Member and Spouse

You and your spouse are eligible for an annual physical exam. The Plan will pay 80% of the allowance, after you've met your annual deductible. **NOTE:** Medicare-eligible retirees and their Medicare-eligible spouses are entitled to the Routine Physical Exam benefit only if the services are covered by Medicare. The Plan's annual deductible does not apply to Medicare-eligible retirees.

The Routine Physical Exam also includes coverage (including administration) for Zostavax, a vaccine for the prevention of herpes zoster (shingles). Benefits for this vaccine are paid at 80% of the allowance and are not subject to the annual deductible. **NOTE:** The Zostavax vaccine benefit is not subject to the annual deductible and is also available to Medicare-eligible retirees and their Medicare-eligible spouse (provided such retirees or spouse are not enrolled in a separate Medicare Part "D" prescription plan).

Child Wellness Visits and Examinations

Your eligible children are covered under this Plan for regular wellness visits and examinations. Your benefit includes the required childhood immunizations. Benefits are paid at 80% of the allowance after you've met your annual deductible according to the following maximums:

- Children from birth through age 23 months for a maximum of seven visits; and
- Children age two through age 26 for a maximum of one visit per year.

Well Woman

EWTF encourages women to have an annual wellness exam. The Plan provides the following at 80% of the allowance after you've met your annual deductible:

- One routine pap smear per year and related office visit; and
- One mammogram per year for women age 35 or older.

EWTF encourages women to have an annual wellness exam.

Bariatric Surgery

Summary

UnitedHealthcare's Bariatric Resource Services (BRS) administers this program. Certain criteria determined by BRS must be met prior to a patient having surgery, in order for the surgery to be covered under the Plan.

Bariatric Resources Services (BRS)

BRS is a surgical weight loss solution for those individuals who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. The program is dedicated to providing support both before and after surgery. Nurses help with support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence (COE). A COE is a facility that is a top performing, quality bariatric center that delivers improved clinical and economic outcomes.

After you meet the annual deductible, the Plan pays 80% of the allowance for outpatient medical expenses required for the diagnosis and/ or treatment of an injury or illness.

All authorization for, information about and enrollment for bariatric surgery must be initiated through the BRS Program. Covered participants seeking coverage for bariatric surgery should notify BRS as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) by calling the Bariatric Resource Services program at 1-888 936-7246 to enroll.

Criteria

The Plan covers surgical treatment of morbid obesity, provided all of the following are true:

- You are over the age of 18 and are physically mature;
- You have a minimum Body Mass Index (BMI) of 40, or > 35 with at least 1 co-morbid condition present;
- One (1) surgery is covered per lifetime unless medically necessary complications arise;
- You must use a UnitedHealthcare BRS Bariatric COE;
- You must have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation;
- You must have completed a 6-month physician supervised diet documented within the last 2 years (the physician supervised diet is not covered by the Plan);
- Revisions (performed primarily for weight gain) are excluded from coverage under the Plan; and
- Excess skin removal is not covered under the Plan, unless medically necessary.

Once the criteria are met and it's time to choose where the patient has the procedure, the case manager will direct the patient to a COE.

Benefit Coverage

The benefit provides for one (1) surgery per lifetime. The all-inclusive maximum lifetime benefit relating to this procedure is $100,000. This includes benefits paid at the normal coverage rate for the surgery plus all procedures and pre- and post-operative expenses but does not include services resulting from complications due to the surgery. After the $100,000 maximum is reached, eligible expenses are covered at 50%.

Questions

Questions that are specifically related to the Bariatric Resource Services program should be directed to 1-(888) 936-7246.

Gardasil

In general, vaccines and immunizations are covered only for patients up to the age of 18. However, in light of the indications of the effectiveness of Gardasil and the benefits of helping to protect against HPV, the benefit applies to all eligible members through the end of their 26th year and dependents through the end of the month in which

they reach age 26. Benefits are paid at 80% of the allowance after the annual deductible is met.

Outpatient Medical Expenses

After you meet the annual deductible, the Plan pays 80% of the allowance for outpatient medical expenses required for the diagnosis and/or treatment of an injury or illness.

The following are considered covered outpatient medical expenses:

- X-ray examinations and diagnostic laboratory and pathology tests;
- Radiation therapy, including charges for X-ray, radon, radium and radioactive isotope treatments;
- Surgical dressing, splints, trusses, braces and crutches;
- Oxygen and its administration, including the rental of necessary equipment;
- Blood transfusions, including the cost of blood, blood plasma and plasma expanders;
- Surgical appliances required to replace or aid natural organs or body parts, including, among others, artificial limbs, eyes, and larynxes, and electronic heart pacemakers;
- Rental (or purchase if more cost-effective) of durable medical equipment;
- Physician services;
- Services of a licensed speech therapist or physiotherapist (prior authorization by UHC is required before any services or treatment begins);
- Contraceptive devices not available over-the-counter;
- Anesthesia and its administration; and
- Treatment of a fracture or dislocation of the jaw, oral surgery, or treatment of natural teeth, if medically appropriate as the result of, and within 12 months after, an accidental injury.

If you or your dependents require care in a nursing home, a hospice, or care in your home from a registered nurse or licensed practical nurse, the Plan will pay a percentage of covered costs when this type of care is required.

What's Not Covered

- Dental x-rays unless required as a result of an accidental injury to natural teeth (see page 85);
- Any medical care not prescribed by or under the direction of a physician; and
- Medical services or supplies determined by the Board of Trustees as not medically appropriate for the care or treatment of any illness or injury.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Covered Chiropractic Care

After the annual deductible, the Plan pays for chiropractic care at 80% of the allowance.

What You Need To Do

After the first 20 chiropractic visits covered by the Fund, you must obtain a referral from your doctor to verify that any chiropractic services are medically appropriate in order for charges to be considered for payment. Then contact the UHC Prior Authorization Department at 1-800-850-1418.

While services such as manual manipulation and electrical stimulation are generally covered if *medically appropriate*, the administration of services such as the application of hot packs and cold packs and other routine self-care services are not covered.

What's Not Covered

- Exercise and wellness regimes and expenses;
- Physical therapy by a chiropractor unless referred by a medical physician;
- Hot and cold packs;
- Routine self-care services;
- Nutritional supplements; and
- Care that is not medically appropriate.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Home Health Care, Nursing Home Care and Hospice Care Benefits

If you or your dependents require care in a nursing home, a hospice, or care in your home from a registered nurse or licensed practical nurse, the Plan will pay a percentage of covered costs when this type of care is required. ***These benefits must be pre-authorized in order to be covered under the terms of the Plan.***

What You Need To Do

If you are in need of home health care, contact the UHC CARE Program at 1-800-850-1418 for pre-approval. For care in a hospice, call the UHC CARE Program at 1-800-850-1418 to pre-approve the facility.

Home Health Care

The Plan covers expenses for home health care instead of hospitalization or beginning within 24 hours after discharge from a hospital confinement. The Plan will pay 80% of the allowance for covered home health care visits by a registered nurse or licensed practical nurse, after you've met your annual deductible. The Plan will pay 100% of the allowance for home health care visits by a home health care aide.

Covered home health care expenses will be paid, provided that the home health care service:

- Is required for care or treatment of an injury or illness which resulted in covered medical expenses;
- Consists of in-home visits by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) or home health care aide under supervision of a Medicare-certified home health care organization; and
- Is approved in advance by the UHC Clinical Services Program 1-800-850-1418.

Nursing Home Care

After a hospital stay, the Plan will reimburse for convalescent nursing home expenses up to 50% of the average semi-private room rate charged by the discharging hospital for up to 60 days per spell of illness.

When combined with hospital expenses for the same spell of illness, covered nursing home expenses are payable at 100% of the allowance up to the maximum benefit of $7,000. Charges that exceed $7,000 combined hospital and nursing home expenses are payable at 80% for the same spell of illness.

Convalescent nursing home confinement is considered "required" only if it:

- Is ordered by the attending physician;
- Begins within seven days of discharge from a hospital confinement of at least two days; and
- Is due to an illness or injury resulting in covered medical expenses.

Hospice Care

The Plan pays 100% of the allowance for hospice care in a pre-approved facility or by an approved hospice care provider for in-home care. Call UHC at 1-800-850-1418 to pre-approve the facility or provider.

Durable Medical Equipment

Durable medical equipment (DME) is reusable medical equipment such as walkers, wheelchairs, or hospital beds. In general, DME is covered at 80% of the allowance. DME must be medically appropriate and directly related to the treatment of the patient's particular illness or injury. Limitations may exist on the rental of some DME. Before renting or buying DME, it is recommended that you contact the Fund Office at 301-731-1050 or at 1-800-929-3983 to verify that the equipment is covered.

Gynecological Care and Maternity

Benefits for gynecological and maternity care are payable on the same basis as expenses resulting from an illness. After you have satisfied your annual deductible, covered charges made by a surgeon or a physician are payable at 80% of the allowance. If you have participated in the free "Healthy Pregnancy Program" offered through UHC, benefits are payable at 85% (rather than 80%) of the allowance for delivery charges by the obstetrician. For information about child wellness visits and immunizations, see page 65. Dependent children are not eligible for maternity care.

"Healthy Pregnancy" Maternity and Pre-Natal Healthy Baby Program

UHC provides a prenatal education and information program to all EWTF members and spouses. The objective of this program is to promote good health for mother and child, and to reduce the incidence and severity of Neonatal Intensive Care Unit needs by identifying high-risk pregnancies and enrolling members into specialized obstetrical case management. The Plan covers allowable delivery charges for the attending obstetrician at 85% (rather than 80%) for those participants who have participated in this "Healthy Pregnancy Program."

What You Need To Do

Contact UHC at 800-850-1418 as soon as you or your spouse's pregnancy is confirmed to receive free pre-natal care information through the "Healthy Pregnancy Program." If you have any questions regarding maternity benefits or payment of claims, please contact an EWTF Service Representative at (301) 731-1050.

Maternity

Maternity care expenses for a member or the member's spouse can include emergency care, charges by physicians and surgeons in or out of the hospital, assistants or co-surgeons, and anesthesiologist's charges. No maternity coverage is provided for a member's pregnant child.

Hospital Expenses for Mother/Newborn Child

The first $7,000 of eligible expenses for room and board and other hospital services are paid in full for both the covered mother and newborn child (100% of the allowance, no deductible applies). For expenses in excess of $7,000, the plan will pay 80% of the allowance. You must notify the Fund office and enroll your newborn in the Plan within 30 days from birth. No coverage is provided for the newborn child of a covered dependent child.

Obstetrician's Charges

The physician's charges are paid at 80% of the allowance after you've satisfied your annual deductible. If you participated in the "Healthy Pregnancy Program," the benefits are paid at 85% once the annual deductible is met.

Charges for global obstetrical/pregnancy services (antepartum care, delivery, and post-partum care) are paid after the birth of the child.

Services of a Midwife

The Plan pays 80% of the allowance for obstetrical services for delivery at home by a midwife. The midwife must be a certified nurse, work through a medically directed service organization and be under the direct supervision of a board certified Obstetrician-Gynecologist throughout pre-natal care, delivery, and during postpartum care. If the services of a nurse-midwife are used, no benefits are payable for charges by an obstetrician unless required due to complications.

Duration of Hospital Stay Following Childbirth

The Plan does not require that a provider obtain prior authorization from UHC or issuer for prescribing a length of stay less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

If you have participated in the free "Healthy Pregnancy Program" offered through UHC, benefits are payable at 85% (rather than 80%) of the allowance for delivery charges by the obstetrician.

Mastectomy and Breast Reconstructive Surgery

In accordance with the Women's Health and Cancer Rights Act of 1998, this Plan will provide the following coverage for a Participant or Dependent who is receiving benefits in connection with a mastectomy and who elects breast reconstruction surgery following such mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of the mastectomy, including lymphedemas.

What's Not Covered

- In-vitro fertilization, artificial insemination, or other treatment of infertility, or services to reverse tubal ligation, vasectomy, or other voluntary, surgically induced fertility;
- Abortions, unless justified by a physician as medically appropriate to protect the life of the patient, or with prior written approval of the Fund Office, when certified in writing by a physician who is board certified in obstetrics and gynecology prior to performing the procedure, that the fetus suffers from a severe performing disability which is likely to seriously affect the quality of life of the child if the pregnancy were carried to term; and
- Charges incurred by a dependent child in connection with pregnancy, childbirth, miscarriage or related medical condition.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Prescription Drug Benefits

Prescription Drug Benefits

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage.

The Plan has an agreement with **CVS Caremark**, a Pharmacy Benefit Manager, to help administer your prescription drug benefit. Under the agreement, if you purchase prescription drugs from pharmacies that participate in the program, you will save money.

Medicare Part D

The EWTF Plan provides prescription benefits to Retirees. The Plan's actuary has determined that the benefits provided under the Plan exceed the Medicare Part D prescription coverage for Medicare eligible participants. The Plan therefore receives a subsidy from the Medicare program for providing these benefits. If you or a covered dependent enrolls in a separate Medicare Part D program, you will **permanently** lose your prescription benefits with EWTF.

Purchasing your maintenance medication (medication like insulin or blood pressure medication that you take on an on-going basis) by mail order is the most cost-effective method.

Mail Service Program

Purchasing your maintenance medication (medication like insulin or blood pressure medication that you take on an on-going basis) by mail order is the most cost-effective method. You are allowed two (2) fills of a maintenance medication at your local pharmacy before you are required to use the CVS Caremark Mail Service.

To order prescription drugs by mail, go to the CVS Caremark website at ***www.caremark.com*** or contact the Fund Office for a mail order form. You may also contact CVS Caremark at 1-800-386-0329 for a mail order form. Medications can be ordered for pick-up at a CVS pharmacy by going to the CVS website at ***www.cvs.com***.

Using Your Prescription Card

When you need to fill a prescription quickly and your prescription is not subject to the Mandatory Mail Order Program described above, you may use your EWTF Benefit Card at a participating CVS Caremark Network pharmacy and make your co-payment of $10 for each generic prescription, $25 for each preferred (brand) prescription or $35 for each non-preferred brand prescription. You should check with your pharmacy to be sure that it participates in the Caremark Prescription Drug Program. **NOTE:** Wherever possible, use CVS Caremark's Mail Order Program or a CVS pharmacy—it saves you time and money!

There is a 34-day limit for prescriptions filled over the counter at local pharmacies other than CVS pharmacies. To reduce your costs, any of your long-term medication needs must be directed to the mail order program or to a CVS pharmacy.

You should always provide your EWTF Benefit Card. But after presenting your card, you should ask your pharmacist for the retail price of the drug you are purchasing. In some cases, the retail price will be less than the co-payment so in such cases it would be to your advantage to self-pay for the prescription.

Using a Non-Network Pharmacy

If you do not use your EWTF Benefit Card, you are required to pay the full cost when you purchase a prescription drug. You may then request a form for direct reimbursement from the Fund Office and submit it along with your bill to:

Caremark Claims Department
PO Box 52196
Phoenix, AZ 85072-2196

For example:

Darrell needs to have his prescription filled. The retail cost for the brand name for his prescription is $150; however, the Plan's discounted wholesale price for this drug is $55.

With EWTF Benefit Card (Participating Pharmacy)	Without EWTF Benefit Card (Non-Participating Pharmacy)
Darrell pays his $25 co-payment	Darrell pays the entire cost of the prescription up front ($150)
	Darrell requests a form from the Fund Office for direct reimbursement
	Darrell submits his form with the prescription receipt to CVS Caremark and receives reimbursement for $30. ($55 minus the $25 co-payment)
Darrell's total out-of-pocket cost—$25	**Darrell's total out-of-pocket cost—$120**

Prior Authorization

Prior Authorization (PA) is a tool to screen a prescribed drug or drug class by specific criteria. Caremark's Prior Authorization tools are comprised of objective criteria that are based on sound clinical evidence.

If your physician prescribes a brand medication that is no longer on Caremark's formulary list or another prescribed medication that requires prior authorization, you or your doctor may call the PA team at 1-800-626-3046 to find out what information is needed in order for the PA team to make an informed decision.

Drug Choice Management Program

Please Note: In order to help control costs for you, your eligible family members and for the EWTF Plan, the CVS Caremark network will, if appropriate, recommend a "preferred medication" for some prescriptions. When you present a prescription to a participating pharmacy, the pharmacist, "on-line" with CVS Caremark, may receive information that there is a "preferred" medication that is a less costly alternative. If you and the pharmacist agree to the alternative, the preferred medication will be dispensed. If you do not agree, the original prescription will be filled. Either way you receive your prescription without delay.

If the alternative medicine is not chosen, CVS Caremark will write to your physician communicating the alternative medicine. If the doctor agrees with the change, the preferred medication will be written on a replacement prescription and sent to the pharmacy. Then, the preferred medication will be provided when your prescription is refilled. If the physician does not agree, the original medication will continue to be provided on refills. No change is made without the approval of your physician.

If your physician mandates the use of the drug prescribed and would not authorize substitution of an equivalent medication, a network preferred medication, or a generic substitute, the physician can make that clear when writing the prescription.

Specialty Pharmacy

Specialty drugs are medications that are typically high-cost and require a customized medication management program, including medication use review, patient training, coordination of care, and adherence management for successful use. These drugs are used to target chronic or complex disease states.

CVS Caremark operates specialty pharmacies to deal with this class of medications, including handling and delivery of specialty pharmaceuticals that have very limited stability and shelf lives.

More information about the CVS Specialty Pharmacy can be found at: www.cvscaremarkspecialtyrx.com.

Opioid Utilization Management Program

The Plan works with CVS Caremark to address opioid abuse and/or misuse by providing no more than a 3 day supply of an immediate release (IR) opioid prescription for recipients age 19 or younger unless:

- A Prior Authorization (PA) is obtained; or
- The prescription is for cancer treatment; or
- The prescription is for sickle cell disease treatment; or
- The prescription is for palliative care.

CVS Health Vaccination Program

The Plan has implemented the CVS Health Vaccination Program to cover the administration of seasonal influenza vaccinations under the prescription drug benefit at participating pharmacies in CVS Health's broad retail vaccination network. Under this program, the influenza vaccine is covered at 100%, with no cost to you and your eligible dependents. Please note that the program is effective from August through April (or per individual state requirements) and the seasonal vaccines can only be administered once the vaccine has been released to the marketplace by the manufacturer.

Covered Expenses

The Plan covers a portion of the cost of covered prescription drugs, including:

- Legend drugs;
- Injectable insulin and a limited coverage for diabetic supplies;
- Other state-controlled drugs prescribed by a doctor and dispensed by a pharmacy for treatment of a non-occupational illness or injury;
- Vitamins available by prescription only and which do not contain mineral supplements, provided there is no over-the-counter equivalent; and
- Anti-obesity drugs (which must be prior authorized by having the prescribing provider contact CVS Caremark at 1-800-626-3046).

What's Not Covered

No benefits are payable under this provision for:

- Any drug removed from the formulary list by the pharmacy benefit manager;
- Any drug not requiring a prescription, unless the drug is a compound of two or more drugs which may be compounded only by prescription;
- Any experimental or investigational drug;
- Fees for administration of a drug or insulin;
- Medication to be taken at the place it is dispensed;

- Medication taken while hospitalized or a patient in an approved facility (The cost of some medication taken while in a nursing home may qualify for reimbursement under the medical plan. For more information, contact the Fund Office.);
- Refills exceeding five in a six-month period, or the number specified by the prescribing doctor;
- Refills more than six months from the date of the original prescription;
- Medication otherwise available free under a local, state or federal program (e.g., workers' compensation);
- Fertility drugs;
- Erectile dysfunction drugs;
- Laetrile, enzymes, vitamins, minerals and dietary supplements (except as specifically covered under this Plan);
- Drugs to enhance sexual performance;
- Drugs, medicines and supplies intended for personal hygiene use, such as toothpaste and cleaning devices;
- Wigs;
- Therapeutic devices such as support garments, hypodermic needles, or syringes, except if used for insulin; and
- Take-home drugs or medicines, except when provided as part of emergency room treatment under special urgent circumstances which do not permit use of the regular prescription drug benefit procedures.
- Drugs excluded under the CVS Drug Exclusion Plan Design Strategy Program

Please see page 19 for an in-depth listing of your Plan's exclusions.

If you have a question about whether or not a new drug is covered by the Plan, contact the Fund Office at 301-731-1050 or at 1-800-929-3983.

Employee Assistance Program

Employee Assistance Program

Note: This benefit provided for both Standard Plan (full) and "H" Plan (limited) coverage.

The Employee Assistance Program (EAP) is a free, confidential program that provides **counseling services for you and your family**. The EAP, provided through Business Health Services, has counselors available **24 hours a day, seven days a week** to help you deal with job stress, depression, marital, family or financial problems. Use the EAP to navigate through the process of finding an appropriate mental health professional if your issue cannot be treated within the eight free sessions. Contact the EAP by calling 1-800-765-3277.

How the EAP Works

If you are having trouble dealing with job stress, financial issues, depression or family problems, contact the EAP by calling 1-800-765-3277. A counselor will speak with you and set up an appointment, if necessary. You may meet with your counselor for up to eight free counseling sessions. Also, the counselors at Business Health Services (BHS) can refer you to a qualified, low- cost, or no-cost provider or program through the UHC network to meet your needs. See page 11 for information about your Mental Health benefits.

If your level of care or the name of the person/provider changes, you should contact the EAP for free access to the Benefit Navigation Program.

Mental Health and Substance Misuse Benefits

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage.

You and your family members are eligible to receive inpatient or outpatient care for the treatment of mental health and substance misuse. The Plan will pay for covered expenses, including hospitalization and psychological testing, if clinically appropriate.

Benefit navigation with the EAP for any mental health or substance misuse treatment is available. Contact the EAP by calling 1-800-765-3277.

What You Need To Do

You should contact the EAP at 1-800-765-3277 for benefit navigation before beginning any course of mental health or substance misuse treatment. Next, set-up an appointment to meet with an EAP counselor for an assessment and, if appropriate, a referral. If you are referred to a provider for treatment, be sure to show your EWTF ID card to receive the Plan discounts. Give the provider the group number 78-340001. The provider should make sure this number is on each claim that is submitted on your behalf.

Outpatient Benefits

Benefits for outpatient treatment for mental health and substance misuse are paid at 80% of the allowance once the annual deductible has been met. Outpatient services may be rendered by a physician, psychiatrist, psychologist or a duly licensed and certified social worker (if the services are clinically appropriate and given under the supervision of a physician).

Inpatient Benefits

The first $7,000 of eligible expenses for room and board and other covered inpatient services are paid in full. Charges you incur that exceed $7,000 are paid at 80% of the allowance.

Psychological Testing

Benefits are payable at 80% of the allowance subject to the annual deductible. When psychological testing has been ordered to determine if the patient has Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD), contact BHS for benefit navigation and referral to a provider of service.

Filing Claim

If you use a participating provider, your claims should be mailed to:

UnitedHealthcare Integrated Services
PO Box 30783
Salt Lake City, UT 84130-0783

EWTF Group Number

The group number for EWTF is 78-340001. The group number should be given to each provider and included on each claim submitted.

What's Not Covered

The Plan does not provide benefits for:

- Court ordered treatment; or
- Marriage counseling (except through the EAP benefit).

See "Expenses that are Not Covered" on page 19 for more information.

If you are having trouble dealing with job stress, financial issues, depression or family problems, contact the EAP by calling 1-800-765-3277.

Dental Benefits

Dental Benefits

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage.

Healthy teeth and gums are an important part of your overall health. That's why the **Plan will pay 100% of covered expenses for preventive dental services when you visit a CIGNA Dental PPO provider for dental care**. Your dental benefits network is with **CIGNA Dental.** Of course, you are free to visit any dentist you wish, but you can save yourself, your covered dependents, and the Plan money if you visit a dentist who participates in the CIGNA Dental Network. You also may locate a participating dental provider by visiting *www.cigna.com*.

To find a participating provider, you may visit the CIGNA website (www.cigna.com).

What You Need To Do

To find a participating provider, you may visit the CIGNA website (*www.cigna.com*). When you make your appointment, identify yourself as a member of the EWTF. Show the provider your EWTF ID card to be eligible for the PPO discounted rates. If you are having any dental service that is expected to cost more than $600, you must have your dentist complete a "treatment plan" form (see page 84). These forms are available from the Fund Office.

Maximum Annual Benefit (Age 18 & Older)

The Plan pays for necessary dental care as described in this section, up to $3,000 per covered adult per calendar year. There is no dollar limitation for covered dental services rendered to an eligible patient under age 18.

For a list of preferred provider dentists convenient to you, please visit the CIGNA web-site at *www.cigna.com* or contact the Fund Office at 301-731-1050 or at 1-800-929-3983.

Please be sure to show your EWTF ID card when you go for your appointment. If you do not have the dental designation on your card, the participating dental providers do not have to honor the Plan's discounted rates and you will be responsible for any balance after the Fund Office processes the claim.

Submitting your Dental Claims

When you use a CIGNA PPO provider, your dentist will submit your claims for you. All CIGNA dental claims should be electronically transmitted to EDI# 30506 or mailed directly to:

EWTF
PO Box 21274
Eagan, MN 55121

EWTF Group Number

The dental group number is 3339689.

Non-PPO Dental Coverage

You are not required to visit a CIGNA PPO provider to receive dental care. If you visit a dentist who does not participate in the CIGNA PPO, you are responsible for payment of the amount the dentist charges above the PPO discounted rate in addition to your Patient's Portion.

You may need to pay for services at the time you receive them and submit a claim form to apply for reimbursement. Send the completed claim form to:

Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811

Covered Preventive Services

Preventive Services are payable at 100% of the allowance when you visit a PPO provider, or 80% of the allowance when you visit a non-PPO provider, up to an annual maximum of $2,000 (except for dependent children under age 18).

Covered Basic Dental Services

The schedule on page 12 shows the Basic Dental Services that are covered by this Plan. Most Basic Services are covered at 80% of the allowance, in or out of the network, up to an annual maximum of $2,000 (except for dependent children under age 18). Remember—if you visit a dentist who does not participate in the CIGNA Dental PPO, you are responsible for charges above the allowance, if any. Refer to the Schedule of Benefits on page 12 for a list of how dental services are paid.

Covered Major Dental Services

The schedule on page 12 shows the Major Dental Services that are covered by this Plan. If you use a CIGNA PPO provider, Major Services are covered at 80% of the allowance up to an annual maximum of $2,000 (except for dependent children under age 18). If you do not use a PPO provider, Major Services are covered at 50% of the allowance.

Covered Orthodontia Services

The Plan provides orthodontia services for dependent children up to age 26 at 50% of the allowance up to a lifetime benefit of $3,000. No coverage is provided for the member or spouse.

When a Treatment Plan is Required

You are required to submit a "treatment plan" or pre-authorization for Major Services provided by your dentist to the Fund Office for prior approval when the cost of the treatment is expected to exceed $600. By submitting a proposed treatment plan in advance, both you and your dentist know what is covered under the Plan before the work is done. This also allows you to authorize direct payment to the dentist.

Continuing Treatment When Your Coverage Ends

If your dental care coverage terminates while you are undergoing certain treatments, your covered dental expenses for these treatments continue to be covered for up to 30 days. The types of treatments that are included under this provision are:

- An appliance or its modification for which an impression was taken prior to termination of dental benefits;
- A crown, bridge or gold restoration for which the tooth was prepared prior to termination of dental benefits; and
- Root canal therapy provided that the pulp chamber was opened prior to termination of dental benefits.

What's Not Covered

Dental care benefits are not provided for:

- Any dental care, treatment or supply not prescribed by or under the direction of a dentist;
- Replacement of a lost, stolen, or broken prosthetic device;
- Appliances or restoration for the purpose of splinting, increasing vertical dimension or restoring occlusion;
- Dental services and supplies rendered solely for cosmetic purposes, unless required as a result of an accidental injury sustained while covered under this Plan or unless specifically provided under another provision of this Plan;
- An appliance or its modification, a crown, bridge, or gold restoration, or root canal therapy for which the impression was made, the tooth was prepared, or the pulp chamber was opened prior to coverage under this Plan;
- Replacement of an existing partial or full denture, splint or fixed bridgework; crowns and/or inlays installed as multiple abutments; splints for periodontal treatment; or prosthetic appliances, fixed or removable, used as an adjunct to periodontal treatment, unless satisfactory evidence is presented to the Fund that the existing denture or bridgework was installed at least 36 months prior to its replacement and the prosthetic appliance, fixed or removable, is required to replace a natural tooth;
- Dental services or prosthetics, or the fitting of these items, other than as provided in the dental benefit, unless required due to an accidental injury; or
- Orthodontics or other treatment or procedure designed to prevent or correct malocclusion of the teeth.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Vision Benefits

Vision Benefits

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage.

Regular eye care is an important part of your overall health. That's why the **Fund has contracted with Vision Service Plan (VSP) to provide vision care services at no cost or at discounted rates.** This arrangement represents a considerable savings to you when compared with the cost of such services outside the panel of providers. You are still eligible to receive vision care benefits if you do not go to a VSP Panel provider for services; however, your out-of-pocket expenses may be higher.

What You Need To Do

To find a participating provider near you, visit the VSP website ***(www.vsp.com)*** or contact VSP at 1-800-877-7195. When you call to make your appointment, identify yourself as a member of the EWTF. If you use a non-VSP provider, you or the eye doctor should submit a detailed bill itemizing charges directly to VSP at the following address:

Attn: Out-of-Network Provider Claims
Vision Service Plan
PO Box 997100
Sacramento, CA 95899-7100

To find a participating provider near you, visit the VSP website (www.vsp.com) or contact VSP at 1-800-877-7195.

VSP Provider

When you use a VSP provider, you may have a vision exam and, if indicated, a complete vision analysis, once per every two calendar years, at no cost to you. In addition, if lenses for eyeglasses are prescribed, the Plan pays 100% of the allowance once per every two calendar years.

New frames (chosen from a designated selection of styles) are paid in full up to the amount of the $150 allowance every two calendar years. If you select contact lenses, the Plan pays $100 toward their cost once per every two calendar years.

If your prescription changes before you are eligible for new frames, lenses or contacts and the following criteria are met, your lenses and frames or contacts will be replaced every one calendar year instead of every two calendar years:

- A new prescription differs from the original by at least .50 diopter sphere or cylinder;
- An axis change of 15 degrees or more; or
- .5 prism diopter change in at least one eye.

Non–VSP Provider

Benefits paid to non-VSP providers are limited to the allowances payable to VSP providers.

These benefits may not cover 100% of the charge. If your vision care provider charges more than the VSP allowance, you are responsible for the charges that exceed the allowance amount. You must mail your claim to VSP within six (6) months of the date you receive vision services. Claims received after this period will not be honored.

Safety Glasses

Safety glasses are available to actively working eligible Members once each calendar year. Lenses are covered in full. Safety frames are covered up to $65 plus 20% of any out-of-pocket costs.

Computer Glasses

Computer glasses are available to actively working eligible Members. If computer glasses are prescribed, the Plan pays 100% of the allowance once every two (2) calendar years. New frames shall be paid in full up to the amount of the $90 allowance every two calendar years.

What's Not Covered

This benefit does not cover expenses in connection with the following treatments or supplies:

- Non-prescription glasses;
- Sunglasses;
- Photosensitive, plastic, cosmetic tinted (other than pink 1 or 2) or oversized lenses, although you have the option of paying the difference in cost between these lenses and the cost of clear, standard size lenses;
- Replacement or repair of lost or broken lenses or frames;
- Orthoptics, vision training, or vision aids for aniseikonia;
- Medical or surgical treatments, as these are provided for under other provisions of the Plan such as post-cataract lenses or implants;
- Eye surgery for conditions which routinely can be corrected through corrective lenses (e.g. laser correction surgery); and
- Any eye examinations or the fitting of glasses except as provided above.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Hearing Aid Benefits

Hearing Aid Benefits

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage.

The Plan provides hearing care benefits once every three (3) years for you and your eligible family members. Before purchasing hearing aids, please contact the Fund Office to verify eligibility for this benefit.

What You Need To Do

The Plan provides for hearing aid exams without requiring a referral; however, a referral is required from your physician or certified audiologist to purchase hearing aids. Subsequent hearing aid exams and purchases will not require an additional referral. Next, you should obtain your hearing exam and submit your claim to the Fund Office for reimbursement of eligible expenses.

Repairs to a hearing aid will be a covered benefit that will count as a new hearing aid for purposes of the maximum amount allowed for the hearing aid benefit.

What's Not Covered

- Battery replacements for hearing aids;
- Hearing aid purchases without an initial referral from a physician and/or non-licensed audiologist.
- Hearing aids or examinations for their prescription or fitting other than what's provided in the hearing aid benefit.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Supplemental Medicare Benefits

Supplemental Medicare Benefits

If Medicare is the primary payer for your medical expenses, the Supplemental Medicare Benefit is designed to reimburse you for your annual deductible and Patient's Portion you pay under Medicare. When you receive treatment or services for a medical expense covered by Medicare, submit your claim and your Medicare Explanation of Benefits to the Fund Office for **reimbursement of your Medicare annual deductible and/or Patient's Portion.**

The benefits provided under the Plan exceed the Medicare Part D prescription coverage for Medicare eligible participants.

If your spouse and/or dependents are not covered by Medicare, they will remain eligible for non-Medicare retiree dependent coverage (see page 35) under this Plan.

The Plan's annual deductible does not apply to Medicare-eligible retirees.

Medicare Parts A & B

If you are a Retiree, the Plan assumes you are enrolled for Medicare Parts A and B if you are eligible to do so (e.g. due to age or disability) and will not pay for any expenses that are covered under Medicare Parts A and B even if you are not actually enrolled. Therefore, it is essential that you submit your application for Medicare Parts A and B as soon as possible (e.g. at least three months before you reach age 65) to assure continued coverage.

The Plan pays your Medicare deductibles and your Patient's Portion.

This Plan does not pay the Medicare Part B premium for Participants.

Medicare Part D

The EWTF Plan provides prescription benefits to Retirees. The Plan's actuary has determined that the benefits provided under the Plan exceed the Medicare Part D prescription coverage for Medicare eligible participants. The Plan therefore receives a subsidy from the Centers for Medicare and Medicaid Services (CMS) for providing these benefits. If you or a covered dependent enrolls in a separate Medicare Part D program, you or your dependent will permanently lose your prescription benefits with EWTF.

What's Not Covered

This plan does not cover:

- Medicare Part B premiums; or
- Any expenses that Medicare does not cover.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Weekly Accident and Sickness **Benefit**

Weekly Accident and Sickness Benefit

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage.

If you are an eligible Active Electrical Worker or Active Non-Bargaining Unit Employee and become disabled due to a non-occupational illness or accidental injury, the Plan pays you a Weekly Accident and Sickness Benefit to **help protect your financial security while you're disabled.** Retired Participants, Participants on COBRA, Surviving Spouses and Dependents are not eligible for Weekly Accident and Sickness Benefits.

Eligibility

To be eligible to receive the Weekly Accident and Sickness Benefit, you must be under the regular care of a doctor and following the prescribed course of treatment. You are required to provide written certification by your doctor that you continue to be disabled. You also may be asked to submit to an examination by a doctor appointed by the Trustees to certify your disability.

The Board of Trustees reserves the right to have you examined, at its own expense and by a physician of its own choosing, as it sees fit when deciding on a disability application.

Note: Payment of this benefit beyond 13 weeks requires specific advance approval by the Board of Trustees following your request for extended benefits and review of updated medical information.

What You Need to Do

You must obtain a written certification of your disability from your doctor. Next, contact the Fund Office by calling 301-731-1050 or at 1-800-929-3983. You are required to provide written proof to the Fund Office before your benefits can begin.

How the Weekly Accident and Sickness Benefit Works

The amount of your benefit is based on a percentage of the gross pay you ordinarily would receive for a normal workweek of 40 hours (or less). For periods of less than a full week, the weekly benefit is divided by seven to determine the benefit for each day of disability.

The amount of the Weekly Accident and Sickness Benefit payable is reduced by the amount of any compensation paid, or payable, by your employer or other third party during the period. Payment of the Weekly Accident and Sickness Benefit begins on the first day of a disability that is due to an accident, and on the eighth day of a disability that is due to an illness (including pregnancy).

Benefit based on a percentage of regular gross compensation and a normally scheduled work week of 40 hours (maximum) or less:	Benefit
First 13 weeks	50% up to a maximum of $350 per week
Next 13 weeks-Subject to Trustee Approval	40% up to a maximum of $210 per week

In order to obtain benefits for more than the initial 13 weeks, you must request an extension of benefits for up to an additional 13 weeks with supporting documentation such as a current medical doctor's report.

Maintaining Eligibility While On Disability

If you are disabled due to a ***non-occupational cause****, you are credited up to 135 hours per month for the first three months of disability as needed to maintain your and your covered dependents' coverage under the Plan. If you are granted the additional 13 weeks of Accident and Sickness Benefit, you may maintain your and your covered dependents' eligibility under the Plan by payment of $20 per month for Subsidized Coverage ("S" Coverage). S Coverage provides for only medical, mental health, prescription coverage, and death benefits; no coverage is provided for dental or vision. This option for a $20 payment is available for six (6) months, after which you may qualify to continue your and your covered dependents' coverage (while disabled) by paying monthly at the current rate of contribution to the Plan times 135 hours, provided you have at least one hour in your hours bank or you worked at least one hour of covered employment in the previous month. If you do not qualify to continue your and your covered dependents' coverage (while disabled) by paying monthly at the current rate of contribution to the Plan times 135 hours, you may qualify for COBRA continuing coverage.*

If you are disabled due to an ***occupational cause****, you are credited up to 135 hours per month for the first three months of disability as needed to maintain your and your covered dependents' coverage under the Plan, except that this coverage will not apply for any claims related to your occupational injury. If you are granted additional Workers' Compensation benefits after the first three months of your disability, you may maintain your and your covered dependents' eligibility under the Plan, except with regard*

to claims relating to your occupational injury, by payment of $20 per month for S Coverage. S Coverage provides for only medical, mental health, prescription coverage, and death benefits; no coverage is provided for dental or vision. This option for a $20 payment is available for six (6) months, after which you may continue your and your covered dependents' coverage (while disabled) by paying monthly at the current rate of contribution to the Plan times 135 hours, provided you have at least one hour in your hours bank or you worked at least one hour of covered employment in the previous month. If you do not qualify to continue your and your covered dependents' coverage (while disabled) by paying monthly at the current rate of contribution to the Plan times 135 hours, you may qualify for COBRA continuing coverage.

Multiple Periods of Disability

If you become disabled again from the same disability or from a different cause, your successive period(s) of disability are considered one period of disability unless:

- They are separated by at least one (1) calendar (or payroll) month of work during which you complete 135 hours of work in covered employment;
- The subsequent disability is due to an illness or injury entirely unrelated to the cause of the previous disability; or
- The later illness or injury begins after you have been released by the attending physician and have returned to work on a full-time basis.

What's Not Covered

No Weekly Accident and Sickness Benefit is payable:

- When the disability is due to alcohol or substance use disorder unless you are an inpatient receiving benefits under the substance use disorder treatment provisions of the Plan (see page 79); or
- If you are not under the regular care of a physician or not following the course of treatment prescribed including scheduled doctor visits.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Accidental Dismemberment and Loss of Sight Benefits

Accidental Dismemberment and Loss of Sight Benefits

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage.

The Accidental Dismemberment and Loss of Sight Benefit is payable to you if, while covered by the Plan, **you lose a limb or the full and permanent loss of your sight as a result of an accident.** The Plan defines "accident" as a violent, external, unexpected and unintentional event. This benefit is payable without regard to whether or not your accident occurred at work. If your accident is due to a work-related accident, see the following section for details about your Supplemental Occupational Accident Benefits. Retired Participants, Employees on COBRA, Surviving Spouses and Dependents are not eligible for this benefit.

What You Need To Do

You must provide satisfactory written proof of loss, usually in the form of a physician's statement, to the Fund Office within one year of the date of the loss. Contact the Fund Office at 301-731-1050 or at 1-800-929-3983 to claim your benefit under this provision.

The maximum benefit payable for the loss of one hand, one foot or the sight in one eye is $5,000. If you suffer two or more of these losses, the maximum benefit payable is $10,000.

What's Not Covered

No benefits are payable under the Plan, if your loss occurs as a direct or indirect result of:

- Any bodily or mental infirmity, illness, or bacterial infections (except pyogenic infections which occur due to an accidental cut or wound);
- Any medical or surgical treatment of any kind of disease;
- Travel in any moving aircraft aboard which the individual is giving or receiving training or has any duties;
- Any injury or illness caused by or arising from an act of war, whether declared or not, or a conflict involving armed forces;
- Suicide, attempted suicide, or any intentionally self-inflicted injury, attempted or committed while sane or insane;
- Any injury or illness caused by or arising from the attempt to commit, or in the commission of, a felony; or
- Any injury or illness caused by or arising from the use or misuse of controlled substances.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Supplemental Occupational Accident Benefits

Supplemental Occupational Accident Benefits

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage. Additionally, Retired Employees and Employees on COBRA are not eligible for Supplemental Occupational Accident Benefits.

If you are an eligible Active Employee and, as a result of a **work-related accident or injury, become disabled or dismembered, lose speech, sight or hearing, or die** as the result of a work-related accident, you or your beneficiary may be eligible for Supplemental Occupational Accident Benefits through this Plan. A loss must occur within one year from the date of an accident to be covered under Supplemental Occupational Accident Benefit.

The Supplemental Occupational Accident Benefits consist of two separate categories:

1. The first category is **Supplemental Worker's Compensation Benefits**, which covers occupational accidents involving Death, Dismemberment, Severe Burns or Loss of Hearing, Sight or Speech, as well as bereavement and trauma counseling relating to such occupational accidents. ***This benefit is guaranteed pursuant to an insurance contract with Nationwide.***
2. The second category is **Worker's Compensation Supplemental Income** involves general bodily injury that results in your receiving weekly wage loss workers compensation benefits. ***This benefit is self-insured by EWTF.***

Worker's Compensation Supplemental Income is intended to ensure that all eligible employees injured in occupational accidents receive the same benefits regardless of where the accident occurs. Depending on where you work, such benefits may be provided fully under local workers' compensation laws.

Your Occupational injury may make you eligible for either the Supplemental Worker's Compensation Benefits, Worker's Compensation Supplemental Income, or both.

What You Need To Do

You must provide satisfactory written proof of loss, usually in the form of a physician's statement or death certificate, to the Fund Office within one year of the date of the loss. Contact the Fund Office at 301-731-1050 or at 1-800-929-3983 to begin receiving your benefit.

Supplemental Workers' Compensation Benefits (Insured through Nationwide)

Amounts Payable for Occupational Accidental Death, Dismemberment, Loss of Sight, Speech or Hearing:

Accidental Death, Dismemberment, Loss of Sight, Speech or Hearing	
For Loss of	**Maximum Benefit Payable**
One hand	$50,000
One foot	$50,000
Sight of one eye	$50,000
Hearing of one ear	$50,000
Two or more of the above	$100,000
Speech	$100,000
Thumb and index finger of same hand	$25,000
Life	$100,000

Amounts Payable for Occupational Accidental Severe Burns:

Accidental Severe Burns	
For Severe Burn of	**Maximum Benefit Payable**
75% or more of the body	$100,000
Between 50% - 74% of the body	$50,000
Between 25% - 49% of the body	$25,000

The amount payable in the event of worker's compensation supplemental income is an amount which, when combined with the weekly benefit payable under workers' compensation, equals 66-2/3% of the member's basic weekly wage rate, but not more than $150 per week.

For purposes of this benefit, a Severe Burn means a cosmetic disfigurement of the surface of the body due to an accidental injury that is a full-thickness or third-degree burn, as determined by a Physician.

Amounts Payable for Bereavement and Trauma Counseling relating to an Occupational Accidental Injury or Death:

If a participant suffers an injury or death for which occupational accident or death benefits are payable under this section, a counseling benefit of up to $100 per session for up to 5 sessions is available to the participant or the participant's mother, father, spouse, children or siblings, for up to one year after the date of the occupational accident, provided the counseling:

- is ordered, and performed, by a Physician;
- meets generally accepted standards of medical practice; and
- is required to assist the counseled individual in coping with the loss resulting from the occupational accident or death.

How Supplemental Occupational Accident Benefits are Paid

The death, dismemberment, severe burn and loss of sight, speech or hearing benefits available under this provision are paid as lump sum amounts. If multiple losses occur because of a single accident, the maximum amount payable is the highest benefit amount payable for the single loss suffered.

Workers' Compensation Supplemental Income (Self-insured by EWTF)

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage. Additionally, Retired Employees and Employees on COBRA are not eligible for Supplemental Occupational Accident Benefits.

The amount payable in the event of worker's compensation supplemental income is an amount which, when combined with the weekly benefit payable under workers' compensation, equals 66-2/3% of the member's basic weekly wage rate, but not more than $150 per week. Payment of this benefit may be delayed until it is clear what you are receiving through your worker's compensation claim.

Permanently and totally disabled is the inability to perform the duties of your job for 12 months and, beyond the first 12 months, the complete inability to engage in any occupation or employment for which you are fitted by reason of education, training, or experience.

Workers' Compensation Supplemental Income	Maximum
First 52 weeks	$150 per week
Next 52 weeks	$150 per week
If determined to be permanently and totally disabled after first 52 weeks*	$1,000 per month
***The maximum payment for worker's compensation supplemental income is $50,000.**	

When Your Worker's Compensation Supplemental Income Coverage Ends

The Workers' Compensation Supplemental Income payments continue until the first of the following events occurs:

- You cease to receive Workers' Compensation payments; or
- The total amount of Workers' Compensation Supplemental Income paid equals $50,000; or
- The amount of Workers' Compensation Supplemental Income paid, when added to the amount paid under Supplemental Workers' Compensation Benefits, totals $100,000; or
- The 104-week benefit period is exhausted; or
- You die.

Upon your death, any portion of the up to $100,000 maximum benefit not already paid to you due to disability, dismemberment, or loss of sight, speech or hearing is paid as a Death Benefit to your designated beneficiary.

What's Not Covered

No Supplemental Occupational Accident Benefits are payable when a loss results from:

- Commuting to and from work; or
- Suicide, attempted suicide, or any intentionally self-inflicted injury committed while sane or insane; or
- Viral or bacterial infection (except from an accidental cut or wound); or
- Any injury for which workers compensation is not payable.

Please see page 19 for an in-depth listing of your Plan's exclusions.

Death Benefit

Death Benefit

Note: This benefit provided for Standard Plan (full) coverage only; no provision for "H" Plan (limited) coverage.

In the event of your death, **your beneficiary may receive a benefit**, the amount of which depends on your eligibility category at the time of your death.

What You Need To Do

Make sure you have a beneficiary (or beneficiaries) listed and on file at the Fund Office. Your beneficiary must submit a certified copy of your death certificate and request the Death Benefit in writing within one year of the date of your death.

Make sure you have a beneficiary (or beneficiaries) listed and on file at the Fund Office.

Eligible Active Electrical Worker or Active Non-Bargaining Unit Employee

If you die while you are an Active Electrical Worker or an Active Non-Bargaining Unit Employee, your beneficiary will receive a Death Benefit of $25,000. Surviving Spouses and Dependents are not eligible for benefits under the Death Benefits provision.

Eligible Retired Employee

If you retired on or after July 1, 1971, your beneficiary will receive a Death Benefit of $6,000 upon your death. However, if you retired before age 60 on a disability pension and remain disabled, your beneficiary is entitled to the full Death Benefit of $25,000 until you reach age 62. At that time, the regular retiree Death Benefit of $6,000 takes effect.

Designating Your Beneficiary

You may designate one or more persons to receive any benefit(s) payable under the Plan at your death by completing a form provided by the Fund Office. Any change of beneficiary also must be made by completing a new form. No designation or change is accepted by the Fund Office on or after the date of your death.

If you fail to designate a beneficiary or if your beneficiary (or one of your beneficiaries) does not survive you, any Death Benefit is paid in the following order:

- Your spouse, if any;
- Your Individual Account Plan beneficiary, if any;
- Your Pension Plan beneficiary, if any; or else
- Your estate.

If a participant has no spouse at the time of his or her death, but he or she previously designated a spouse as beneficiary and subsequently obtained a divorce from that spouse, it shall be presumed that the divorce nullified the beneficiary designation unless the Trustees determine, based upon written documentation, that the participant reaffirmed the election of his or her former spouse as beneficiary after the effective date of the divorce.

If you designate a minor as your beneficiary, you must also designate a custodian to receive payment for the benefit of the minor, under the Uniform Transfers to Minors Act. Otherwise, any Death Benefit payable to a minor is paid to the legally appointed guardian of the minor.

Filing Your Benefits Claims

Filing Your Benefits Claims

Filing a claim is easy if you follow the steps described in this section. If a claim is denied or reduced, there is a process you can follow to have your claim reviewed by the Board of Trustees.

What You Need To Do

- Show your EWTF Benefit Card so that your physician will know where to submit your claim.
- If you use a UHC provider, UHC will file your claim for you.
- Call the Fund Office at 301-731-1050 or at 1-800-929-3983 or send an e-mail request to *info@ewtf.org* to request claim forms if you are applying for reimbursement for charges incurred from a non-UHC provider.
- File your claims and all requested forms within one (1) year of the date of your treatment or service in order to receive your benefit.
- Return the completed, signed form, along with any attachments to:

  Electrical Welfare Trust Fund
  10003 Derekwood Lane, Suite 130
  Lanham, MD 20706-4811

- If you are applying for reimbursement for charges from a dentist submit the signed dental form and any attachments to:

  Electrical Welfare Trust Fund
  10003 Derekwood Lane, Suite 130
  Lanham, MD 20706-4811

- If you are a retired participant and covered under Medicare, submit your claim and Medicare Explanation of Benefits to:

  Electrical Welfare Trust Fund
  10003 Derekwood Lane, Suite 130
  Lanham, MD 20706-4811

Generally, there are no claim forms to file if you use UHC providers for medical care, CIGNA Dental PPO providers for dental care, and the VSP network for vision benefits.

Filing a Claim

Generally, there are no claim forms to file if you use UHC providers for medical care, CIGNA Dental PPO providers for dental care, and the VSP network for vision benefits. If your provider does not submit your claim, it is your responsibility to do so.

To assure prompt, accurate action on your claim, be sure that the claim form and the attached bills are complete. They should contain all necessary information such as the name of the patient, the diagnoses, dates and descriptions of services, and itemized charges.

All claims must be properly completed and filed within one year of the date of service, except that non-participating vision provider claims must be submitted to VSP within 6 months of the date of service. Otherwise, no benefits will be paid.

Under the Medicare Secondary Payer law, the Fund Office must have Social Security numbers for you and each of your dependents. Benefits will not be paid without the patient's Social Security number on file.

Status of Claim

If you are calling the Fund Office to check the status of your claim, you will need to have the following information:

- Member's identification number;
- Name of the patient;
- Date of service;
- Name of the provider of service (i.e.: doctor, hospital, etc.);
- Billed amount; and
- EWTF reference number, if known.

Contact with Your Providers

Under the EWTF contract with UHC, your providers of medical services must contact UHC at 1-866-596-8447 if there are any questions about your claims. (NOTE: This rule does not apply to your dental providers or if your provider submits your claims to Medicare as the primary coverage. In such a case, the providers may contact the Fund Office directly).

Proof of Payment

The EWTF will require proof of payment for any and all claims, including payment of deductibles and/or Patient's Portion before the out-of-pocket maximum has been reached. The Fund will notify you if further proof of payment is required.

Federally Issued Identification Numbers

A federally issued Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) for you and each of your dependents must be provided to the Fund Office upon enrollment. If you fail to provide either a Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)for yourself or any of your dependents this will result in termination of coverage under the Plan for that person. In the case of newly added children or a spouse, the Fund Office will wait for a period of up to six (6) months for you to provide a Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)before canceling coverage.

Payment of Claim

Generally, payment of a claim is made directly to you, unless you "assign" your benefit, as explained below. If you die before all claims have been paid, if you fail to provide a forwarding address, or if you are deemed to be incompetent, the Board of Trustees will make payment to your spouse or any other person they determine is entitled to the payment.

Overpayment of Benefits

If the Fund pays benefits in error, such as when the Fund pays you or your dependent more benefits than you are entitled to, or if the Fund advances benefits that you or your dependent are required to reimburse either because, for example, you have a compensable Workers' Compensation claim or have received a third party recovery,

you are required to reimburse the Fund in full and the Fund shall be entitled to recover any such benefits.

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by you or your dependent to reimburse the Fund for an overpaid amount will be considered a breach of your agreement with the Fund that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependent affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

If you or your dependent refuse to reimburse the Fund for any overpaid amount, the Fund has the right to recover the full amount by any and all methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your dependents' future benefit payments payable by the Fund under the Plan. For example, if the overpayment or advancement was made to you or on your behalf as the Fund participant, the Fund may offset the future benefits payable by the Fund to you and any of your dependents. If the overpayment or advancement was made to or on behalf of your dependent, the Fund may offset the future benefits payable by the Fund to you and any of your dependents.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

If your claim is denied, you may appeal the decision in writing within 180 days.

Assignment of Benefits

Normally, the provider will ask you to approve an assignment of benefits form to have payment of claims made directly to your provider. Under no other circumstances may benefits under the Plan be assigned.

Claim Denial

If your claim is denied, you may appeal the decision in writing within 180 days. Submit your written appeal to:

Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811

Claims and Appeals Procedure

Claims and Appeals Procedure

The Plan maintains a claims and appeals procedure which includes three major components:

- Filing of benefit claims;
- Notification of benefit determinations; and
- Appeal of adverse benefit determinations.

You may appoint an authorized representative to act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Trustees may establish reasonable procedures for determining whether an individual has been permitted to act as an authorized representative on your behalf. In urgent care circumstances, a health care professional with knowledge of your medical condition may act as your authorized representative.

Plan Provisions and Consistent Treatment Requirement

All administrative processes and safeguards of the Plan are administered to ensure and to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, Plan provisions treat similarly situated claimants consistently. Definitions of the terms used in this appeals procedure are set forth later in this section.

Claims for Benefits

A claim for benefits for the purpose of this Procedure is a request for a Plan benefit or benefits made by you in accordance with these procedures for filing benefit claims. This includes any pre-service and post-service claims.

Timing of Notification of Benefit Determination for Initial Claims

Urgent Care Claims

In the case of a claim involving urgent care, the Plan will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical urgency, but not later than 72 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

In the case of a failure by you or your authorized representative to provide enough information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

The Plan will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

- The Plan's receipt of the specified information; or
- The end of the period afforded to you to provide the specified additional information.

Concurrent Care Decisions

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination.

The Plan will notify you in accordance with these procedures of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical urgency. The Plan will notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with the Notification provision of these Procedures.

Pre-Service Claims Timing Rules

If a claim is neither Urgent nor Concurrent, then it is either a pre-service claim or a post-service claim. In the case of a pre-service claim, the Plan will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan.

This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-Service Timing Rules

In the case of a Post-service claim, the Plan will notify you of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim.

This period may be extended one time by the Plan for up to 15 days, provided that the Plan: (a) determines that such an extension is necessary due to matters beyond the control of the Plan; and (b) notifies you, prior to the expiration of the initial 30-day

period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Calculating Time Periods

General Rule

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

Time Periods During Extensions

In the event that a period of time is extended as permitted due to your failure to submit information necessary to decide a claim, the period for making the benefit determination will 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.

Manner and Content of Notification of Benefit Determination or Adverse Notification on Appeal

Rules for Non-Urgent Care Notification of Benefit Determination

The Plan will provide you with written notification of any adverse benefit determination of a claim or appeal.

The notification will set forth:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- 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 claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits will be determined by reference to the definition of Relevant set forth in these Procedures (see page 118);
- 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;

You may appoint an authorized representative to act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination.

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- If the adverse benefit determination is based on clinical guidelines for medical appropriateness or experimental treatment or similar exclusion or limit, 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.

Urgent Care Claims

In the case of an adverse benefit determination involving urgent care, the information required by this Procedure may be provided to you orally, provided that a written or electronic notification in accordance with this section is furnished to you not later than three (3) days after the oral notification.

In the case of an adverse benefit determination concerning a claim involving urgent care, the Plan will provide, in addition to the materials described above, a description of the expedited review process applicable to such claims.

Appeal of Adverse Benefit Determinations

Following is the procedure by which you will have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the Plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

You have 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination.

The review on appeal will not afford deference to the initial adverse benefit determination and will be conducted by such individual, individuals or entity designated by the Trustees who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees, or other appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Plan will provide to you the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

The health care professional engaged for purposes of a consultation on appeal under these Procedures will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Urgent Care Appeals

In the case of a claim involving urgent care, the review process shall be expedited:

- A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you; and
- All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

Appeals of Concurrent Care Denials

Appeals of the denial of concurrent care claims are governed by the appeal rules of this Procedure depending on the nature of the claim as follows:

- Urgent Care Appeal Rules;
- Pre-service Appeal Rules; and
- Post-service Appeal Rules.

Right to Supplement Claims

You may submit written comments, documents, records, and other information relating to the claim for benefits.

Right to Access to Documents

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits will be determined by reference to the Definitions set forth in this Procedure (see page 118).

Right to Consideration of All Documentation

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

Urgent Care Claims

In the case of a claim involving urgent care, the Plan will notify you, in accordance with the Manner and Content of Notification on Review Provision on Appeal of this Procedure of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.

Pre-Service Claims

In the case of a pre-service claim, the Plan will notify you, in accordance with the Manner and Content of Notification on Review Provision on Appeal of this Procedure, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than:

The Plan will provide notification not later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.

Post-Service Appeals

In the case of a post-service claim, the Plan will notify you, in accordance with the Manner and Content of Notification on Review Provision on Appeal of this Procedure, of the Trustees' benefit determination on review as follows.

The Board of Trustees will make its decision at the next regularly scheduled meeting following receipt of your appeal, unless there are special circumstances, in which case the Board of Trustees will decide the appeal at its next regularly scheduled meeting. If you submit your appeal within 30 days of the next scheduled Board of Trustees meeting, the Board of Trustees may decide the appeal at the second scheduled meeting, or, if there are special circumstances, the third meeting after it receives your appeal. If the Board of Trustees requires a postponement of its decision to the next meeting, you will receive a notice describing the reason for the delay and an expected date of the decision.

The Board of Trustees will send you a notice of its decision within five days of the date the decision is made. The decision of the Board of Trustees is final and binding.

Informal Review by UHC

If your claim for medical or hospital benefits is denied, before appealing that denial to the Board of Trustees as described above, you may contact UHC with any questions or concerns that you have regarding the claim denial. If you choose to do so, please contact the UHC directly at

1-800-850-1418 for important information regarding the appropriate procedures, including any time limits.

Whether or not you choose to address your concerns to UHC, you have the right to appeal a benefit denial to the Board of Trustees as described above. However, if you choose to address your concerns to UHC, you must do so before you appeal to the Board of Trustees and, if you are not satisfied with the results through UHC and wish to file an appeal to the Board of Trustees, you must do so within 180 days from the day you received the claim denial from the Fund Office or other Fund provider. If you do not choose to address your concerns to UHC and wish to appeal directly to the Board of Trustees, you must do so within 180 days from the day you received the claim denial from the Fund Office. Please remember that if you are not able to resolve your concerns by contacting UHC, you must appeal to the Board of Trustees before filing a suit against the Fund.

Furnishing Documents

In the case of an adverse benefit determination on review, the Plan will provide such access to, and copies of, documents, records, and other information described in the Manner and Content of Notification set forth on page 113.

Definitions

"Adverse benefit determination" means any of the following:

- A denial of a benefit;
- Reduction of a benefit;
- Termination of a benefit; or
- Failure to provide or make payment (in whole or in part) for a benefit.

This includes any of the foregoing that is based on:

- A determination of a participant's or beneficiary's eligibility to participate in a Plan;
- Application of any utilization review; or
- A determination that a particular covered item is experimental or investigational or not medically appropriate.

"Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

"Notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of the Notice Section of this Procedure described below as appropriate with respect to material required to be furnished or made available to an individual.

"Post-service claim" means any claim for a benefit under a group health plan that is not a "pre-service claim."

"Pre-service claim" means any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"Relevant" A document, record, or other information shall be considered "relevant" to your claim if such document, record, or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or
- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.

"Urgent Care Claim" is any claim for medical care or treatment with respect to which the applications of the time periods for making non-urgent care determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or,
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Any claim that a physician with knowledge of your medical condition determines is an "urgent care claim" will be treated as an "urgent care claim."

Documents to Be Furnished Under These Procedures

Any material, including reports, statements and documents, required to be furnished by these procedures will be furnished using measures reasonably calculated to ensure actual receipt of the material by Plan participants and beneficiaries.

Recovery for Third Party Liability

Recovery for Third Party Liability

> You and/or your dependent are required to notify the Fund within ten days of any accident or injury for which someone else may be liable.

Purpose of Third-Party Liability Provisions

In some instances, you may be injured on the job or in a car accident or some other type of accident for which a third party is responsible. In those situations, an employer's workers' compensation carrier, your own or someone else's auto insurance company, or another third party, may be responsible for paying your medical bills as well as your weekly accident and sickness expenses. Under those circumstances, the Fund is not responsible for paying, and does not cover, your medical bills and accident and sickness expenses relating to the accident.

Waiting for someone else to pay for your injuries can be difficult, particularly in situations where your doctor or hospital requires pre-determination of payment. Recovery can sometimes take a long time. Therefore, while the Fund is not responsible for paying your bills in these circumstances, the Board of Trustees recognizes the difficulty of waiting for payment from a third party and has developed a program to temporarily advance benefits to you while you wait for payment from the responsible third party .

How Third Party Liability Recovery Works

The Third Party Liability provisions of the Plan entitle the Fund to collect, directly from any responsible third party or insurance carrier, or from you, any money it advances to pay benefits relating to injuries you sustained and for which a third party is legally obligated to pay. In exchange for your written promise to pay back the Fund in full, from any recovery you receive, the Fund will advance you benefits for medically appropriate treatment which the Fund would cover in the event that no third party was involved. Your acceptance of these advanced benefits constitutes your agreement to repay the Plan in the event you receive a recovery in any form from any other person or party relating to the accident.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the injury or illness, and regardless of whether you and/or your dependent actually receive the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the injury or illness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified.

This recovery includes amounts payable under your or your dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. Neither the "make-whole" doctrine nor the "common fund" doctrine apply to the Fund's rights of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your dependent in obtaining recovery.

The Fund has a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. You and your dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for Fund costs and expenses.

Also, if you or your dependent receive any benefit payments from the Fund for any injury or illness, the Fund is subrogated to all rights of recovery available to you or your dependent arising out of any claim, demand, cause of action or right of recovery that has accrued, may accrue or which is asserted in connection with such injury or illness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such injury or illness in your or your dependent's name and also has a right to intervene in any action brought by you or your dependent, including any action against an insurance carrier including under any uninsured or underinsured motor vehicle policy.

Any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or on behalf of, you or your dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your dependent or your attorney may receive as a result of the accident or injury, no matter how these amounts are characterized or who pays these amounts, are excluded from Plan coverage, as provided in this Section.

What You Need To Do

Under the Plan's Third Party Liability provision, a participant must fulfill the following obligations in order to have his/her claims processed through the Fund:

- You and/or your dependent are required to notify the Fund within ten days of any accident or injury for which someone else may be liable. Further, the Fund must be notified within ten days of the initiation of any lawsuit or settlement negotiations relating to the accident and of the conclusion of any settlement, judgment or payment relating to the accident to protect the Fund's claims.
- You and your dependent, if applicable, must sign the Subrogation Agreement provided by the Fund. This Subrogation Agreement also must be executed by your or your dependent's attorney, if applicable. However, even if you or your dependent or a representative of you or your dependent or a representative of you or your dependent (including your or your dependent's attorney) do not execute the required Subrogation Agreement and the Fund nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute your or your dependent's agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you or your dependent recovers from a third party.
- You must file claims with the Fund Office on time;
- You must cooperate with Plan representatives as may be necessary or appropriate to enable the Plan to recover payments from any third party;
- You must immediately reimburse the Plan for any expenses paid by the Plan with any money recovered from a third party, no matter how characterized;
- You must not do anything to impair, prejudice or discharge the Plan's right of subrogation to recover from any third party; and
- You must assign to the Plan the right to bring an action against any third party responsible for the injuries sustained if you decline or fail to bring such action.
- Under this provision, you and/or your dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your dependent's receipt of any recovery. **If you are asked to do so, you must contact the Fund Office immediately.** You or your dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your dependent chooses not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. Where you or your eligible dependent chooses not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes

legal action to recover what it has paid, the acceptance of benefits obligates you and your dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

- You or your dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your dependent waives any of the Fund's rights to recovery or fails to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

Failure to Comply with Third Party Liability Procedures

Any refusal by you or your dependent to allow the Fund a right to subrogation or to reimburse the Fund from any recovery you receive, no matter how characterized, up to the full amount paid by the Fund on your or your dependent's behalf relating to the applicable injury or illness, will be considered a breach of the agreement between the Fund and you that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependent affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law. Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your dependent's claim will not be considered filed and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

If you or your dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by any and all other methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your dependents' future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation Agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

The Recovery Incentive Program provides a cash incentive to participants who discover and arrange for recovery of overcharges made on their own hospital bills that, in turn, result in savings dollars for the Plan.

If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that tthe Fund is paid the full amount owed. the Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

Recovery Incentive Program

The Recovery Incentive Program provides a cash incentive to participants who discover and arrange for recovery of overcharges made on their own hospital bills that, in turn, result in savings dollars for the Plan. The rules of the program are as follows:

- The cash incentive paid to a participant for recovering an amount that was initially overcharged on a hospital bill for that participant or his or her dependent is 25% of the actual amount of the overcharge that the hospital agrees is invalid as a result of direct negotiations between the participant and the hospital;
- The maximum paid by the Plan in any calendar year to a participant under this program may not exceed $500. Hospital overcharges totaling less than $25 are not eligible for the recovery incentive;
- The Trustees and administrative staff of the Plan may not get involved in resolving any differences between the participant and the hospital with respect to disputed charges. Participants are solely responsible for handling such disputes; and
- For purposes of the cash incentive, only hospital expenses that the Plan covers are included. It does not include amounts for telephone bills, television rental, newspapers, etc., for purposes of determining the amount payable to the participant under this program.

Proof of eligibility for a cash incentive must be submitted to the Plan in the form of a copy of the initial itemized hospital bill with the overcharges circled, and a copy of the adjusted bill showing that the hospital corrected the discrepancy. Such proof must be submitted to the Fund Office within 45 days following the date of discharge from the hospital. Within 30 days after receipt of proof and verification that the overcharge was recovered, the Fund will write the participant a check in the amount of the cash incentive.

The Trustees have the sole right at any time to amend or modify these rules or terminate the Recovery Incentive Program entirely.

Coordination of Benefits

Coordination of Benefits

Members of a family may be covered under more than one group health plan, possibly resulting in duplication of health care coverage. To avoid payment for the same benefit as a result of this duplication, **the medical, dental, prescription drug and vision benefits provided by this Plan are coordinated with similar benefits payable under other plans, including Medicare**.

What You Need to Do

When you (or a preferred provider) submit a claim for benefits, you must report all other group health insurance you have to avoid unnecessary payment from this Plan. Determine which Plan is "primary" for the covered person claiming benefits by reviewing the below. You will need to file the claim with the Primary Plan first. You may then file a claim with the "Secondary" Plan to pay for any eligible outstanding charges.

You must report other group health insurance coverage you have on the claim form that you submit when you request benefits from the Plan. In order to assure proper administration of the coordination of benefits provisions of the Plan, the Board of Trustees reserves the right to:

- Request updated other insurance information and suspend benefits for your dependents if the information is not received after three attempts;
- Exchange information with other parties regarding your and your dependents' other insurance coverage, to the extent necessary to provide for the coordination of benefits under the Plan;
- Make payments to other parties in satisfaction of Plan liabilities; and
- Recover any excess payments made.

Methods of Coordination

If you or your dependents have other health care coverage in addition to the coverage provided under this Plan, benefits are coordinated by looking first to what is called the "primary plan." If any charges remain after the primary plan has paid benefits, then the secondary plan will process those remaining claims.

If you have other coverage, which is determined to be primary, the Plan will pay as secondary. For example, if your spouse has other group insurance as an employee and is covered as a dependent on this Plan, the coverage for your spouse under this Plan is secondary and the coverage under your spouse's employer-sponsored plan is primary.

Order of Benefit Determination Rules

A plan that does not have a coordination of benefits rule consistent with this section shall always be the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the applicable rule:

- The plan that covers the individual as an enrollee or an employee shall be the primary plan and the plan that covers the individual as a dependent shall be the secondary plan;
- If the individual is a dependent child whose parents are not divorced or legally separated, the primary plan shall be the plan that covers the parent (as an enrollee or employee) whose birthday falls first in the calendar year;
- If the individual is the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the plan of the parent with custody of the child;
  - then, the plan of the spouse of the parent with custody of the child;
  - then, the plan of the parent not having custody of the child, and
  - finally, the plan of the spouse of the parent not having custody of the child.
- The plan that covers the individual as an active employee (or as that employee's dependent) shall be the primary plan and the plan that covers the individual as a laid-off or retired employee (or as that employee's dependent) shall be the secondary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The plan that covers the individual under a right of continuation that is provided by federal or state law shall be the secondary plan and the plan that covers the individual as an active employee or retiree (or as that employee's dependent) shall be the primary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the plans that cover the individual is issued out of the state whose laws govern this plan, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.
- If none of the above rules determines the order of benefits, the plan that has covered an individual for the longer period of time shall be primary.

When you (or a preferred provider) submit a claim for benefits, you must report all other group health insurance you have to avoid unnecessary payment from this Plan.

Steps to Follow if You or Your Family Members are Covered by More Than One Plan

Coordination of Benefits may result in lower out-of-pocket expenses to you and members of your family if you follow the coordination of benefit procedures for this Plan and any other plan for which a family member may be covered.

If EWTF is primary plan:

- Submit the claim using the procedures described in the applicable section of this SPD;
- Upon receipt of EWTF Explanation of Benefits (EOB), submit a copy of original claim and EOB to spouse's health plan.

If Spouse's health plan is primary:

- Submit a copy of the claim to that plan, following that plan's guidelines for submittal;
- Upon receipt of the other plan's Explanation of Benefits (EOB), submit copy of both the EOB and the claim to EWTF.

Coordination Of Benefits With Medicare

Medicare Parts A & B

When you reach age 65 or become disabled, you are eligible for hospital insurance benefits ("Part A") and supplementary medical insurance ("Part B") under Medicare. If you are a Medicare-eligible retired employee, or a Medicare-eligible dependent of a retiree, Medicare is the primary plan, and this Plan is the secondary plan to the extent of the Supplemental Medicare Benefits described on page 91. In all other circumstances, this Plan is the primary plan and Medicare is secondary.

The Plan's annual deductible does not apply to Medicare-eligible retirees.

There are special rules for Medicare-eligible individuals with end-stage renal disease (ESRD). Please contact the Fund Office for more information.

Note: If you are a Retiree, you and your dependents are responsible for enrolling in the Medicare Parts A and B program promptly. Otherwise, you will not receive the additional benefits and coverage for which you are eligible. This Plan does not cover any expenses Medicare would have covered if you, or your Medicare-eligible spouse, had enrolled in a timely manner. To enroll in Medicare, visit an office of the Social Security Administration, or enroll online, about three months before your 65th birthday.

TRICARE

If you are covered by both this Plan and TRICARE, this Plan is the primary plan and TRICARE is the secondary plan.

Motor Vehicle No-Fault Coverage Required By Law

If you are covered by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

Workers' Compensation

This Plan does NOT provide benefits if the medical expenses are covered by workers' compensation or occupational disease law.

Medicaid

The Plan complies with the requirements of ERISA §609(b) regarding participants and beneficiaries eligible for Medicaid. The Plan shall not reduce or deny benefits for any participant or dependent to reflect the fact that such an individual is eligible to receive medical assistance under a state Medicaid plan. Under state and federal law, should a participant or dependent covered under the Plan be entitled to payment of a claim under the Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the participant or dependent's right to payment under the Plan to the extent of the amount paid by Medicaid, and reimbursement under the Plan will be made in that amount directly to the state.

Your Privacy Rights

Your Privacy Rights

This Notice of Privacy Practices describes how we may **use and disclose your protected health information to carry out treatment, payment or health care operations** and for other purposes that are permitted or required by law. The rights described in this Notice apply to you, your spouse, and your dependents. It also describes your rights to access and control your protected health information and the Plan's duties if this information is improperly accessed or disclosed. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

This Plan is required to abide by the terms of this Notice of Privacy Practices. The terms of the notice may be changed at any time. The notice is effective for all protected health information maintained at that time. The Plan will provide you with a Notice of Privacy Practices if you call the Fund Office and request that a copy be sent to you in the mail.

If you have any questions about this notice, please contact:

Privacy Official
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or
1-800-929-EWTF (3983)

How the Plan May Use or Disclose Your Health Information

The following categories describe the ways that the Plan may use and disclose your health information. For each category of uses and disclosures, you will receive an explanation as to what is meant, and some examples will be presented. Not every use or disclosure in a category will be listed. However, all the ways that the Plan is permitted to use and disclose information will fall within one of the following categories:

Payment Functions

The Plan may use or disclose health information about you for payment functions. This includes, but is not limited to, functions such as to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. For example, payment functions may include reviewing the clinical guidelines for medical appropriateness of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under the plan.

Health Care Operations

The Plan may use and disclose health information about you to carry out necessary insurance-related activities. Such activities may include underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and

improvement activities; submitting claims for stop-loss coverage; disease or care management; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration. For example, health care operations functions may include referring you to a disease management or well-baby program, projecting future benefit costs, or reviewing the accuracy of the plan's claims processing functions.

Required by Law

As required by law, the Plan may use and disclose your health information. For example, the Plan may disclose medical information when required by a court order or subpoena in a litigation proceeding such as a malpractice action. In addition, the Plan is required to give you access to certain health information when you request it. Further, the Plan may be required to use and disclose your health information to the Secretary of the Department of Health and Human Services for purposes of reviewing whether the Plan is in compliance with federal privacy regulations.

Public Health

As required by law, the Plan may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting abuse or neglect, including child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health Oversight Activities

The Plan may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.

Judicial and Administrative Proceedings

The Plan may disclose your health information when required in the course of any administrative or judicial proceeding, including a subpoena issued by any administrative agency or court.

Law Enforcement

The Plan may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors

The Plan may disclose the health information of a deceased pariticipant or dependent to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.

Organ and Tissue Donation

The Plan may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.

Public Safety

The Plan may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

National Security

The Plan may disclose your health information for military, national security, prisoner and government benefits purposes.

Workers' Compensation

The Plan may disclose your health information when authorized by and as necessary to comply with workers' compensation or similar laws.

Health Care Information

The Plan may contact you to give you information about health-related benefits and services that may be of interest to you.

Disclosures to Plan Sponsors

The Plan may disclose your health information to the Board of Trustees of this group health plan, for purposes of administering benefits under the plan.

When The Plan May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, the Plan will not use or disclose your health information without written authorization from you. If you do authorize the Plan to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, the Plan will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though the Plan will be unable to take back any disclosures that have already been made with your permission.

When EWTF Must Provide You a Breach Notification

If your protected health information is used, accessed, or disclosed in a manner not described in this Notice of Privacy Practices, we will investigate the "breach" and take available steps to mitigate the harm. In addition, if we determine that the breach poses a significant risk of financial, reputational, or other harm, we will send a "breach notification" notice to you and any other affected individual within 60 days of the breach. The breach notification notice will: (1) briefly describe the breach; (2) describe the types of protected health information that were disclosed; (3) describe the steps to take to

protect yourself from potential harm caused by the breach; (4) describe what we are doing to investigate and mitigate the breach and to prevent future breaches; and (5) instruct you to contact us.

Disclosure of Your Health Information to Family Members

Unless you request otherwise, the Plan will disclose your health information to your spouse and dependents if the information is directly relevant to payment for health care by the Plan.

Statement of Your Health Information Rights

Right to Request Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. EWTF is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to:

Privacy Official
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or
1-800-929-EWTF (3983)

Right to Request Confidential Communications

You have the right to receive your health information through a reasonable alternative means or at an alternative location. To request confidential communications, you must submit your request in writing to:

Privacy Official
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or
1-800-929-EWTF (3983)

The Plan is not required to agree to your request.

Right to Inspect and Copy

You have the right to inspect and copy health information about you that may be used to make decisions about your Plan benefits. To inspect and copy such information, you must submit your request in writing to:

Privacy Official
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or
1-800-929-EWTF (3983)

The Plan must act on your request within 30 days if the information is maintained on site or within 60 days if it is maintained offsite. A 30-day extension is allowed. If your request is denied, you will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights, and a description of how you may complain to the Secretary of the Department of Health and Human Services.

If you request a copy of the information, the Plan may charge you a reasonable fee to cover expenses associated with your request.

Right to Request Amendment

You have a right to request that the Plan amend your health information that you believe is incorrect or incomplete. The Plan is not required to change your health information and if your request is denied, you will be provided with information about the denial and how you can disagree with the denial.

The Plan must act on your request within 60 days. A 30-day extension is allowed.

To request an amendment, you must make your request in writing to:

Privacy Official
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or
1-800-929-EWTF (3983)

You must also provide a reason for your request.

Right to Accounting of Disclosures

You have the right to receive a list or "accounting of disclosures" of your health information made by the Plan, except that the Plan does not have to account for disclosures made for purposes of payment functions or health care operations, made to you, or made pursuant to a written authorization signed by you or your personal representative. To request this accounting of disclosures, you must submit your request in writing to:

Privacy Official
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or
1-800-929-EWTF (3983)

Your request should specify a time period of up to six (6) years and may not include dates before April 14, 2003. The Plan will provide one list per 12-month period free of charge; you may be charged for additional lists. The Plan must act on your request within 60 days. A 30-day extension is allowed if you are told why the delay is necessary and when the accounting will be available.

Right to Paper Copy

You have a right to receive a paper copy of this Notice of Privacy Practices at any time. To obtain a paper copy of this Notice, send your written request to:

Privacy Official
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or
1-800-929-EWTF (3983)

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact:

Privacy Official
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or
1-800-929-EWTF (3983)

Changes to this Notice of Privacy Practices

The Plan reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. The Plan will promptly revise the Notice and distribute it to you whenever material changes are made to the Notice. Until such time, the Plan is required by law to comply with the current version of this Notice.

Personal Representatives

You may exercise your rights through a personal representative, who will be required to produce evidence of his or her authority to act on your behalf before he or she will be given access to your health information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A notarized power of attorney for health care purposes; or
- A court order of appointment of the individual as your conservator or guardian.

Unless you request otherwise the Plan will consider the following individuals your personal representative, but will always request verification of identity prior to disclosing health information:

- A parent of an unemancipated minor child; or
- Your spouse.

If you wish to restrict access to your health information, see the "Right to Restriction" provision above.

The Plan may deny access to a personal representative if such action is necessary to protect your rights.

Complaints

Complaints about this Notice of Privacy Practices, about how the Plan handles your health information, or about how the Plan handles its breach notification obligations, should be directed to:

Privacy Official
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or
1-800-929-EWTF (3983)

The Plan will not retaliate against you in any way for filing a complaint. All complaints to the Plan must be submitted in writing. If you believe your privacy rights (including your breach notification rights) have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services and mail it to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
Room 509F HHH Building
200 Independence Ave., SW
Washington, DC 20201

You also may address your complaint to one of the regional Office for Civil Rights. A list of these offices can be found online at *www.hhs.gov/ocr/office/about/rgn-hqaddresses*.

Federal Regulations

The federal government regulates the use and disclosure of health information. These regulations are at 45 Code of Federal Regulations Parts 160 and 164. This Notice summarizes your rights under these regulations. The regulations will supersede any discrepancy between the information contained in this notice and the regulations.

Your ERISA Rights

Your ERISA Rights

As a participant in the Electrical Welfare Trust Fund, **you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA)**. ERISA provides that all Plan participants are entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay 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 plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Glossary

Glossary

A

Accident – a violent, external, unexpected and unintentional event.

Allowance or Allowed Amount – a pre-determined cost agreed upon by the Plan for a particular service. This also may be called "eligible expense," "payment allowance" or "negotiated rate." If the provider charges more than the allowed amount, the patient may have to pay the difference. (See Balance Billing.)

Appeal – a request by a Plan participant or beneficiary that the Board of Trustees reconsider the claim under circumstances in which the initial claim was denied in whole or in part.

Approved Facility – a legally operated institution, other than a hospital, that provides care and treatment through medical, diagnostic or surgical facilities on the premises, under the supervision of a physician and approved by the Board of Trustees.

B

Balance Billing – when a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill for the remaining $30. A preferred provider may not balance bill for covered services.

Benefit Navigation – a process to help the participant obtain, or be referred to, clinically appropriate treatment for mental health or substance use disorder issues by a qualified and covered mental health professional.

C

Medical Appropriateness – Only expenses for treatments, services and supplies provided by a hospital, physician or other appropriately licensed provider in the diagnosis or treatment of an illness or injury may be considered to be medically appropriate. In addition, the treatments, services and supplies must be:

- Consistent with the diagnosis and treatment of the condition
- In accordance with medical practice
- Required other than for the convenience of the patient or provider
- The most appropriate treatments, services or supplies that can be provided safely

Also, care as a hospital inpatient is considered as medically appropriate only if the care cannot be provided safely on an outpatient basis.

Note: Simply because it is given by, or on the orders of, a doctor does not designate a treatment, service or supply as medically appropriate. Further, the fact that a provider labels a treatment, service or supply as medically appropriate does not make a treatment, service, or supply automatically covered under the Plan.

Co-insurance or Participant Portion – your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the Plan's

allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The Plan pays the rest of the allowed amount.

Complications of Pregnancy – conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not complications of pregnancy.

Co-Payment – a fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. For example, your co-pay for a prescription drug or for a service as specified under the Plan is fixed. Your co-insurance for a medical visit is not fixed because it is a percentage of the charge.

Covered Medical Expenses – only those expenses for medically appropriate treatments, services, and supplies relating to the benefits as provided under the terms of this Plan.

D

Deductible – an amount determined by the Board of Trustees that must be satisfied before EWTF pays a percentage of the allowed amount. A new deductible is effective each January 1.

Durable Medical Equipment (DME) – equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs and crutches.

E

Emergency Medical Condition – an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation – ambulance services for an emergency medical condition.

Emergency Room Care – emergency services you get in an emergency room.

Emergency Services – evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services – services that the Plan does not pay for or cover.

Experimental - A drug, device, medical treatment, or procedure is considered Experimental or investigative unless:

1. The approval of the U.S. Food and Drug Administration and approval for marketing the drug or device has been given at the time the drug or device is furnished;
2. The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment, or procedure, was reviewed and approved by the treating facility's institutional review board or other such body serving a similar function, if federal law requires such review or approval;

3. Reliable evidence shows that the drug, device, medical treatment, or procedure is not the subject of on-going Phase I or Phase II clinical trials, or the research, experimental study, or investigational arm of ongoing Phase III clinical trials, or is not otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Notwithstanding the above, a drug, device, medical treatment or procedure that is administered as part of a clinical trial is not considered Experimental to the extent the Fund is required by law to cover it.

G

Generic Drugs – a less expensive alternative to brand name drugs. The generic version of any drug contains identical active chemical ingredients and must meet the same manufacturing standards and federal requirements for safety and effectiveness as a brand name drug.

H

Habilitation Services – health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical therapy, including physical therapy provided in the form of aqua therapy, occupational therapy, speech-language pathology and other services for people with disabilities in a variety of impatient and/or outpatient settings.

Home Health Care – health care services a person receives at home.

Hospice Services – services to provide comfort and support for persons in the last stages of a terminal illness, and for their families.

Hospitalization – care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospitalization Outpatient Care – care in a hospital that usually doesn't require an overnight stay.

Hours Bank – hours you work in excess of the required 135-hour minimum each month, or hours worked in a month in which you work less than 135 hours, are credited to a "bank" so that you may apply those hours to maintain your coverage if you work fewer than 135 hours in a later month.

N

Network – the facilities, providers and suppliers your Plan has contracted with to provide health care services.

Non-Participating (non-par) – an entity that is not in the preferred provider network.

Non-Preferred Brand – brand drugs that are not on the preferred list maintained by CVS Caremark. These drugs typically cost more than their preferred brand alternatives.

Non-Participating Provider – a provider who doesn't have a contract with your Plan to provide services to you. You'll pay more to see a non-participating provider.

P

Participating – an entity that is a part of the participating provider network and accepts as payment in full the allowance.

Patient's Portion or Co-Insurance – your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. (See Co-Insurance and copayment above)

Period of Disability – begins at the time you become disabled and ends when you are no longer disabled.

Permanently and Totally Disabled – the inability to perform the duties of your job for 12 months and, beyond the first 12 months, the complete inability to engage in any occupation or employment for which you are fitted by reason of education, training or experience.

Physician – a doctor, chiropractor, podiatrist, psychologist, optometrist, or surgeon licensed to practice medicine or perform surgery.

Preferred Brand – brand drugs that are on the preferred list maintained by CVS Caremark. Preferred brands drugs also are referred to as "formulary drugs."

Participating Provider – a provider who has a contract with your network to provide services to you at a discount.

Prescription Drugs – drugs and medications that by law require a prescription.

Pre-Determination or Prior Authorization – a finding, prior to the receipt of a health care service or supply, regarding whether a health care expense is covered under the Plan. Certain benefits under the Plan require a pre-determination to be covered.

Primary Care Physician – a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under law, who provides, coordinates or helps a patient access a range of health care services.

Provider – the entity who provides the service, treatment or procedure for the patient.

R

Reconstructive Surgery – surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services – health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical therapy, including physical therapy provided in the form of aqua therapy, occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

S

Self-Funded Plan – your employer's contributions—and any income earned from investments of your employer's contributions—pay for the health care expenses that you and your fellow participants incur for the services you receive under the Plan. The EWTF Plan makes the final decisions about what is covered and what is paid and EWTF writes the checks to pay benefits.

Skilled Nursing Care – services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist – a physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care such as a physical therapist or a nurse practitioner.

Spell of Illness – a period beginning when you are first confined in a hospital, nursing home or other approved facility and ending when you are discharged and you recover completely from the condition causing the confinement, or you go at least one year during which you are not confined again for the same condition.

U

UCR (Usual, Customary and Reasonable) – the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care – care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

W

Work – a job you perform in covered employment for an employer who makes contributions to the Fund on your behalf.

Plan Information

Plan Information

Name of Plan

Electrical Welfare Trust Fund

Type of Plan

Employee Health and Welfare Benefit Plan that provides medical care, pharmaceutical care, dental care, vision care, hearing care, weekly accident and sickness benefits, death benefits and accidental dismemberment and loss of sight benefits to eligible employees and their qualified dependents.

Name of Plan Sponsor

The Board of Trustees of the Electrical Welfare Trust Fund

Agent for Service of Legal Process

Michael McCarron
Fund Administrator
10003 Derekwood Lane, Suite 130
Lanham, MD 20706

Service of legal process also may be made upon the Fund Manager or any member of the Board of Trustees

Type of Administration

Collectively bargained, jointly trusteed labor-management trust

IRS Employer Identification Number

526038507

Plan Number

501

Plan Year

January 1 to December 31

Sources of Plan Financing

The Plan is funded by contributions made by individuals and employers under the provisions of collective bargaining and other agreements and any income earned from investment of employer contributions.

All monies are used exclusively to provide benefits to eligible employees and their dependents, and to pay all expenses incurred with respect to the operation of the Plan. The Board of Trustees periodically reviews the funding status of the Plan.

Sponsoring Organizations

Plan Participants and beneficiaries may receive from the Fund Office, upon written request, a complete list of the employers participating in the Plan.

Healthcare Network

The Plan's current provider for its healthcare network is UnitedHealthcare Choice Plus Network (UHC). You can see a directory of Participating Providers by viewing the UHC website at http://directory.uhis.com.

Dental Benefits

The Plan's current provider for dental benefits is CIGNA Dental PPO. You can get a copy of a directory by calling CIGNA at 800-797-3381 or reviewing their website at www.cigna.com.

Vision Benefits

Vision benefits are provided through Vision Service Plan (VSP). You can reach VSP by calling 1-800-877-7195 or by visiting their website at www.vsp.com.

Prescription Drug Benefits

The Plan's current provider for Prescription Drug Benefits is CVS Caremark at 1-800-386-0329.

Utilization Review

The Plan's Utilization Review is handled through UHC CARE Program at 1-850-800-1418.

Employee Assistance Plan (EAP)

The Plan's current EAP provider is Business Health Services (BHS) at 1-800-765-3277.

Supplemental Occupational Accident Benefits

The supplemental occupational accident benefits are provided under an insurance policy with Nationwide Insurance Company. All other benefits are provided on a self-insured basis.

Nationwide Mutual Insurance Company
One Nationwide Plaza
Columbus, OH, 43215

Plan Administrator

The Plan Administrator and Plan Sponsor is the Board of Trustees of the Fund. Fund Manager has been appointed by the Board of Trustees as the day to day administrative manager of this Plan. The name, address and telephone number of the Fund Manager is:

Michael McCarron
Electrical Welfare Trust Fund
10003 Derekwood Lane, Suite 130
Lanham, MD 20706-4811
301-731-1050 or 800-929-3983
Fax: 301-731-1065

Collective Bargaining Agreement

A copy of the Collective Bargaining Agreement(s) pursuant to which participating employers contribute to the Plan may be obtained by participants and beneficiaries upon written request to the Fund Manager.

Documents for Examination

Documents for Examination

Documents to Be Made Available for Examination

Where certain documents are required to be made available for examination by participants and beneficiaries in the principal office of the Plan and in such other places as may be appropriate to make available all pertinent information to all participants and beneficiaries, disclosure will be made pursuant to the provisions of this paragraph. Such documents will be current, readily accessible, and clearly identified, and copies must be available in sufficient number to accommodate the expected volume of inquiries. The Plan will make copies of the Summary Plan Description, latest annual report, and the bargaining agreement, trust agreement, contract or other instruments under which the Plan is established or operated available at all times at the Trust Fund Office.

Summary Plan Descriptions and Summaries of Material Modification

For purposes of Summary Plan Descriptions and Summaries of Material Modification, materials furnished upon written request will be mailed to an address provided by the requesting participant or beneficiary or personally delivered to the participant or beneficiary.

Providing Documents at Employer Establishments or the Union Offices

The Plan is not required to maintain the Plan documents at all times at each employer establishment or union hall or office, but such documents will be made available at any such location within ten calendar days following the day on which a request for disclosure at that location is made. The Plan will make Plan documents available at the appropriate employer establishment or union meeting hall or office within the required ten day period when a request is made directly to the Plan or through a procedure separately establishing reasonable rules governing the making of requests for examination of Plan documents. If the Plan prescribes such a procedure and communicates it to Plan participants and beneficiaries, the Plan will not be required to comply with a request made in a manner which does not conform to the established procedure.

The procedure for making requests to examine Plan documents will permit requests to be made in a reasonably convenient manner both directly to the Plan and at each employer establishment, or union meeting hall or office where documents must be made available in accordance with this paragraph. If no such reasonable procedure is established, a good faith effort by a participant or beneficiary to request examination of Plan documents will be deemed a request to the Plan for purposes of this paragraph.

With respect to the Union and employers, documents will be made available for examination in the principal office of the employee organization and at each employer establishment in which at least 50 participants covered under the Plan are customarily working. In employment situations where employees do not usually work at, or report to, a single establishment, the Plan will take measures to ensure that Plan documents are available for examination at the meeting hall or office of each union local in which there are at least 50 participants covered under the Plan.

Discretionary Authority of the Board of Trustees and its Designees

Plan Amendment and Termination

Discretionary Authority of the Board of Trustees and its Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

Plan Amendment and Termination

The Board of Trustees reserves the right to terminate or amend the Plan including the right to amend or terminate benefits or eligibility for any class of participant, including retirees, when in their sole discretion they determine such action is in the best interest of the Fund and its participants. In addition, the Plan may be terminated by the Trustees if there is no longer an agreement in effect between the Employers and the Union requiring contributions to the Electrical Welfare Trust Fund.

Should the Plan terminate, the Trustees will apply remaining assets of the Fund to continue benefits beyond the date of termination. The Trustees reserve the right to amend the eligibility rules at the time of termination. All benefits are funded from current contributions and are not guaranteed. In any case, the Trustees will use any remaining assets of the Fund to provide benefits and pay administration expenses or otherwise to carry out the purpose of the Plan in accordance with the Plan Document and Trust Agreement until the entire remainder of the Fund has been disbursed.

ELECTRICAL WELFARE TRUST FUND
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