Summary Plan Description (SPD)
and Restated Plan Document

I.B.E.W. Local Union No. 124
Health and Welfare Fund

As of March 1, 2020

I.B.E.W. Local Union No. 124
Health and Welfare Fund

Board of Trustees/Plan Administrator

Union Trustees	*Employer Trustees*
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1100 Main Street, Suite 2001
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Consultant

Cheiron, Inc.

To All Participants:

The Board of Trustees is pleased to provide you with this Plan booklet that contains an up-to-date description of all Plan benefits available to you and your Dependents as of March 1, 2020. This Plan is designed to help you and your eligible Dependents meet the cost of medical care in the event of injury or sickness and to provide benefits at the time of death. This booklet also contains information concerning your rights as a participant under the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA).

We urge you to read this booklet carefully so that you will be aware of the valuable benefits available to you and your Dependents. If there is something that you do not understand about the Plan or if you need information about your eligibility for benefits, please feel free to contact the Fund Office. The Fund Office and the Board of Trustees will make every effort to assist you with any matter related to the program.

To keep your eligibility records accurate, notify the Fund Office in writing about any change in:

- Address
- Dependent status (birth, adoption, legal placement for adoption, custody, death, marriage, legal separation, divorce, etc.)
- Designated life insurance beneficiary

We believe your health Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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 grandfathered health plan status can be directed to the Fund Office at 816-943-0277. 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

Sincerely,

Board of Trustees

The Trustees reserve the right to amend, modify or discontinue all or part of this Plan wherever, in their judgment, conditions so warrant.

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I. Schedule of Benefits

Death Benefit	
Active Employee	$10,000
Spouse of Active Employee	$3,500
Retired Employee under Age 65	$5,000
Accidental Death and Dismemberment Benefit	
Full Benefit Amount	
Active Employee	$5,000
Retired Employee under Age 65	$5,000
Weekly Accident and Sickness Benefit (Active Employees)	
Weekly Benefit	$300
Maximum Period	26 weeks
Benefit Begins:	
Accident	1st day
Sickness	8th day
Additional Accidental Expense Benefit	
Maximum Benefit	$300
Major Medical Benefits	
Calendar Year Deductible per Person	$525 per adult OR $175 per with completion of HRA and biometric screening $100 for children
Deductible does not apply to Mental Health and Substance Abuse Services.	
Calendar Year Maximums	
Physical, Occupational, Speech Therapy	45 visits (combined)
Outpatient Cardiac Rehabilitative Services	36 visits
Lifetime Maximums:	
Smoking Cessation	$100
Travel and Lodging for Approved Transplants	$10,000 *(in-network Center of Excellence only)*
Coinsurance:	
Preferred Provider Organization (PPO) Provider or Facility (See Page 25)	90%
Non-PPO Provider or Facility	65%
When Member Resides Outside PPO Area	80%
Out of Pocket Maximums	
PPO Providers or Facilities	$15,000 per individual $30,000 per family
Non-PPO Providers or Facilities	Unlimited

Emergency Care Benefit	
Maximum for Facility Fee per Non-Emergency	50% to a maximum of $75
Emergency Room Physician Fee	50% of allowable charge
Physical Examination Expenses Benefit (Employee and Spouse)	100% up to $250, deductible and coinsurance apply thereafter.
Chiropractic Treatment Benefit	
Calendar Year Deductible	$100
Calendar Year Maximum	$500
Coinsurance	80%
Hearing Aid Benefit (participating provider must be used)	One hearing aid or replacement device per ear each three-calendar year period paid at 100% up to $1,000 then deductible and coinsurance applies.

Employee Assistance Plan (EAP)

The Plan offers an Employee Assistance Plan that can provide up to five calls at no charge to you and your Dependents for a wide range of personal situations. This is in addition to benefits under the Mental Health and Substance Abuse coverage. EAP benefits are provided by New Directions Behavioral Health. For assistance with any of these issues, we encourage you to continue to contact New Directions Behavioral Health by calling 1 (833) 964-6338.

Prescription Drugs *(not subject to Major Medical deductible)*

Retail Program at a Participating Pharmacy *(up to a 34-day supply or 100-unit doses, whichever is greater)*

	Participant Copays
Active Employees and Retirees not Eligible for Medicare:	
Up to $2,000 in Fund payments (Mail Order and Retail)	
Generic	10%, minimum $5
Brand Name Formulary	20%, minimum $15
Brand Name Non-Formulary	30% minimum $30
After $2,000 in Fund payments (Mail Order and Retail)	50%
Retirees Eligible for Medicare:	
Generic	50%, minimum $5
Brand Name	50%, minimum $15
Mail Order Program *(up to a 90-day supply)*	
Generic	$5
Brand Formulary	$25
Brand Non-Formulary	$50

For prescriptions relating to treatments of chronic diseases (diabetes, hypertension, coronary artery disease (CAD), and asthma), a $25 mail-order brand non-formulary copayment, $15 mail-order brand formulary copayment and $0 mail-order generic copayment applies.

Participants who utilize a brand name drug with a generic equivalent are subject to the Mandatory Generic Program described on page 34.

Specialty Drugs *(up to a 30-day supply)*	
Through Sav-Rx Specialty Drug Program	10%, $3,000 annual max

Vision Care Expense Benefit	
Two-Consecutive Calendar Year Maximum (New Period Beginning Every Even Numbered Calendar Year)	$300
Annual Safety Glasses Maximum	$100

Dental Care Expense Benefit	**Reimbursement Level Non-Network**	**Reimbursement Level In-Network**
Deductible (Coverage A, B, C, and D)	$0	$0
Maximum per Calendar Year (applies to A, B, C only)	$1,000	$1,500
Coverage A – Diagnostic and Preventive Coinsurance	80%	100%*
Coverage B – Basic Services, Fillings and Extractions Coinsurance	80%	80%**
Coverage C – Prosthetic Devices, Bridges and Dentures Coinsurance	50%	50%
Coverage D – Orthodontia Benefit Coinsurance	50%	50%
Coverage D – Orthodontia Lifetime Maximum	$2,000	$2,000
Coverage E – *Medical Deductible Applies*		
Coverage E – Dental Implants – Coinsurance	80%	80%
Coverage E – Dental Implants – Lifetime Maximum	$4,000	$4,000

II. Eligibility

A. Eligibility for All Benefits

Each Employee who has performed work which is under the jurisdiction of Local Union No. 124, International Brotherhood of Electrical Workers, ("IBEW") and on whose behalf contributions are made by Contributing Employers to this IBEW Local Union No. 124 Health and Welfare Fund will become eligible for the benefits provided by the Fund if and when the requirements listed in this Section are met. The Trustees have accepted several collective bargaining agreements with different levels of Employer contributions required for different work classifications. Based on the collective bargaining agreement and classification of work, an Employee may become eligible for benefits either on a quarterly or on a monthly basis according to the rules in that section.

Depending on the classification, the Employee may be eligible for single or family coverage. Under the family coverage, all Dependents of the Employee who meet the Plan's definition of Dependent are covered. The Dependents will become eligible and will lose eligibility on the same date as the Employee. Single coverage provides coverage only for the Employee, and no Dependents will be eligible for benefits under single coverage. If a spouse or a child of an active participant voluntarily waives coverage under the Plan, they can reapply for eligibility under the Plan only if evidence of continuous coverage through another group health plan is provided.

The Benefits Office maintains a list of work classifications that determine Quarterly Coverage or Monthly Coverage and if an Employee has single or family coverage, and will provide more information to you regarding the same on request.

The benefits under this Plan do not affect an Employee's eligibility for any workers' compensation insurance. These benefits, with the exception of Death Benefits as explained in this booklet, only cover non-occupational accidents and sicknesses.

B. Initial Eligibility for Quarterly Coverage

Eligibility for quarterly coverage is determined by the total contributions made by Contributing Employers to the Fund on an Employee's behalf. When contributions are first received by the Fund, they are credited to the appropriate Employee's dollar bank. The Board of Trustees, from time to time, will determine the amount of contributions that must be in an Employee's dollar bank in order to gain initial eligibility for benefits. This amount of required contributions is referred to as the Initial Deposit Requirement (IDR). The current Initial Deposit Requirement is equal to 480 hours times the current H&W contribution rate. The accumulation of these contributions can be made over a 12 consecutive month period.

An Employee will become eligible for benefits on the first day of the third month that follows the month the Initial Deposit Requirement is credited to that Employee's dollar

bank. When initial eligibility falls within an eligibility quarter, as described in the chart below, an Employee receives coverage for the remainder of the eligibility quarter plus the next eligibility quarter.

If a contributing Employer fails to pay the required contributions for any reason, no credit will be given. Contributions that are received late will be credited back to actual work dates and refunds of self-contributions will be made when applicable. Hours worked after the last Sunday of the month will be credited to the next month.

Table 1

Work month	Work Hours	Current JW Rate	Employer Contributions	Quarterly Deposit Requirement	Bank	Eligibility Month
July	160	$9.99	$1,598.40		$1,598.40	No eligibility
Aug	160	$9.99	$1,598.40		$3,196.80	No eligibility
Sept	160	$9.99	$1,598.40		$4,795.20	Dec, Jan, Feb, and March
Oct	160	$9.99	$1,598.40	$2,397.60	$2,397.60	Dec, Jan, Feb and March
Nov, Dec, Jan	450	$9.99	$4,495.50	$2,397.60	$2,397.60	April, May and June

C. **Continued Eligibility for Quarterly Coverage**

Once the initial eligibility requirements for quarterly coverage are met, an Employee will continue to be eligible as long as the Employee is working for a Contributing Employer and maintains the Quarterly Deposit Requirement for continuing eligibility in his dollar bank. Employees currently have a Quarterly Deposit Requirement of 240 hours times the current contribution rate for each contribution quarter as stated on the next page:

Table 2

Contribution Quarter	Eligibility Quarter
August, September, October	January, February, March
November, December, January	April, May, June
February, March, April	July, August, September
May, June, July	October, November, December

The Quarterly Deposit Requirement will be subtracted from the Employee's dollar bank to meet the cost of continuing the benefits. The Trustees may change, from time to time, the Quarterly Deposit Requirement to support the cost of the benefit program. If contributions in an Employee's dollar bank exceed the Quarterly Deposit Requirement, the excess will be carried forward in the dollar bank. An Employee may accumulate up to a maximum of two times the Quarterly Deposit Requirement, which will allow the employee an additional full quarter of eligibility without needing additional contributions on his behalf. Contributions in excess of two times the Quarterly Deposit Requirement will not be accumulated.

D. **Credit While Disabled:**

If an Employee becomes disabled and does not have the Quarterly Deposit Requirement in his dollar bank to continue eligibility or his dollar bank falls below the Quarterly Deposit Requirement during his disability **and** the Employee collects either (1) workers' compensation benefits for a disability resulting from an injury that occurred while performing work for a Contributing Employer, or (2) Weekly Accident and Sickness Benefits from this Plan, the Employee will receive weekly disability credits to his dollar bank equal to the average number of hours of contributions paid on the Employee's behalf during the twelve work months preceding their disability multiplied by the average hourly contribution rate for that period. However, if an Employee qualifies for and takes a medical leave under the Family and Medical Leave Act (FMLA), the Employee won't receive disability credits for the same period of time for which his Employer is paying contributions to the Health and Welfare Fund in accordance with the FMLA. In no event will more than 26 weeks of disability credits be granted during any 52 consecutive week period.

E. **Termination of Quarterly Coverage**

Eligibility for benefits will terminate as of the earliest of the following:

1. The first day of the eligibility quarter (January 1, April 1, July 1, or October 1) immediately following the end of a contribution quarter (October 31, January 31, April 30, or July 31) in which the Employee does not have Continuing Eligibility Deposit Requirement in the Employee's dollar bank.

2. Upon retirement under the IBEW Local Union No. 124 Pension Fund, on the last day of the month immediately preceding the first day of the month when retirement payments begin.

3. On the date of entrance into active duty with the Armed Forces of the United States, subject to the Uniformed Services and Employment and Reemployment Rights Act of 1994 (USERRA).

4. With respect to an Employee's spouse or Dependent, the date of any of the COBRA qualifying events.

5. With respect to the spouse and/or Dependent of a deceased Employee, the date the deceased Employee's coverage would have ended had the Employee left covered employment on the date of his or her death. This will include using the eligibility dollar bank that was accumulated by the deceased Employee.

If a Dependent's coverage ends, COBRA Continuation Coverage may be available.

F. Reinstatement of Benefits for Quarterly Coverage

Each employee previously eligible under the Quarterly Coverage, whose eligibility terminated and who returns to active work with a contributing Employer will be required to meet the requirements in the Initial Eligibility section in order to be reinstated for eligibility. An Employee who qualifies for initial eligibility under the Alternative Initial Eligibility rule for newly organized bargaining units may not be reinstated for eligibility under the alternative rule if his eligibility terminates.

Each Employee eligible under this Plan, whose eligibility terminates because of entrance into active duty with the Armed Forces of the United States and who returns to active work with a contributing Employer within 90 days following the date of release from such active duty will become eligible under this Plan on the date he returns to active work.

G. Self-Contributions for Quarterly Coverage

If an Employee is notified that their eligibility will terminate because their dollar bank does not contain the Quarterly Deposit Requirement, the Employee may arrange with the Fund Office to make direct contributions to continue eligibility. The amount of the

self-contributions will be the difference between the balance in the dollar bank and the Deposit Requirement.

Self-contributions will be allowed for up to four consecutive eligibility quarters provided the Employee remains available for and is actively seeking work in employment with a Contributing Employer in the jurisdiction of the Fund. However, if no contributions are made on their behalf by Contributing Employers during any two consecutive contribution quarters, the Employee's right to make self-contributions will be limited to one eligibility quarter and further continuation of coverage will be subject to the COBRA rules. Self-contributions will not be allowed if an Employee works for an Employer whose bargaining relationship with the Local Union has terminated or if the Employee works for a non-contributing employer.

An Employee will not be allowed to qualify for Initial Eligibility by making self-contributions. However, any balance in the dollar bank as of the date eligibility ended, as described in the Termination of Benefits section that is not applied to offset the required self-contributions may be carried forward for a period of up to 12 months of the termination date to be used to meet the requirements described in the Initial Eligibility for Quarterly Coverage section.

H. Alternate Initial Monthly Eligibility to Obtain Quarterly Coverage for Newly Organized Bargaining Units

If the Trustees accept a newly organized bargaining unit this Alternate Initial Eligibility rule may apply which provides for initial eligibility as of the first day of the third month for which Employer contributions are required to be paid on behalf of the Employee. The Employee is required to have Employer contributions each month to maintain eligibility.

In order for this Employee to transition to Quarterly coverage, an Employee must accumulate contributions in an amount equal to the Initial Deposit Requirement (IDR). The accumulation of contributions can be made over a 12 consecutive month period. An Employee will not be allowed to have the extended Quarter Coverage until such time that he accumulates contributions in excess of the IDR.

An Employee can qualify for benefit coverage under the Plan under this Special rule only one time. If an Employee loses eligibility under this Alternate Initial Eligibility rule, this eligibility is not available again in the future, except pursuant to USERRA coverage.

If an Employee has eligibility as a result of this Alternate Initial Eligibility rule, that Employee's eligibility will terminate as a result of either: termination of employment with a Contributing Employer for a period of 30 consecutive days, or failure to accumulate contributions equal to the Initial Deposit Requirement in a 12-consecutive month period. For more information about this Alternate Initial Eligibility rule, contact the Fund Office.

I. Termination of Alternate Initial Eligibility for Quarterly Coverage

1. On the last day of the month in which an Employee is eligible under the Alternative Eligibility rules within 12 consecutive months and the Employee does not accumulate the Initial Deposit Requirement and stops working for a contributing Employer

2. The last day of the month following the month in which an Employee failed to be employed by a Contributing Employer for a period of 30 consecutive days

3. Refer to paragraphs 2, 3, 4 and 5 as above stated in the Termination of Quarterly Coverage section on pages 6-7.

J. Self-Contributions for Alternate Initial Eligibility

If an Employee is initially eligible as a result of the Alternate Initial Eligibility rule, they may be allowed to make self-contributions for up to four consecutive months if the employee loses eligibility as a result of the termination of employment with a contributing Employer or due to disability before accumulating contributions for the Initial Deposit Requirement. The Employee must remain available for and actively seek employment with a contributing Employer in the jurisdiction of the Fund.

Self-contributions must be received in the Fund Office no later than the 15th day of the month preceding the eligibility quarter for which coverage is to be provided. Self-contributions received after this deadline will not be accepted and eligibility remains terminated.

K. Initial Eligibility for Monthly Coverage

An Employee may become eligible for benefits on the first day of the month following the month in which the Employee:

1. Completes three months of employment with contributing Employers; and

2. Credited with 500 straight time hours of contributions.

Please see example:

Table 3

	June	July	Aug	Sept
WORKHOURS	200	150	150	150

E = Eligible; I = Ineligible	I	I	I	E

L. **Continued Eligibility for Monthly Coverage**

If an Employee has eligibility as a result of this Initial Eligibility rule, eligibility will continue as long as 300 hours of contributions are made by the Employer, in the prior 3-month period. In this example please refer to Table 3 above.

Table 4

	SEPT	OCT	NOV	DEC	JAN	FEB
WORK HOURS	150	200	50	0	0	150
E = Eligible; I = Ineligible	E From initial eligibility Hours worked June, July, and August	E From initial eligibility Hours worked June, July, and August	E 300 hours in 3 months prior (July, Aug, and Sept)	E 300 hours in 3 months prior (Aug, Sept, and Oct.)	E 300 hours in 3 months (Sept, Oct, and Nov)	I Less than 300 hours worked (Oct, Nov, and Dec.)

M. **Credit While Disabled**

If an Employee becomes disabled and does not have 300 hours to continue eligibility **and** the Employee collects either (1) workers' compensation benefits for a disability resulting from an injury that occurred while performing work for a Contributing Employer, or (2) Weekly Accident and Sickness Benefits from this Plan, the Employee will receive weekly disability credits to the hour bank equal to the average number of hours of contributions paid on the Employee's behalf during the twelve work months preceding their disability. However, if an Employee qualifies for and takes a medical leave under the Family and Medical Leave Act (FMLA), the Employee won't receive disability credits for the same period of time for which his Employer is paying contributions to the Health and Welfare Fund in accordance with the FMLA. In no event will more than 26 weeks of disability credits be granted during any 52 consecutive week period

N. Reinstatement of Benefits for Monthly Coverage

An employee who qualifies for initial eligibility under the initial eligibility for monthly coverage and who returns to active work with a contributing Employer will be required to meet the following requirements in order to be reinstated for eligibility:

If a period of less than six months has elapsed since the Employee's eligibility was terminated, the employee will be eligible on the first day of the next month following the date the employee completes two consecutive months of employment with a contributing Employer provided 200 hours of contributions are made on their behalf.

If a period of six or more months has elapsed since the Employee's eligibility was terminated, the employee will be required to satisfy the requirements in the Initial Eligibility for monthly coverage.

Each Employee eligible under this Plan, whose eligibility terminates because of entrance into active duty with the Armed Forces of the United States and who returns to active work with a contributing Employer within 90 days following the date of release from such active duty will become eligible under this Plan on the date the employee returns to active work.

O. Alternate Initial Eligibility for Monthly Coverage for Newly Organized Bargaining Units

If a member is given Alternate Initial Eligibility for monthly coverage, they would become eligible the first of the 3rd month of reported hours and Employer contributions. Continued eligibility follows the rules under Continued Eligibility for monthly coverage.

P. Self-Contributions for Monthly Eligibility

If an Employee is notified that their eligibility will terminate because they have not gotten the required number of hours and Employer contributions, they can make a self-pay for 4 consecutive months. The cost is 80 hours times the current H&W rate of their classification.

Q. Special Eligibility Situations:

Monthly Coverage may be Family or Single coverage, which is determined by the applicable collective bargaining agreement.

An Employee who is transitioning from monthly coverage to quarterly coverage must maintain hours each month until enough hours with Employer contributions are met to obtain IDR. Once IDR is met, then Employee will transition to quarterly coverage.

An Employee who is transitioning from quarterly coverage to monthly coverage must have hours each month unless the Employee has extended eligibility.

Reciprocity-Work Performed in another Jurisdiction – If an Employee leaves the geographic jurisdiction of the Local Union No. 124 to perform work in the geographic jurisdiction of another local union of the I.B.E.W., the Employee may be eligible for continued coverage because of the reciprocal agreement among I.B.E.W. welfare funds. At the time the Employee is assigned to work in another geographic jurisdiction, the Employee should verify with the IBEW Local Union 124 to make sure they are signed up with ERTS. The Employee could also ask the Benefit Office about their eligibility before starting to work outside of the Local 124 geographic jurisdiction. Continuation of coverage is not automatic. An Employee must request and complete the reciprocity form to assure that there will be no loss of benefits.

R. **Non-Bargained Initial Eligibility**

(This section does not apply to the Employees who are Alumni, or are Employees of the Union, the Benefit Center, Inc., NECA, and the Electrical Joint Apprenticeship and Training Fund for whom contributions are paid by the Fund.)

Contributing Employers may elect to cover their Non-Bargained Employees under this Plan as long as all full-time (35 hours per week or more) Employees have contributions paid to the I.B.E.W. Local Union No. 124 Health and Welfare Fund. Such Employers shall be obligated by a written agreement approved by the Trustees to make contributions to the I.B.E.W. Local Union No. 124 Health and Welfare Fund. Part-time Employees who work at least 24 hours per week may be eligible under the Plan if the Employer makes contributions for part-time Employees pursuant to a written agreement. Non-bargained Employees must have contributions made on their behalf equal to two months of contributions before their eligibility for benefits begins.

The benefits under this Plan do not affect an Employee's eligibility for any workers' compensation insurance. These benefits, with the exception of Death Benefits as explained in this booklet, only cover non-occupational accidents and sicknesses.

S. **Termination of Non-Bargained Employee Coverage**

1. For non-bargained Employees, on the last day of the month in which employment with the Employer is terminated or on the last day of the month in which the Employer fails to make contributions on the Non-Bargained Employee's behalf or Collective Bargaining Agreement Employee's behalf

2. Refer to paragraphs 2, 3, 4 and 5 as above stated in the Termination of Quarterly Coverage section on pages 6-7.

T. Uniformed Services Employment and Reemployment Rights Act (USERRA)

Definitions:

Health Coverage means Hospital, surgical, medical, dental, and vision coverage that is provided under the Plan.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to USERRA and any interpretive regulations or rulings).

Covered person means an Employee or Dependent as defined in the Definitions Section.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed services mean the United States Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

U. Continuation of Group Health Coverage

1. If an Employee's Health Coverage ends because of service in the uniformed services, such Employee may elect to continue such Health Coverage, if required by USERRA, until the earlier of:

    a. The end of the period during which the Employee is eligible to apply for reemployment in accordance with USERRA; or

    b. 24 consecutive months after coverage ended.

2. To continue coverage, an Employee must pay the required premium, unless service in the uniformed service is for fewer than 31 days. The Fund Office will inform the Employee of procedures to pay premiums. The USERRA premium is the same amount as the COBRA premium.

3. Continued Health Coverage under this USERRA section will end at midnight on the earliest of:

    a. The day the Plan is terminated;

b. The day a premium is overdue; or

c. The day a Covered Person again becomes covered under the Plan.

V. Dollar Bank

An Employee may use money in his or her dollar bank, if any, toward the USERRA premium. If the Employee does not choose to continue coverage under USERRA, then COBRA may be elected.

Return to Work

When an Employee returns to work pursuant to USERRA, such Employee will receive immediate eligibility. The Alternate Initial Eligibility Rules above will then apply**.**

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA will apply.

W. Family and Medical Leave Act (FMLA)

The Trustees have adopted procedures to comply with the Family and Medical Leave Act of 1993 (FMLA). Under the FMLA, eligibility for benefits must be extended to you and your covered Dependents if you are an active participant, have been granted leave by your Employer under the FMLA and your Employer makes the required contributions to the Fund.

The FMLA requires your Employer to inform you of your rights and obligations under this law. You may contact the local Wage and Hour division of the United States Department of Labor if you have questions regarding the FMLA.

If you have been granted FMLA leave, your Employer must notify the Fund Office to prevent a loss of eligibility. You may wish to notify the Fund Office yourself when you are granted FMLA leave, but you are not required to do so. Your Employer will be asked to complete some forms to verify your eligibility for benefits while on leave. Your Employer must pay for your extended eligibility before the Fund will provide benefits.

Your Employer will be required to pay the cost of coverage in an amount equal to contributions for 35 hours of work per week for each week you are on FMLA leave.

III. Benefits for Retired Employees

A. Retirees Not Eligible for Medicare

Eligibility Requirements:

1. Maintain eligibility under the Fund for thirty-six (36) out of the sixty (60) months immediately preceding the effective date of retirement.

2. Retire under the Regular, Early Retirement, or Disability Pension provisions of the I.B.E.W. Local Union No. 124 Pension Plan, the Local Union No. 124 Intercommunication Division Pension Fund, or the National Electrical Benefit Fund. If you retire under the National Electrical Benefit Fund, you must also have worked under a collective bargaining agreement that required contributions to the Health and Welfare Plan at the same rate specified by the Inside Agreement for a minimum period of five (5) years.

3. Submit a written Application to the Fund Office no later than sixty (60) days following the effective date of retirement.

4. Make self-contributions as required by the Trustees.

5. Not be eligible for Medicare.

All self-contributions for retiree coverage must be received in the Fund Office no later than the 15th day of the month preceding the eligibility quarter for which coverage is to be provided. Self-contributions received after this deadline will not be accepted and eligibility for benefits will end.

B. Retired Non-Bargained Employees Not Eligible for Medicare

Eligibility Requirements:

- Non-bargained Employee of a contributing employer who retires from employment at age 62 or later.

- Maintain eligibility under the Fund for at least five consecutive years immediately before your retirement.

- Submit a written Application to the Fund Office no later than sixty (60) days following the effective date of retirement.

- Make self-contributions as required by the Trustees. Self-contributions must be received in the Fund Office no later than the 15th of the month before the month for which coverage is provided. Self-contributions received after the deadline will not be accepted and eligibility for benefits will terminate.

- Not be eligible for Medicare.

1. Retirees Eligible for Medicare

If you are an eligible Retired Employee of at least age 65, you may self-pay for the Medicare Supplement Benefit, the prescription drug benefit for Medicare retirees, and the Dental Expense Benefit. This coverage also applies to Dependent spouses eligible for Medicare.

Prior to your 65th birthday it is important that you and/or your spouse learn about your Medicare benefits from the Social Security Administration. For questions about coverage from this Plan or help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office.

2. Continuation of Benefits for Spouses and Dependents of Retired Employees

When you become covered under the Medicare Supplement Benefit because you are eligible for Medicare, your spouse will also be covered under the Medicare Supplement Benefit. However, if your spouse or Dependent child is not eligible for Medicare, you may make self-contributions to the Fund to keep your spouse and/or Dependent children covered under the Retired Employee benefits until they become eligible for Medicare. Dependent children will continue to be covered under the Retired Employee benefits as long as they meet the definition of a Dependent. The Trustees will determine the monthly self-contribution rate. In the event of your death or divorce, your spouse and/or Dependent children may continue to be covered for benefits until your spouse remarries or fails to make the required self-payment.

3. Continuation of Benefits for Spouses and Dependents of Retired Non-Bargained Employees

If you are an eligible Retired non-bargained Employee of at least age 65 (who has been continuously covered for retiree non-bargained coverage) and your spouse and/or Dependent child has not reached age 65, you may make self-contributions to the Fund to continue coverage for your spouse and/or Dependent children until your spouse reaches age 65 under Retired Employee benefits. Dependent children will continue to be covered as long as they meet the definition of a Dependent and make the required self-contribution. The Trustees will determine the required amount of self-contributions.

In the event of your death or divorce, your spouse and Dependent children may continue coverage until your spouse remarries, fails to make the required self-payment, or when your Dependent child no longer meets the definition of a Dependent.

4. Return to Active Employment by Retired Employees

If you return to active employment, you will become eligible for Active Employee benefits again when you meet the Initial Eligibility rules. Until you meet the eligibility requirements for the Active Employee benefits, you may continue to receive coverage under the Plan by making self-contributions in an amount and manner determined by

the Trustees. If you stop working, you will not be eligible for run out as described in the Plan and you must pay the retiree premium as soon as your pension payment restarts.

C. COBRA

Continuation Coverage - *The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), provides for continuation of health coverage for you and your eligible Dependent(s) who otherwise would lose coverage under the Plan. Each eligible Dependent has an independent right to elect COBRA continuation coverage. Parents may make the election on behalf of their Dependent. You may continue health coverage by making self-contributions to the Fund.*

The circumstances (qualifying event) under which you and/or your Dependents may lose coverage under the Plan and the period of time you may make self-contributions to continue benefits are described below.

1. Employee

You and your eligible Dependent(s) will lose coverage when your employment ends or you do not work the hours required to maintain eligibility under the Plan. Under COBRA, retirement is considered a termination of employment.

You may continue coverage for all benefits (except the Death Benefit and Weekly Accident and Sickness Benefit) for yourself and your eligible Dependents by making self-contributions to the Fund. You may self-contribute starting on the date you lost eligibility until the earliest of:

a. A period of 24 months;

b. Eligibility for Medicare; or

c. Your death.

2. Spouse and/or Dependent Children

Your spouse and/or Dependent children lose health coverage under this Plan when one of the following qualifying events occurs:

a. You lose eligibility under the Plan. Your spouse and/or Dependent children may continue benefits by self-contributions for a period of 24 months.

b. You and your spouse are divorced. Your spouse and/or Dependent children may make self-contributions for up to 36 months.

c. You retire and become eligible for Medicare and are not eligible and do not choose the Retiree benefits. The maximum period of COBRA coverage for eligible Dependents will be extended to 36 months from the initial qualifying

event even if you become eligible for Medicare during the original 24 months of continuation coverage.

d. Your death. Your spouse and/or Dependent children may continue coverage for a period of 36 months. If you were eligible for the benefit program of the I.B.E.W. Local Union No. 124 Health and Welfare Fund for at least three years before your death, the Fund will provide coverage, without payment, for your spouse and Dependent children during the first 12 months; your spouse and/or Dependent children may continue benefits for the remaining 24 months by making self-contributions. However, the Fund will provide coverage, at no cost, for the first 12 months of the COBRA continuation period to your surviving spouse and/or Dependent children if you were eligible for the active Employee's benefit program for at least 15 years before your death. Your spouse may continue to self-contribute for health coverage until he or she becomes eligible for Medicare or remarries and for any Dependent children until each reaches the limiting age.

e. Your Dependent child no longer meets the definition of a Dependent. Your Dependent child may continue coverage by making self-contributions for a period no greater than 36 months.

If an individual is eligible for self-contributions under more than one of the circumstances described above, a maximum of 36 months of continued coverage applies, except for the spouse of a deceased Employee who had 15 years of coverage under the Fund, as stated above.

3. Coverage

Continued coverage will start from the first day of the month following the month in which the first qualifying event occurred.

Your Employer will notify the Fund Office in the event of your death, termination of employment, or eligibility for Medicare. However, it is your responsibility (or your Dependent's responsibility) to notify the Fund Office within 60 days of a divorce or when your Dependent child loses Dependent status under the Plan. Failure to keep the Fund Office informed of these changes may affect your rights to continue your or your family's health care under the Plan.

If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA continuation coverage is in effect, you may add this child to your coverage. The Fund Office must be notified as soon as possible after the birth or placement in order for the child to be added.

If at the time or within 60 days of the first qualifying event you or your eligible Dependent is totally disabled (as determined by the Social Security Administration), the maximum period for which payments may be made by or on

behalf of the disabled individual will be extended five months to a total of 29 months from the first qualifying event. The disabled individual must notify the Fund Office within 60 days of a determination of disability by the Social Security Administration and before the end of the 24-month maximum period. This five-month extension of COBRA continuation coverage also applies to the non-disabled family members of the disabled individual.

After a qualifying event has occurred, the Administrative Manager will notify you of loss of coverage and of the monthly amount of contributions required to continue eligibility for benefits.

You and/or your eligible Dependent(s) will have sixty (60) days from the date on which coverage under the Plan would otherwise terminate, or sixty (60) days from receipt of Notice from the Administrative Manager to elect continuation coverage. If you and/or your eligible Dependent(s) do not elect continuation coverage within the sixty (60) day election period, coverage under the Plan will end as of the date the coverage would have otherwise ended without regard to the sixty (60) day election period.

After you and/or your eligible Dependent(s) elect to receive continuation coverage under the Plan, the first premium must be made within forty-five (45) days of the election. Failure to make the required premium payment within the initial forty-five (45) day period will result in the loss of COBRA continuation coverage. Thereafter, you must pay each month. Premium payments are due on the 1st of each month at the Fund Office. However, you will have a 30-day grace period in which to make the payments. Failure to make the required premium payments after the thirty (30) day grace period will result in the loss of COBRA continuation coverage.

4. **Termination of Continued Health Benefits**

Health benefit coverage will terminate on the earliest of the following:

a. You and/or your eligible Dependent fail to make any required self-payment.

b. You and/or your eligible Dependent become covered under another group health plan. However, if you or your eligible Dependent has a health problem that is excluded from or limited under the other group health plan, you or your eligible Dependent will be allowed to continue payments under the Fund until the 24- or 36-month period has expired.

c. You and/or your eligible Dependent have reached the maximum number of months of continued coverage as previously explained.

d. You and/or your eligible Dependent become entitled to Medicare.

D. Extended Coverage for Full-Time Students: Michelle's Law

Coverage for an enrolled Dependent child who is a Full-time Student at a post-secondary school and needs a medically necessary leave of absence will be extended until the earlier of the following:

- one year after the medically necessary leave of absence begins; or
- the date coverage would otherwise terminate under the Plan.

Coverage will be extended only when the enrolled Dependent is covered under the Plan because of Full-time Student status at a post-secondary school immediately before the medically necessary leave of absence begins and the enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- the enrolled Dependent is suffering from a serious Sickness or Injury;
- the leave of absence from the post-secondary school is medically necessary, as determined by the enrolled Dependent's treating Physician; and
- the medically necessary leave of absence causes the enrolled Dependent to lose Full-time Student status for purposes of coverage under the Plan.

A written certification by the treating Physician is required. The certification must state that the enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary. For purposes of this extended provision, the term "leave of absence" shall include any change in enrollment at the post-secondary school that causes the loss of Full-time Student status.

IV. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Special Assistance Available

If you are eligible for health coverage but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their CHIP or Medicaid programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. Contact information for Kansas and Missouri are included below.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS-NOW** or

www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for this health plan.

KANSAS – Medicaid	**MISSOURI** – Medicaid
Website: https:// //kdheks.gov/hcf/Medicaid/ Phone: 800-766-9012	Website: http://dss.mo.gov/mhd/index.htm Phone: 573-751-6944

Special Enrollment

An eligible employee and/or dependent will be allowed to enroll in the Plan during a special enrollment period if they:

- lost coverage under Medicaid or CHIP; or
- become eligible to participate in a premium assistance program under Medicaid or CHIP

You must request special enrollment within 60 days of the loss of Medicaid/CHIP or the eligibility determination.

V. Death Benefit

The applicable Death Benefit as shown in the Schedule of Benefits will be paid if you are an active employee or a retired employee under age 65 (even if covered by Medicare). If your spouse dies while you are an active employee, the applicable death benefit will be paid to you. Retirees age 65 or older and COBRA participants are not eligible.

A. **Beneficiary**

Payment will be made to the beneficiary or beneficiaries you (or your spouse) designate. You may change the beneficiary at any time and as often as desired by contacting the Health and Welfare Fund Office. If you have not named a second beneficiary, we suggest you do so.

If your spouse is the designated beneficiary and you get divorced, that designation is automatically revoked.

It is important to keep updated beneficiary information on file with the Fund Office. You should notify the Fund Office if you get married or divorced.

If you have not designated a beneficiary, or if your beneficiary predeceases you, payment will be made to your first survivor in the following successive classes:

- Your spouse (the employee in case of a spouse's death);
- Your children;
- Your parents;
- Your brothers and sisters; or
- Your estate.

If there is more than one survivor in the class to which payment is being made, the survivors in that class will share the benefit equally.

The beneficiary may disclaim the death benefit by submitting the approved disclaimer to the Fund Office no later than twelve (12) months after your (or your spouse's) death.

VI. Accidental Death and Dismemberment Benefit

A. *For Active Employees and Retired Employees (under age 65)*

The Accidental Death and Dismemberment Benefit provides a lump sum if you die or suffer one of the losses listed below within 90 days after, and as a direct result of, an accident including bodily injuries. The amounts payable are as follows:

1. The full benefit amount is shown in the Schedule of Benefits for the loss of:
    a. Life;
    b. Both hands;
    c. Both feet;
    d. One hand and one foot;
    e. Sight of both eyes;
    f. One hand and the sight of one eye; or
    g. One foot and the sight of one eye.

2. One-half of the full benefit amount shown in the Schedule of Benefits for the loss of:
    a. Sight of one eye;
    b. One hand; or
    c. One foot.

The maximum amount paid as a result of any one accident is the full benefit amount.

B. Exclusions and Limitations

The purpose of this benefit is to cover losses due to an accident. Therefore, losses for the following are not payable under this benefit:

1. Bodily or mental infirmity.
2. Ptomaine or bacterial infections, except infections introduced through a visible wound accidentally sustained.
3. Suicide while sane or insane or intentional self-inflicted injury.
4. War, or any act of war, whether declared or undeclared.
5. This benefit is not payable to COBRA participants or retirees age 65 or older.

VII. Weekly Accident and Sickness Benefit

For Active Employees Only

A. Weekly Benefit

If you become disabled while eligible and are unable to work as a result of a sickness for which benefits are not payable under any workers' compensation law or an accidental bodily injury that is not work-related, you will be entitled to a weekly benefit as shown in the Schedule of Benefits. The Weekly Accident and Sickness Benefit is only available to active Employees presently working or during your self-payment period but this benefit is not available under COBRA.

You must provide proof of a disability of sufficient severity to prevent you from performing any and every duty of your occupation. You must be under the care of a legally qualified Physician (D.O., M.D., or surgeon) of your choice to be entitled to benefits. The opinion of a chiropractor (D.C.) alone will not be sufficient for this benefit.

B. Payment Begins

The weekly benefit will begin on the first day of disability due to an accident and the eighth day for disability due to sickness. These benefits are payable up to a maximum of 26 weeks during any 52-consecutive week period.

C. Successive Disabilities

Successive periods of disability separated by less than 40 hours of active employment in a consecutive two-week period will be considered one continuous period of disability unless the disabilities are from different and unrelated causes and the second disability began after you returned to active work on a full-time basis.

D. Exclusions and Limitations

The Weekly Accident and Sickness Benefit is not payable for:

1. Any period of disability during which you are not under the direct care of a legally qualified Physician, D.O., M.D., or surgeon.

2. Any disability due to accidental bodily injuries arising out of and in the course of your employment.

VIII. Additional Accident Expense Benefit

A. For Employees, Retirees, and Dependents (except for individuals for whom Medicare coverage is primary)

If you or your Dependent sustain an injury as a result of an accidental, non-occupational injury and, as a result, directly and independently of all other causes, incur any Usual, Reasonable and Customary Charges, the Fund will pay for the treatment or service up to the maximum shown in the Schedule of Benefits for a given accident. The expenses must be incurred within 90 days after the date of the accident and while you or your Dependent is still eligible under this Plan.

Additional Accident Expense Benefits cover expenses:

1. By a Hospital for room and board and other services required for purposes of treatment above other benefits.

2. By a Physician or surgeon for Usual, Reasonable, and Customary Charges for professional services including the cost of supplies in connection with the treatment above other benefits.

3. For the services of a graduate registered nurse.

B. Exclusions and Limitations

Payment will not be made under the Additional Accident Expense Benefit for the following expenses:

1. Charges for any treatment or service not prescribed by a Physician.

2. Charges for the replacement or repair of any prosthetic device.

3. Charges for any treatment or service that is compensated for or performed in a Hospital owned or operated by the United States government or at federal government expense, except for charges required to be paid to the Veterans Administration for treatment of a non-service related disability or otherwise as required by federal law.

4. Charges for any treatment or service due to suicide attempts or self-inflicted injuries, unless the injury or suicide attempt is the result of a mental or nervous disorder.

5. Charges incurred for treatment or service caused or sustained by you or your Dependent as a result of any injury or sickness caused by, or resulting from, participation in an attempt to commit a felony or in the commission of a felony.

6. Charges incurred, caused, or sustained for treatment or service as a result of an injury or sickness caused by participation in an occurrence where you or your Dependent is the instigator, provoker, and/or aggressor.

7. Charges for any surgical or medical services not provided by a Physician or surgeon.

8. Charges for any treatment or service due to injury arising out of or in the course of any employment for wage or profit.

IX. Major Medical Expense Benefit

A. For Employees, Retirees, and Dependents *(except for individuals for whom Medicare coverage is primary)*

If you and/or your Dependent(s) incur covered expenses due to a non-occupational sickness or injury, payment will be made under the Major Medical Expense Benefit. The Plan will pay the percentage stated in the Schedule of Benefits after you meet your annual deductible.

B. The Deductible

The deductible is the amount of medical expenses you or your Dependent must pay before being entitled to Major Medical Expense Benefits. Employees and spouses, who complete the wellness participation requirement in the prior calendar year, as well as all dependent children, receive the reduced deductible shown in the schedule of benefits. Employees and spouses who do not complete the wellness participation requirement have the higher deductible amount. Look for communications from the Trustees on how to satisfy the wellness participation requirement.

If two or more eligible persons in the same family are injured in the same accident, only one deductible will be applied to the total expenses resulting from the accident.

C. **Preferred Provider Organization (PPO)**

The PPO is a group of Hospitals and Physicians that provide medical care at reduced rates when Fund members receive care from providers in the group (PPO provider). Using PPO providers helps you and the Plan save money. You have a lower coinsurance and a cap on your out-of-pocket costs if you use PPO providers.

New Directions Behavioral Health is responsible for the PPO providers for mental health and substance abuse. Blue Cross and Blue Shield of Kansas City ("BlueKC") is responsible for all other PPO providers. Provider participation is subject to change. Verify provider participation in the BlueKC, the National Blue Networks, and/or New Directions as applicable prior to receiving services.

To find a Blue KC PPO Provider:

- Go to the Blue National Doctor and Hospital Finder Website: http:// www.mybcbs.com
- Call the National Provider Finder number at (800) 810-BLUE.

You will need the three digit account specific prefix: (IWV). This is the prefix that listed on the front of the identification card.

To find a New Directions PPO Provider or to access the EAP call: 1 (833) 964-6338.

D. **Wellness Benefits**

The Plan offers a health assessment annually, as well as biometric screening. You may also be contacted by a Health Coach or a Disease Management Nurse and offered coaching assistance in managing your risk factors and or any chronic conditions. Wellness benefits are strictly voluntary, although you may have a financial incentive to participate. You may dis-enroll at any time and all information shared is strictly confidential.

E. **Transplants – Blue Distinction Centers**

Facilities designated as Blue Distinction Centers for Transplants have dedicated teams that provide a full range of transplant services, in one or more of seven specific transplant types: heart, lung (deceased and living donor), combination heart/lung, liver (deceased and living donor), simultaneous pancreas-kidney (SPK), pancreas (PAK/PTA), and bone marrow/stem cell (autologous & allogeneic). Blue Distinction Centers for Transplants receive specific designations, identifying which of these particular type(s) of transplant programs have received Blue Distinction recognition.

Call the customer service number on the back of your ID card if you would like additional information about Blue Distinction Centers for Transplants. You can also visit www.mybluekc.com to find a Blue Distinction Center near you.

In addition to receiving coverage for the medical services connected to your transplant you are also eligible to receive financial assistance for travel and lodging if you (or your Dependent) receive your transplant at a Blue Distinction Center, up to the lifetime maximum shown in the Schedule of Benefits). Travel and lodging are limited to the recipient and one companion (two companions if the recipient is under age 18).

F. Emergency Care Benefit

Expenses for outpatient services in the emergency room of a Hospital are a covered expense if emergency care is needed. If the servicing physician determines the treatment to be of a non-emergency nature, expenses incurred are only payable for the Usual, Reasonable, and Customary Charges in an amount not to exceed the maximums or percentages shown in the Schedule of Benefits.

G. Physical Examination Expense Benefit

A physical or general health examination performed by a Physician, including charges for the medical examination and clinical laboratory tests, will be covered at 100% up to $250 as shown in the Schedule of Benefits for any calendar year. Deductible and coinsurance apply after $250, subject to the Exclusions listed on page 32 and 33.

The Physical Examination Benefit is not intended to cover the cost of ordinary visits to a Physician or any medical care connected with a sickness or disability. Such costs are covered under other Plan benefits.

Physical Exam Benefit Exclusions:

1. Pap Smears, Mammograms, Colonoscopies, and PSA testing. (These services are covered under Major Medical.)

2. Services or supplies covered in whole or in part under any other provisions of the Plan.

3. Physical examination received in connection with an injury or sickness.

4. Physical examination not performed by a Physician or other provider authorized by the Plan

Be sure to have your physician complete the biometric screening form when you have a physical. The form is available at www.mybluekc.com

H. Chiropractic Treatment Benefit

Expenses due to a non-occupational illness or injury for office visits to a licensed chiropractor and/or X-rays taken by a chiropractor, chiropractic modalities, physical therapy, and lab work, will be paid as shown in the Schedule of Benefits, subject to the following Exclusions:

1. X-rays performed by a person other than the attending chiropractor.

2. Visits or treatment incurred other than at the office of the chiropractor.

3. Treatment due to injury arising out of or in the course of any employment for wage or profit.

4. Acupuncture.

I. Hearing Aid Benefit

The Hearing Aid Benefit will pay charges as shown in the Schedule of Benefits during a three consecutive calendar year period for hearing aids and required examinations. Covered hearing aid expenses are the charges that a Participant is required to pay for hearing aids and required examinations. You must use a participating provider if Non-Medicare Eligible or a Medicare provider if Medicare Eligible for your examination and a participating provider must refer you to an audiologist and/or hearing aid provider in order for expenses to be covered.

You must use a participating provider for your examination who must refer you to an audiologist and/or hearing aid provider

Hearing Aid Exclusions:

1. Services or supplies covered in whole or in part under any other portion of the benefit Plan or hearing benefits provided by an employer.

2. Expenses for which benefits are payable under any Workers' Compensation law.

3. Services or supplies provided by a non-participating provider (except if you live outside the participating provider network area).

4. Amplifiers.

5. Hygienic cleaning of the hearing aid.

6. Lip reading or speech reading.

7. Replacement batteries.

8. Maintenance or repair of the hearing aid other than earpiece replacement.

9. Surgical implants or any devices that must be inserted or removed only by a medical professional or through a surgical procedure.

J. Physical, Occupational, and Speech Therapy Services

The Plan will cover physical, occupational, and speech therapy up to a combined limit of 45 visits per year. The limits will also apply to visits after a surgical procedure and to functional and restoration speech therapy.

K. Bariatric Surgery

Bariatric Surgery is covered when it is determined to be medically necessary according to the Blue Cross and Blue Shield of Kansas City's coverage policy and is performed at an approved in-network facility. Pre-authorization for bariatric surgery is required through Blue Cross and Blue Shield of Kansas City.

L. Covered Expenses

a. Charges made by a lawfully operated Hospital; however, the daily room and board charge may not exceed the Hospital's regular rate for semi-private accommodations.

b. Charges for surgery by a legally qualified surgeon.

c. Charges for Physician visits, including Physician office visits.

d. Charges made by a registered graduate nurse for private duty nursing service, while you or your eligible Dependent is confined in a Hospital.

e. Charges for the following: local ambulance service, equipment, blood, and blood plasma, appliances, X-ray services, laboratory tests, anesthesia, and the administration thereof, by an anesthesiologist or certified registered nurse anesthetist the use of radium and radioactive isotopes, oxygen, and iron lung.

f. Charges for prescription drugs and medications while hospitalized and for Physician's charges for injections.

g. Charges for the treatment of alcoholism and substance abuse.

h. Charges for the treatment of Mental and Nervous Disorders for individual psychotherapy. Service must be rendered by a Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), or a clinical psychologist (Ph.D.) for out-of-network services.

For Mental Health and Substance abuse benefits, contact New Directions by calling 1 (833) 964-6338. You may be eligible to receive up to 5 visits through the EAP program at no cost to you.

i. Charges for all Medicare-approved covered transplants including kidney, heart, lung, liver, heart/lung, bone marrow, cornea, and pancreas transplants.

j. Charges for outpatient physical, occupational, and speech therapy services up to the specified maximum number of visits.

k. Charges for a smoking cessation clinic or program up to the lifetime maximum shown in the Schedule of Benefits.

The Plan covers smoking cessation programs. Contact the fund office for more details.

l. Charges for organ procurement and travel and lodging (in-network only) up to the lifetime maximums shown in the Schedule of Benefits. Travel and lodging are limited to the recipient and one companion or two companions if the recipient is under age 18.

m. Charges for blood storage.

n. Non-emergency Physician or facility charges payable at 50% of the Usual, Reasonable, and Customary Charge. See the Emergency Care Benefit on page 27 for further details.

o. Emergency facility and Physician charges.

p. Charges for diagnosis and treatment for behavioral problems.

q. Charges for diagnosis and treatment for learning disabilities.

r. Charges for Interferon, Pancreatic enzyme supplement MT-20, chemotherapy medication, anti-rejection medication when prescribed for an approved transplant, infusion therapy drugs, and for physician's charges for injections for the treatment of illness or injury, including allergy injections. However, preventive injections are not covered.

s. Charges for outpatient cardiac rehabilitative services following Hospital confinement up to the calendar year maximum shown in the Schedule of Benefits.

t. Charges for well-child examinations and immunizations for Dependent children up to the Plan's limiting age for Dependent children. Coverage includes office visits, immunizations, and routine lab tests required for annual physicals.

u. Charges for the following in connection with a mastectomy:

v. Reconstruction of the breast on which the mastectomy is performed;

w. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

x. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

y. Charges for diagnosis and treatment of spina bifida before or after birth.

z. Charges for women's contraceptives for an employee and/or spouse under the prescription drug benefit, including diaphragms and contraceptive medication taken orally or by an implant, ring, patch, or injection.

aa. Charges for Bariatric Surgery, if the procedures are performed at an approved in-network facility and meet the BlueKC criteria to be medically necessary.

bb. Charges for Hospice coverage for all participants who are not eligible for Medicare. Guidelines developed by BlueKC will be utilized.

cc. Charges incurred for services of a midwife for childbirth provided midwife is licensed in the state where services are performed and practicing within the scope of their license.

dd. Charges for genetic testing for the BRCA gene or for other genetic tests where testing will provide results that could impact a specific course of treatment for a current disease.

M. **Exclusions and Limitations**

Payment will not be made under the Major Medical Expense Benefit for the following expenses:

a. Charges not prescribed as necessary by a legally qualified Physician.

b. Charges incurred for confinement in a Hospital owned or operated by the federal government, except for charges required to be paid to the Veterans.

c. Administration for treatment of a non-service related disability or otherwise as required by federal law.

d. Charges that the covered individual is not required to pay.

e. Charges incurred for the following:

i. Dental work or treatment or dental X-rays, except as required because of accidental injury to sound natural teeth; See Dental Care Expense Benefits on page 36;

ii. Cosmetic surgery, except as required because of accidental injury;

iii. Preventive injections, except as provided for under the Plan;

iv. Eye refractions, eyeglasses, or their fitting; See Vision Care Expense Benefits on page 35;

v. Transportation, except for local ambulance service or as provided under the transplant benefit;

vi. Injury as a result of war, declared or undeclared, including armed aggression; and

vii. Accidental bodily injury or disease arising out of and in the course of employment.

f. Charges incurred for treatment or service caused or sustained by an Employee or Dependent as a result of any injury or sickness caused by or resulting from participation in an attempt to commit a felony or in the commission of a felony.

g. Charges incurred, caused, or sustained for treatment or service as a result of an injury or sickness caused by participation in an occurrence where the Employee or Dependent is the instigator, provoker, and/or aggressor.

h. Elective abortions.

i. Charges that are Experimental or Investigative unless specifically shown as a Covered Charge in the previous section.

j. Charges that are not Medically Necessary.

k. Charges for organ transplants except for those listed in Covered Charges.

l. Marital counseling expenses.

m. Maternity charges for Dependent children.

n. Group therapy or psychological testing for Out-of-Network services.

o. Except as provided under covered services, charges incurred for obesity or morbid obesity such as weight reduction programs, drugs, surgical and nonsurgical treatments, and procedures and reversion of such procedures, including, gastric bypass, gastric banding, open or laparoscopic vertical banded gastroplasty, laparoscopic adjustable gastric banding (Lap-Band system), or any other such procedure, as well as cosmetic or other surgery for removal of excess fat or skin following weight loss, pregnancy or surgery, regardless of medical necessity or supervision by a Physician. Complications from any excluded Expenses are also excluded.

p. Charges incurred for services performed by a midwife for a newborn baby or follow-up visits.

q. Charges incurred for a skilled nursing facility or home health care including skilled nursing unless a letter of medical necessity is written by the treating Physician indicating such skilled nursing facility or home health care is necessary. Charges will only be covered in lieu of hospitalization.

r. Charges for Assisted Reproductive Technology treatments.

s. Charges for Applied Behavioral Analysis therapy.

t. Genetic testing, except as provided for in the covered charges.

u. Services for the purpose of gender reassignment including hormonal therapy and surgery.

X. Prescription Drug Benefit

For Employees, Retirees, and Dependents

The Fund covers a wide selection of medications through the prescription drug benefit, subject to the applicable, coinsurance, copayments, exclusions, and limitations. Not all prescription drugs available in the United States are covered. The Fund also covers certain non-prescription items such as insulin, lancets, and test strips when prescribed by a physician.

Drugs are available at retail pharmacies and via mail order. If you do not use a participating pharmacy, you must pay 100% of the cost and request a reimbursement from the Fund Office. Information about mail-order prescriptions, retail pharmacy locations, and drug classifications can be found online at http://www.savrx.com or by contacting the Fund Office.

Copays shown in the schedule of benefits are for up to a 34-day supply or 100 pills, whichever is greater, for drugs obtained at retail pharmacies. Drugs obtained through mail order are for up to a 90-day supply.

If you have primary coverage through Medicare, you must be enrolled in the Trust-sponsored Medicare Prescription Drug Plan (PDP). The PDP will pay primary, and the prescription drug benefit will pay secondary.

A. Mandatory Generic Program

If you utilize a brand name drug with a generic equivalent available, you will pay the generic copay plus the difference in the cost between the brand and the generic medications. If there is a medical reason you cannot take the generic, ask your doctor to submit a letter of medical necessity to Sav-Rx to waive the difference in the cost.

B. Step Therapy Program

Medications under the step therapy program require the use of a more cost-effective generic drug prior to receiving authorization for brand name medications. The goal of this program is to use a sequential drug therapy, meaning that drugs for a given condition will be dispensed using the most cost-effective sequence–beginning with Step 1 drugs and moving to Step 2 drugs, based on accepted medical guidelines and standards.

C. High Impact Advocacy Program

Medications subject to the High Impact Advocacy program require you to use the designated specialty pharmacy to obtain these medications and enroll in the appropriate patient assistance programs. These programs help you and the fund save money, and Sav-Rx will provide assistance in this process.

D. Specialty Drug Program

The fund will administer all specialty drugs through Sav-Rx Specialty Drug Program. Specialty drugs will require prior authorization prior to filling and will be available for up to a 30-day supply.

E. Exclusions and Limitations

1. The exclusions under the major medical benefit apply to the prescription drug benefit where applicable.

2. The Plan will not cover charges for drugs that do not require a prescription, regardless of where purchased.

3. The Plan does not cover drugs for hair growth, anti-wrinkle drugs, growth hormones, or MedRoxi.

4. Impotence medications are limited to 4 pills every 25 days through retail or 12 pills every 75 days through mail order. The limit on impotence medications will not apply for low dose versions of such medications designed for purposes of treating a prostate condition.

5. Therapeutic Quantity Limits will be placed on selected medications based on FDA approval, manufacturer published guidelines to protect the safety of members. The medications subject to therapeutic quantity limits will change periodically.

6. Prior Authorization will be required for certain classes of drugs that require clinical review for the determination of coverage. The program follows guidelines issued by the Food and Drug Administration (FDA).

7. The Fund will not pay for drugs subject to the Step Therapy program, the High Impact Advocacy program, or the Specialty Drug program except when complying with those programs.

8. The Plan will cover PCSK9 inhibitors, but only after obtaining prior authorization.

XI. Employee Assistance Program

For Employees and Dependents

The EAP offers you and your Dependents a five-call Employee Assistance Plan for a wide range of personal situations at no cost. This is in addition to benefits under the Mental Health and Substance Abuse coverage. The EAP can also help with the selection of Mental Health and Substance Abuse Providers.

If you are located in the Kansas City metropolitan area, you can access the EAP program services by calling 1 (833) 964-6338, which is staffed by licensed EAP staff.

XII. Vision Care Expense Benefits

For Employees, Retirees Not Medicare Eligible and Dependents

If you or your Dependent, while eligible, incur covered vision care expenses, reimbursement of such expenses will be made up to the specified maximum benefit as

shown in the Schedule of Benefits. This maximum benefit is payable during a two consecutive calendar year period. Any combination of covered services is permitted as long as the maximum amount is not exceeded during the two consecutive calendar year period. The two-year period begins with each even-numbered year.

Participants and their spouses and dependents are able to apply their vision benefit toward all related vision expenses related to vision correction. The Health and Welfare Fund has contracted with QualSight to offer laser vision correction at a significantly reduced cost. Learn more about this benefit by visiting QualSight's website at www.qualsight.com.

In addition, an additional annual benefit is provided specifically to cover safety glasses as specified in the schedule of benefits. This additional amount may not be used to increase the normal vision benefit, but only to reduce the cost of safety glasses. The trustees encourage the use of eyeglass vendors that provide free safety glasses with the purchase of normal glasses. Feel free to call the Benefit Center for more information regarding this benefit.

A. Exclusions and Limitations

Payment will not be made under the Vision Care Expense Benefit for the following expenses:

1. Charges for services or supplies that are covered in whole or in part under any other portion of the benefit Plan of the I.B.E.W. Local Union No. 124 Health and Welfare Fund or vision care benefits provided by an employer.

2. Expenses for which benefits are payable under any workers' compensation law.

3. Special procedures, such as orthoptics, vision training, special supplies, including sunglasses (plain or prescription), and sub-normal vision aids.

4. Eye examinations required by an employer as a condition of employment, or that an employer is required to provide by virtue of a labor agreement, or those required by a governmental body.

5. Visual analysis that does not include refraction.

6. Any services or supplies not identified as a covered vision care expense.

XIII. Dental Care Expense Benefits

For Employees, Dependents & Retirees and Their Dependents if Chosen

When you or your Dependent incur covered expenses for dental treatment, the Dental Care Expense Benefit will pay charges as shown in the Schedule of Benefits, according

to the applicable dental fee schedule. You will receive “preferred rates” and a higher level of benefits if you use an In-Network dentist.

A. Covered Dental Expenses

Covered dental expenses are the charges for the following services and supplies when Medically Necessary. The services must be performed by a legally qualified dentist and are subject to the Exclusions and Limitations listed on page 39.

Dental care can be obtained from any dentist. However, In-Network providers offer the maximum level of benefits under the Plan.

Coverage A - Preventive and Diagnostic

The Plan will pay the percentage shown in the Schedule of Benefits for the following Coverage A expenses:

a. Oral examinations, not more than twice in a calendar year. Bitewing X-rays, not more than once in a calendar year. Full mouth X-rays, once in a 36 consecutive month period.

b. Preventive treatment, consisting of:

(i) Oral prophylaxis (cleaning and scaling of teeth) not more than twice in a calendar year;
(ii) Topical fluoride treatment available only to eligible Dependents under 19 years of age, limited to one treatment in a calendar year; and
(iii) Sealants, available only to eligible Dependents under 19 years of age, one treatment per tooth once every five years.

c. Space maintainers.

Coverage B - Basic Fillings and Extractions

The Plan will pay the percentage shown in the Schedule of Benefits for the following Coverage B expenses:

a. Extractions (except for orthodontia).

b. Oral surgery. This includes the necessary procedures for extraction and other oral surgery including pre-operative and post-operative care.

c. Fillings, including silver amalgam, silicate, and acrylic restoration. This provides the necessary procedures to restore the teeth; gold restoration will be provided when teeth cannot be restored with other materials.

d. Administration of general anesthetics when Medically Necessary and administered in connection with oral surgery.

e. Periodontal treatment of disease of the gums. This includes the necessary procedures for the treatment of the tissues supporting the teeth.

f. Endodontic treatment for pulp infection and root canal therapy.

g. Injections of antibiotic drugs.

Coverage C - Prosthetic Devices, Bridges, and Dentures

The Plan will pay the percentage shown in the Schedule of Benefits for the following Coverage C expenses:

a. Initial installation of fixed bridgework.

b. Initial installation of prosthetic devices and dentures.

c. Inlays, onlays, and crowns.

d. Repair or recementing of bridgework, dentures, crowns, and inlays.

e. A replacement will be made of an existing denture only if it is unsatisfactory and cannot be made satisfactory. Services that are necessary to make such appliances satisfactory will be considered an eligible expense. Prosthodontic appliances for the replacement of natural teeth are covered once in a five-calendar year period.

f. Partial dentures if a cast chrome or acrylic partial denture will restore the teeth.

g. Complete standard dentures. If in the construction of a denture, the patient and dentist decide on a personalized restoration or employ specialized techniques, the Plan will pay 50% of the charges, not to exceed the amount specified in the Schedule of Benefits, for the standard denture and the patient must pay the difference in cost.

h. Services or supplies related to the treatment of Bruxism.

Coverage D - Orthodontic

The Plan will pay the percentage shown in the Schedule of Benefits of the covered expenses included under Coverage D for:

a. Orthodontic diagnostic procedures (including cephalometric X-rays).

b. Appliance therapy (braces) including related oral examination, surgery, and extractions.

The maximum lifetime benefit payable for orthodontic treatment is shown in the Schedule of Benefits.

Coverage E – Dental Implants

The Plan will pay the percentage shown in the Schedule of Benefits of the covered expenses included under Coverage E for dental implants were medically necessary as shown in the Schedule of Benefits.

The maximum lifetime benefit payable for dental implants is shown in the Schedule of Benefits.

B. Exclusions and Limitations

Payment will not be made under the Dental Care Benefit for the following expenses:

1. Any service rendered before coverage became effective.

2. Treatment other than by a licensed dentist or licensed Physician, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is rendered under the supervision and guidance of, and billed for by, the dentist.

3. Services or supplies which are cosmetic in nature, including charges for personalization or characterization of dentures.

4. Replacement of a lost, missing, or stolen prosthetic device.

5. Replacement or repair of an orthodontic appliance.

6. Any services that are covered by any workers' compensation laws or employers' liability laws, or services that an employer is required by law to furnish in whole or in part.

7. Services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer.

8. Services or supplies for which no charge is made that the covered person is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.

9. Services or supplies that are not necessary according to accepted standards of dental practice.

10. Services or supplies that do not meet accepted standards of dental practice, including charges for services or supplies that are Experimental or Investigative in nature.

11. Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.

12. Any duplicate prosthetic device or any other duplicate appliance.

13. Plaque control programs that consist of instructions on the care of the teeth, oral hygiene instructions, and dietary instruction.

14. Periodontal splinting.

15. Myofunctional therapy or correction of harmful habits.

16. Expenses for services in the treatment of Temporomandibular Joint Dysfunction.

17. Expenses for services other than those specifically indicated as covered.

18. Expenses for temporary crowns, fillings, dentures, and bridges.

19. Expenses in excess of the maximum benefits shown in the schedule of benefits.

C. Extended Coverage After Eligibility Ends

If coverage ends while you or your eligible Dependent is receiving dental treatment that was started while eligible for benefits, benefits will continue to be paid for such treatment, provided the treatment is completed within one month after the termination date. The extended benefits are subject to all the conditions and limitations of the program.

XIV. Coordination of Benefits

This Plan was designed to help the eligible person meet the cost of treating sickness or injury. Because it is not intended that greater benefits be received than the actual medical expense incurred, the amount of benefits payable under this Plan will take into account any coverage the eligible person has under other group plans; that is, the benefits under this Plan will be coordinated with the benefits payable to the eligible person under other group plans.

The Board of Trustees is in agreement with most health benefit plans on certain rules in determining which Fund shall have primary liability where two or more group coverages are involved and either or both have Coordination of Benefit (“COB”) rules.

To avoid duplication of benefits for allowable expenses, the benefits payable under this Plan may be reduced so that the total benefits payable under this Plan and other group plans will not exceed the allowable expenses incurred during any calendar year.

Other group plans are those whose benefits or services are provided by:

1. Group blanket or franchise insurance coverage;

2. Group Blue Cross or group Blue Shield coverage or any other group pre-payment coverage;

3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans, or any other arrangement of benefits for individuals of a group;

Notify the Fund Office if your spouse or Dependent has health care coverage available through another health care plan.

4. Any coverage under governmental programs and any coverage required or provided by any statute; or

5. Any coverage under the Health Insurance for the Aged and Disabled Provisions of the United States Security Act (Medicare), except this item is subject to any governmental rules or regulations that require insurance benefits to be used before benefits under Medicare are available.

The term other plan also includes all Dependents' benefits provided by this Plan when an individual is covered as both an eligible Employee and an eligible Dependent spouse and when a Dependent child is covered as an eligible Dependent of more than one Employee.

Allowable expense means any necessary, reasonable, and customary item of expense for medical care or treatment covered under at least one of such plans covering the individual for whom a claim is made. However, expenses not covered by this Plan will not be coordinated.

Claimant means the eligible person for whom the claim is made under this Plan.

If you or your Dependent is also covered by another plan or plans, the benefits under this Health and Welfare Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then the other plan(s) pays second.

1. The primary plan (which is the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of COB rules.

2. The secondary plan (which is the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the primary plan will not exceed the greater of:

    a. 100% of total covered expenses; or

    b. The amount of benefits it would have paid had it been the primary plan.

To determine the amount of benefits payable under this Plan, the following order of coordination of benefits will be used:

1. If the other plan does not have COB rules, that plan must determine benefits first.

2. If the other plan has COB rules, the first of the following rules that apply governs:

    a. If a plan covers the claimant as an employee, then that plan will pay its benefits first.

    b. If the claimant is a Dependent child whose parents live together, whether or not they have ever been married, then the plan of the parent whose birthday is earlier in the calendar year will pay first except:

        i) if both parents' birthdays are on the same day, rule 4 below will apply; or

        ii) if any other plan does not include this COB rule based on the parents' birthdays but instead has another rule then that plan's COB rule determines the order of benefits.

3. If the claimant is a Dependent child whose parents do not live together, whether or not they have ever been married, then the following rules apply:

    a. The plan that covers a child as a Dependent of a parent who by court decree must provide health coverage will pay first.

    b. When there is no court decree requiring a parent to provide health coverage to a Dependent child, the following rules will apply:

        i) When the parent who has custody of the child has not remarried, that parent's plan will pay first; or

        ii) When the parent who has custody of the child has remarried, then benefits will be determined by that parent's plan first, by the stepparent's plan second, and by the plan of the parent without custody third.

4. If none of the above rules apply, the Plan that has covered the claimant for the longer period of time will pay its benefits first except when:

    a. One plan covers the claimant as a laid-off or retired employee (or a Dependent of such an employee); and

    b. The other plan includes a COB rule for laid-off or retired employees (or is issued in a state that requires this COB rule by law) then the plan that then covers the claimant as other than a laid-off or retired employee (or a Dependent of such an employee) will pay first.

If part of a plan coordinates benefits and part does not, each part will be treated as a separate plan.

XV. Coordination of Benefits with Medicare

For Active Employees

A. Definitions

Medicare Benefits means benefits for services and supplies that the eligible person receives or is entitled to receive under Medicare Part A or B.

Age 65 means the age attained at 12:01 a.m. on the first day of the month in which the eligible person's 65th birthday occurs. However, if the eligible person's birthday is on the first day of the month, then Medicare benefits will begin effective the first day of the month prior to the birthdate.

Medicare (Title XVIII of the Social Security Act, as amended) provides a program of health insurance. To avoid payment of benefits in a total amount greater than the expense actually incurred, the benefits payable under this Plan will be coordinated with the benefits payable under Medicare for the same expenses.

For eligible active employees, age 65 and older, this Plan will be primary. This means that you will first be reimbursed under this Plan and, if there are any expenses remaining unpaid, you will then be reimbursed for those expenses for which benefits are payable under Medicare. This also applies to a spouse of an active Employee if both the Employee and spouse are age 65 or older.

To have maximum coverage for your Hospital and medical expenses through a combination of Medicare and this Plan coverage, **it is very important that you enroll in both Medicare Parts A and B when eligible. If you are not enrolled in Medicare, you should immediately contact your local Social Security Office.**

B. Effect on Benefits

If according to the following rules, this Plan has primary responsibility for your claims, this Plan determines benefits first without considering the other plans.

If according to the following rules, this Plan has secondary responsibility for your claims, Medicare Benefits are determined or paid first, then benefits under this Plan are paid.

The combined Medicare and Plan benefits will not exceed 100% of the expense incurred.

C. Order of Benefit Determination for You

This Plan has primary responsibility for your claims if all of the following apply:

1. You are at least age 65;

2. You are eligible for Medicare Part A because of age; and

3. You are actively employed by an employer that pays all or part of the required contributions for eligibility.

Also, the Plan has primary responsibility for expenses incurred by you and your Dependents as defined by Social Security if you or your Dependent is eligible for Medicare because of a Disability and have received Social Security disability benefits for 24 consecutive months.

D. For an Eligible Person with End-Stage Renal Disease

This Plan will have primary responsibility for the first 30 months for the claim of an eligible person who is eligible for Medicare benefits because of end-stage renal disease when Medicare has secondary responsibility.

E. Spouse Employment Insurance Premium Reimbursement

The Plan will reimburse members whose spouses elect to take the spouse's employee health insurance (spousal insurance) up to the lesser of the employee only premium for the spousal insurance and $175 per month. All active IBEW Local Union No.124 members currently eligible for benefits through the Plan are eligible for this program. Retirees are not eligible. In order to receive a premium reimbursement, you must provide documentation of coverage and payment as detailed below.

Premiums will be reimbursed based on the following guidelines:

- The member must be eligible for IBEW124's Health and Welfare Plan during the period the premium reimbursement is being requested.

- Premiums will be reimbursed for up to $175 per month or the actual premium, whichever is less.

- Premiums will be reimbursed for the employee only coverage amount for medical and prescription coverage only.

- The spousal insurance must have a deductible less than the amount for self only coverage under Internal Revenue Code § 223(c)(2)(A) ($1,400 per year for 2020) and must meet the minimum value (as defined by the Affordable Care Act (ACA) or must have an actuarial value of at least 60% if the ACA is repealed). Alternatively, the member may waive secondary spouse coverage and not be reimbursed for any medical or pharmacy expenses on behalf of the spouse.

- Documentation of enrollment, benefits, and premiums charged must be provided with each reimbursement request.

- The reimbursement must be requested no later than 13 months after the beginning of the reimbursement period.

XVI. Medicare Advantage Benefit

A. For Retired Employees and Dependents Eligible for Medicare

If you are an eligible Retired Employee, age 65 or over, you may self-contribute for the Medicare Advantage Benefit. This also applies to your eligible spouse and Dependent children. If your spouse or Dependent is not Medicare eligible, you may self-contribute for the benefits for your spouse and Dependent children under the Major Medical benefits.

Benefits will be payable for covered charges, subject to the exclusions and limitations as defined under Medicare.

B. Benefits

Medicare's benefits usually change on a yearly basis. The benefits under this Plan may also change yearly. The benefits under this Plan are designed to supplement the coverage under Medicare.

The medical coverage for retirees eligible for Medicare will be provided through an insured Medicare Advantage plan with United Healthcare. Medicare-covered services are provided with no copay for any Medicare provider. The Plan also covers six podiatry visits, a routine eye exam, a routine hearing exam, an annual routine physical exam, and up to $2,500 toward hearing aids every three years with no copay. Outpatient prescription drugs are covered at the minimum Medicare covered level.

This Plan will not pay any charges not approved by Medicare, including treatment in a facility that is not Medicare approved.

Additional covered benefits include the following benefits paid by the Plan:

1. Prescription drug benefits as described on page 33 to the extent these benefits exceed the minimum Medicare coverage level.

2. Vision care up to $300 per person per two consecutive calendar years starting with the even-numbered year. The Plan covers eye examinations performed by a legally qualified ophthalmologist or optometrist and prescription lenses. Charges for frames are covered when eyeglasses are first received or when new frames are required to accommodate new lenses because existing lenses are not serviceable.

3. Dental benefits on pages 36 through 38, if chosen by the Retiree and the appropriate additional premium is paid.

XVII. Definitions

A. Board of Trustees, Trustees, or Board

The term “Board of Trustees”, “Trustees”, or “Board” means the Union Trustees and the Employer Trustees acting together as the governing body of this Fund pursuant to the provisions of the Trust Agreement.

B. Collective Bargaining Agreement

The term “Collective Bargaining Agreement” means any written agreement entered into by a Union and an Employer covering a collective bargaining unit by the terms of which the Employer is required to make contributions to this Fund and agrees to be bound by all of the terms and conditions of the agreement and the Plan, and by all rules, regulations, and requirements maintained by the Trustees.

C. Contributing Employer or Employer

“Contributing Employer” or “Employer” means an Employer participating in the Health and Welfare Fund who is required to make contributions to the Fund as provided in the Collective Bargaining Agreement between the Union and the Association and such other Employers who have been, or hereafter will be, making such contributions in accordance with the Collective Bargaining Agreement and the terms of the Agreement and Declaration of Trust or an Employer required to make contributions to the I.B.E.W. Local Union No. 124 Health and Welfare Fund pursuant to a written agreement approved by the Trustees.

For the purpose of covering their Employees by the Health and Welfare Plan, Employer also means, with respect to the Employees for whom contributions are required to be paid at the same rates as are required of other Employers, the following: The Union, the Benefit Center, Inc., and the Electrical Joint Apprenticeship and Training Fund. Such organizations are considered Employers only for the purpose of making contributions to cover their Employees and have no other rights or responsibilities as Employers.

D. Dependent

The term “Dependent” means:

1. Your spouse; and

2. Your natural child, adopted child, or stepchild from birth but under 26 years of age

The term “child” includes an adopted child, or stepchild, or any other unmarried minor child (provided you are the legal guardian), or a stepchild who is a member of your household, living in a parent-child relationship and dependent upon you for financial support and maintenance. In addition, a stepchild must be under your legal custody or

your spouse's legal custody. If an unmarried child is incapable of self-sustaining employment because of physical handicap or mental retardation and is dependent upon you for support, his/her benefits will be continued provided his/her incapability started before the child turned age 19 and proof of the Dependent child's incapability is furnished to the Fund Office no later than 31 days after the child became age 19. However, if the incapability is the result of the use of drugs or alcoholic beverages, or injury sustained in the commission of a felony, benefits will not be continued. Proof of the continued existence of such incapability may be requested by the Fund Office from time to time.

The term Dependent also includes children named as alternate recipients under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN). QMCSO procedures are available upon request from the Fund Office free of charge.

E. **Employee**

Employee means:

1. A person employed in employment for which contributions are required to be paid to the Health and Welfare Fund in accordance with the terms of the Collective Bargaining Agreement, a written agreement between an Employer and the Trustees, the Agreement and Declaration of Trust or this Health and Welfare Plan.

2. The employees of the Union, the Benefit Center, Inc., and the Electrical Joint Apprenticeship and Training Fund for whom contributions are required to be paid to the Fund.

The term Employee does not include:

1. An employee of a corporation who owns, or with his/her spouse owns, more than 95% of that corporation;

2. A partner of a partnership; or

3. A sole proprietor.

The term "Employee" does not include anyone whose ownership would, in the opinion of the Trustees, jeopardize the tax-exempt status of the Fund or violate provisions of ERISA.

F. **Experimental or Investigative**

The term "Experimental or Investigative" means treatments, services, supplies, and procedures that require approval by an agency of the U.S. Government that it has not yet received. Experimental treatments, services, supplies, and procedures are also those that largely have been confined to laboratory or research settings. Investigative treatments, services, supplies, and procedures are also those that have progressed to

limited human application but lack wide recognition as proven and effective in clinical medicine. The Trustees have the authority to determine whether a treatment, service, or supply is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended, or approved the treatment, service, or supply does not in itself make it eligible for payment.

G. **Hospital**

The term “Hospital” means a licensed institution, other than an extended care facility that meets all the following requirements:

1. Provides in-patient medical care and treatment for sick and injured persons;

2. Provides full-time supervision by at least one Physician;

3. Continuously provides 24 hour-a-day nursing service by registered nurses;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick individuals on a basis other than a rest home, nursing home, convalescent care facility or a place for the aged;

5. Maintains facilities for surgery except that the requirement of facilities for surgery does not apply to mental institutions or other institutions operated primarily for the therapeutic treatment for the chronically ill;

6. Is operated lawfully in the jurisdiction where it is located; and

7. Is accredited by the Joint Committee on Accreditation of Healthcare Organizations (“JCAHO”).

“Hospital” does not mean convalescent, nursing, rest or extended care facilities, or facilities operated exclusively for the treatment of the aged, whether such facilities are operated as a separate institution or a section of an institution operated as a Hospital.

H. **Medically Necessary**

The term “Medically Necessary” means any service, supply, treatment, or Hospital confinement (or part of a Hospital confinement) that:

1. Is essential to the treatment of the injury or illness for which it is prescribed or performed;

2. Meets generally accepted standards of medical practice; and

3. Is ordered by a Physician.

I. Mental or Nervous Disorder

The term “Mental or Nervous Disorder” means any disturbance of emotional equilibrium, as manifested in maladaptive behavior or impaired functioning, whether caused by genetic, physical, chemical, biological, psychological, social, or cultural factors.

J. Physician

The term “Physician” means a person who is licensed or legally authorized to give medical care or treatment, who is acting within the scope of his license and holding one or more of the following degrees:

1. Doctor of Medicine (M.D.);

2. Doctor of Osteopathy (D.O.);

3. Doctor of Medical Dentistry (D.M.D.);

4. Doctor of Dental Surgery (D.D.S.);

5. Doctor of Podiatry (D.P.M.) with regards to services provided within the scope of his or her license, provided, however, that benefits payable by the Plan will not exceed the benefits that would have been paid to an M.D. or D.O. for treatment of the given condition;

6. Doctor of Chiropractic (D.C.) with regards to services provided for the diagnosis and correction by manual or mechanical means, including incidental X-rays of structural imbalance, distortion or subluxation in the human body for the removal of nerve interference where such interference is the result of or related to distortion; or

7. Clinical Psychologist (Ph.D.).

K. Plan

The term “Plan” means the written Schedule of Benefits and the rules, regulations, and requirements as established by the Trustees.

L. Qualified Medical Child Support Order

The term “Qualified Medical Child Support Order” means a judgment decree or order (including approval of a settlement agreement) issued by a Court of competent jurisdiction or an administrative agency requiring that a medical child support order recognize an Employee’s or his or her spouse’s child as an alternate recipient. Such an order must be approved by the Trustees. QMCSO procedures are available on request from the Fund Office free of charge. A National Medical Support Notice shall constitute a “Qualified Medical Child Support Order” if so determined by the Health and Welfare Fund Office.

M. **Retired Employee**

The term “Retired Employee” means an individual who has been approved to receive a Regular Retirement, Early Retirement, or Disability Pension from the I.B.E.W. Local Union No.124 Pension Plan or the I.B.E.W. Local Union No. 124 Intercommunication Division Pension Fund.

N. **Union**

The term “Union” means the International Brotherhood of Electrical Workers, Local Union No. 124, AFL-CIO, and any other labor organization accepted by the Trustees for participation in this Fund.

O. **Usual, Reasonable and Customary Charge or URC**

The term “Usual, Reasonable and Customary Charge” or “URC” means the medical charge based upon the schedule adopted by the Trustees. The schedule may be changed by the Trustees from time to time.

XVIII. Claim Filing and Appeal Procedures

In order to receive prompt payment of claims, you or your eligible Dependent should follow the procedures listed below as closely as possible. This section describes the procedures for filing claims for benefits from the I.B.E.W. Local Union No. 124 Health and Welfare Plan (the Plan).

A claim for benefits is a request for Plan benefits made in accordance with the Plan’s claims procedures. In order to file a claim for benefits offered under this Plan, if your provider does not file a claim with the Fund, you must submit an itemized bill detailing certain information listed.

The Fund Office will answer inquiries from participants or dependents that are eligible or may become eligible to participate in the Plan. Inquiries may also be made by providers. While the Fund Office will try to answer questions regarding eligibility and coverage, it is important to note that, as stated above, these questions are not considered claims. An individual must incur medical expenses before a claim can be paid. Any answers to questions provided by the Fund Office are not legally binding. Simple inquiries about the Plan’s provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. Any phone call will not be considered a claim. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

The following information must be provided in order for your request for benefits to be a claim, and for the Fund Office to be able to decide your claim.

- Participant name;
- Patient name;
- Patient date of birth;
- SSN of the participant;
- Date of service;
- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association);
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge;
- Number of Units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address; and
- If treatment is due to accident, accident details.

When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal with the Plan regarding the denial by using these procedures.

A. When Claims Must Be Filed

Claims must be filed within one year after:

- Discharge from the Hospital;
- The date of surgery; or
- The date of treatment for emergency outpatient care in the Hospital.

B. Where To File Claims

Your claim will be considered to have been filed as soon as it is received at the Fund Office. Claims should be filed with the Fund Office at the following address:

Mr. Kevin Smith
Fund Administrator
Local Union No. 124 I.B.E.W. Health and Welfare Fund
305 East 103rd Terrace
Kansas City, MO 64114
Tel. 816-943-0277
Fax 816-943-0487

C. Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care provider is not an Authorized Representative unless the Participant specifically designates the provider. However, a Participant is not permitted to assign payment of any claim directly to an out-of-network provider.

D. Claims for Medical Services

The following procedure applies to **claims for Medical Services**:

- Have your Physician complete the Attending Physician's Statement section of the claim form, submit a completed HCFA health insurance claim form, or submit a HIPAA-compliant electronic claims submission. If your provider does not file your claim, then attach all itemized hospital bills or doctor's statements that describe the services rendered.
- Check that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim is delayed, delays in payment will result.

Ordinarily, you will be notified of the decision on your **claim** within *30 days* from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to *15 days* if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end 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 an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case, you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has *30 days* to make a decision on a **claim** and notify you of the determination.

E. Disability Claims

A **Disability Claim** is a claim for weekly accident and sickness benefits.

For **Disability Claims**, the Plan will make a decision on the claim and notify you of the decision within *45 days*. If the Plan requires an extension of time due to matters beyond

the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within *30 days* of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional *30 days*, provided the Plan administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case, you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within *30 days*.

For Disability Claims, the Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

If a claim is denied, the initial adverse benefit determination notice shall contain:

> If the adverse benefit determination is based on a medical necessity 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 the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request.
>
> If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion 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 the claimant upon request; or a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

The adverse benefit determination shall contain a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the claimant to the Plan from health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit

determination, without regard to whether the advice was relied upon in making the benefit determination; and

- A disability determination by the Social Security Administration, regarding the claimant, presented by the claimant to the Plan.

The adverse benefit determination shall be provided in a culturally and linguistically appropriate manner when the claimant's address is in a county where 10 percent or more of the population is literate only in the same non-English language.

F. **Appeal Procedures**

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Fund Office within 180 days after you receive notice of denial.

G. **Review Process**

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making, or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

The Appeals Committee designated by the Board of Trustees will review your claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made based on the record, including such additional documents and comments that may be submitted by you.

If your claim was denied based on a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

H. **Timing of Notice of Decision on Appeal**

Ordinarily, decisions on appeals involving claims will be made at the next regularly scheduled meeting of the Appeals Committee of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30

days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

I. Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will contain:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline, or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on medical necessity, because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim or a statement that it is available upon request at no charge.

J. Adverse Disability Benefit Determinations on Review

Before issuing an adverse benefit determination on review, the Plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided in order to give the claimant a reasonable opportunity to respond prior to that date.

Before issuing an adverse benefit determination on review based on a new or additional rationale, the Plan administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required

to be provided in order to give the claimant a reasonable opportunity to respond prior to that date.

The adverse benefit determination on review shall include a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the claimant to the Plan from health care professionals treating the claimant and vocational professionals who evaluated the claimant;

- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

- A disability determination made by the Social Security Administration, regarding the claimant, presented by the claimant to the Plan.

The adverse benefit determination on review shall be provided in a culturally and linguistically appropriate manner when the claimant's address is in a county where 10 percent or more of the population is literate only in the same non-English language.

The adverse benefit determination on review shall contain a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action within two (2) years of the denial under section 502(a) of the Act. This statement shall also include the calendar date in which the claimant's contractual limitations period expires.

If the Plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except as provided in this section below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of the Act on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of the Act under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by the Trustees. Notwithstanding this paragraph, the administrative remedies available under the Plan with respect to claims for disability benefits will not be deemed exhausted based on *de minimis* violations that do not cause and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the

administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under this paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

A health care professional consulted pursuant to an adverse determination on review shall not be an individual consulted with the initial denial, nor the subordinate of such an individual.

K. Limitation on When a Lawsuit May Be Started

You may not bring a lawsuit to obtain benefits until you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No lawsuit may be brought more than two years after the final decision on review has been reached or in the case of short-term disability benefits, more than two (2) years after the start of disability.

Any lawsuit brought against the Plan must be filed within two (2) years of the date of: (1) a determination denying the claim for benefits, or (2) the expiration of the time for a decision on an appeal.

L. Mandatory Litigation Venue

A participant or beneficiary shall only bring an action in connection with the Plan in the U.S. District Court for the Western District of Missouri.

XIX. Special Provisions for COVID-19

The Plan provides the following special provisions to assist participants in response to the COVID-19 pandemic.

A. COVID-19 Testing

Effective March 18, 2020 until the end of the COVID-19 public health emergency, COVID-19 diagnostic and antibody testing consistent with CDC guidelines will be covered along with covered services and items furnished during an office visit, telehealth, urgent care visit or emergency room visit which results in the ordering or the administration of a COVID-19 diagnostic test with no cost share. This applies to Network and Non-Network provider claims. After the COVID-19 public health

emergency, these services will be covered when medically necessary and will be subject to the Plan's normal cost share.

B. COVID-19 Vaccine and Preventive services

Any qualifying coronavirus preventive service will be covered without any cost sharing effective fifteen (15) business days after the date a qualifying coronavirus preventive service is recommended by one of two agencies: the United States Preventive Services Task Force (USPTF) or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The USPTF would include the qualifying coronavirus preventive item, service, or immunization that is intended to prevent or mitigate COVID-19 by listing and rating it as an ''A'' or ''B'' in its current recommendations. The Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention recommends immunization as well as the age group for which it applies. As of the date of the publication of this document, no such services have yet been approved.

C. COVID-19 Treatment

Effective temporarily between March 18, 2020 and June 30, 2020, the deductible and coinsurance for Inpatient hospitalization and telehealth services will be waived for claims related to the diagnosis and treatment of COVID-19 when such treatment is provided by a Network provider. Non-Network provider claims will continue to be covered at the Plan's normal cost share.

D. Biometric Screening and Health Risk Assessments

Effective January 1, 2020, all health fairs for 2020 have been canceled. However, Biometric Screening and Health Risk Assessments (HRA) will be waived for 2020 due to COVID-19. If you completed the Biometric Screening and HRA by 10/31/2019 and have the lower deductible in 2020, then you will automatically have the lower deductible for 2021. If you did not complete your Biometric Screening and HRA by 10/31/19 and have a high deductible, then you will automatically have a high deductible for 2021. If you have the high deductible and want to complete the HRA and Biometric screening by 10/31/20 then you can get the lower deductible for 2021.

E. Limited Hours Credit

The Plan will credit hours for the month of April 2020, only, for employees who work for Waldinger and who are expected to lose coverage June 1, 2020, if the reason for lack of hours is due to a COVID-19 related reason as defined under the Families First Coronavirus Response Act (FFCRA).

F. **Extensions**

The period from March 1, 2020 until sixty (60) days after the announced end of the COVID-19 National Emergency or such other date announced by the Agencies ("Outbreak Period") will be disregarded in applying timeframes for the following actions by Plan participants, beneficiaries, qualified beneficiaries, or claimants.

- The 60-day election period for COBRA continuation coverage,
- The date for making COBRA premium payments,
- The 30-day period (or 60-day period, if applicable) to request special enrollment (such as adding dependents due to marriage, birth, or adoption),
- The date for individuals to notify the Plan of a qualifying event or determination of disability,
- The date within which individuals may file a benefit claim under the Plan's claims procedure,
- The date within which claimants may file an appeal of an adverse benefit determination,
- The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination, and
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

The Outbreak Period shall also be disregarded when determining the date for providing a COBRA election notice.

XX. Subrogation

In the event the Plan provides Benefits for injury, Sickness or other loss (hereinafter the "injury") to any Covered Person, the Plan shall be automatically subrogated to all rights of recovery to any funds or monies that person, his or her spouse, dependents, parents, heirs, guardians, conservators, next friend, executors, assigns, personal representative or other representatives (individually and collectively called the "Covered Person," for this Section only) may have arising out of said injury, Sickness or other loss. Said recovery shall not be limited by characterization of loss and shall include recovery for personal injury, lost wages, loss of service, disability, and claims for wrongful death, survivor, or other claims under any state or federal law. The Plan is not limited or bound by any judgment or settlement that apportions recovery among the various elements of damage. The Plan shall automatically have a first priority lien and shall be entitled to first dollar reimbursement from any recovery regardless of whether the Covered Person is made whole by said recovery. These rights of reimbursement and subrogation are reserved whether the liability of a third party arises in tort, contract, or otherwise. Regardless of how proceeds are designated, the Plan's rights shall attach to any full or partial judgment, settlement, or other recovery. The Plan shall be entitled to assert a lien against third parties, insurers, attorneys, and other appropriate persons or entities in order to protect its right of subrogation.

This right of subrogation is specifically and unequivocally pro tanto subrogation; that is, subrogation from the first dollar received by the Covered Person, and this pro tanto is specifically and unequivocally to take effect before the whole debt is paid to the Covered Person. The Plan's subrogation rights include without limitation, an automatic first priority lien upon the first-dollar recovery from any settlement or judgment and all rights of recovery of a Covered Person to any payments made by or on behalf of a responsible person including but not limited to, a recovery:

- Against any person, insurer, or other entity that is in any way responsible for providing compensation, indemnification, or benefits for the injury;
- From any fund, or policy of insurance or accident benefit plan providing No Fault, Personal Injury Protection (PIP) or financial responsibility insurance or coverage;
- Uninsured or underinsured motorist insurance;
- Under motor vehicle medical payment insurance; and
- Under specific risk accident and health coverage or insurance, including without limitation premises or homeowners medical payments insurance or athletic or sports "school" or "team" coverages or insurance.

These rights of reimbursement and subrogation are reserved whether the liability of a third party arises in tort, contract, or otherwise. Regardless of how proceeds are designated, the Plan's rights shall attach to any full or partial judgment, settlement, or other recovery.

The Covered Person, or if a minor, the Covered Person's parent or legal guardian, conservator or next friend shall execute and deliver such documents and papers (including, but not limited to an Accidental Injury Questionnaire, Subrogation Agreement and Authorization to Release Medical Information) to the Fund Office as the Plan may require. The Covered Person shall do whatever else is necessary to protect the rights of the Plan, including allowing the intervention by the Trustees or Plan or the joinder of the Trustees or Plan in any claim or action against the responsible party or parties.

The Trustees are vested with full discretionary authority to determine eligibility for Benefits, to construe subrogation and other Plan provisions, and to reduce or compromise the amount of the Plan's recoverable interest where, in the sole discretion of the Trustees, circumstances warrant such action. No settlement, however, shall be binding on the Plan without the Plan's written approval thereof, and the Plan expressly reserves the right to collect the entire amount of its subrogation interest in all cases. The amount of the Plan's subrogation interest shall be deducted first from any recovery from any entity or source by or on behalf of the Covered Person regardless of any common fund or make-whole doctrines. The amount payable to the Plan, pursuant to the subrogation right, shall not be reduced pursuant to the application of any common fund doctrine, any make-whole doctrine, and/or any other common law/state law doctrine purporting to reduce the amount of the Plan's recovery.

The Plan reserves the right to initiate an action in the name of the Covered Person or his guardian, conservator, or next friend to recover its subrogation interest, and the Covered Person or his guardian, conservator, or next friend will cooperate fully with the Plan in such instances.

In the event of any failure or refusal by the Covered Person (1) to execute the Subrogation Agreement or any other document requested by the Fund Office, or (2) to take any other action requested by the Fund Office to protect the interest of the Plan, the Plan may withhold payment of Benefits or deduct the amount of any payments made from future claims of the Covered Person.

The Covered Person shall not do any act or engage in any negotiations that would reduce, compromise, or prejudice the Plan's rights to first recovery from any third party. In the event the Covered Person recovers any amount by settlement or judgment from any person, corporation, insurance carrier, governmental agency, or other responsible party, (1) the Plan shall be repaid in an amount equal to the full amount of Benefits paid by the Plan; and (2) no further Benefits for treatment or services related to the injury leading to the settlement or recovery will be paid by the Plan. If the Covered Person refuses or fails to repay such amount, or otherwise interferes with the Plan's right to subrogation, the amount of the Plan's claim shall be deemed to be held in constructive trust, and the Plan shall be entitled to seek restitution, impose a constructive trust or seek any other legal action against the Covered Person or other party. In addition, the Plan reserves the right to offset and/or deduct any amounts paid as Benefits against future claims submitted by the Participant and his or her Eligible Dependents.

The Plan shall not pay or be held responsible for any portion of the Covered Person's legal fees or expenses related to any recovery whether by settlement or judgment. The Plan reserves the right to first dollar from any recovery to the full amount of Benefits paid by the Plan and hereby claims a first lien against the proceeds of any settlement or judgment and priority over any claim or lien of legal counsel, insurers, or any other third party. The Covered Person shall provide all of the above-referenced individuals with notice of the Plan's first right of subrogation. However, the Trustees may, in their discretion, agree to share legal fees and expenses with the Covered Person or his guardian, conservator, or next friend provided any such agreement is established in writing.

The "make whole" rule, any similar state law doctrine or the "common fund" doctrine is specifically and unequivocally rejected. The Plan's right of first dollar subrogation or reimbursement applies regardless of whether the Covered Person is made whole or receives a partial recovery and regardless of the characterization or application of any recovery. The subrogation and reimbursement provisions of the Plan will apply even in the absence of a written agreement. Any person who is represented by counsel will give notice of the written agreement, and a copy thereof, to their counsel.

The Plan has the right to offset any pending or future claims against any recovery by the eligible individual or Eligible Dependent to the extent the recovery exceeds the unreimbursed Benefits paid by the Plan, even if no Benefits have been paid by the Plan. The Plan will also have a lien to the extent of the Benefits paid, which may be filed with any person claimed to be liable to the Covered Person on account of the loss incurred.

If the Covered Person, his or her guardian, conservator, or next friend does not attempt a recovery of the Benefits paid by the Plan or for which the Plan may be obligated, the Plan shall be entitled to institute legal action against the responsible party or parties in the name of the Plan or Trustees in order that the Plan may recover all amounts paid to or on behalf of the Covered Person.

In an action brought by the Plan, the reasonable cost of recovery, including the Plan's attorneys' fees, shall first be deducted from any recovery by judgment or settlement against the responsible party or parties. The Plan's subrogation interest, to the full extent of Benefits paid or due as a result of the occurrence causing the injury or Sickness, shall next be deducted with the balance paid to the Covered Person.

XXI. Privacy Policy

The Plan is required to protect the confidentiality of your protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Plan.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

- Receive confidential communications regarding your health information, as applicable;
- Copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Plan's Privacy Official at the Fund Office.

XXII. Notice from the Board of Trustees

All benefits will be paid in accordance with the terms of the Plan. Settlement of all claims will be decided by the Board of Trustees. No Employer or Union nor any representative of any Employer or Union is authorized to make a claim determination nor any such person act as agent of the Trustees.

The Trustees reserve the right to amend, modify, discontinue, or terminate all or part of this Plan whenever, in their judgment, conditions so warrant. Eligible Employees and their eligible Dependents will be notified of any Plan changes.

Any information regarding this Plan must be communicated in writing, signed on behalf of the full Board of Trustees either by the Trustees or if authorized by the Trustees, signed by the Fund Administrative Manager or the Fund attorney.

The Board of Trustees has the power and discretionary authority to construe the provisions of the Agreement and Declaration of Trust and the provisions of the Health and Welfare Plan. Any construction, rule, regulation, administrative decision, or determination in regard to a claim for benefits adopted by the Trustees in good faith will be final and binding on all individual employers, individual employees, beneficiaries of the Health and Welfare Fund, the Union and all other parties.

XXIII. Important Information about the Plan

The following information concerning the Health and Welfare Fund is being provided to you to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

1. **Name of Plan** This Plan is known as the I.B.E.W. Local Union No. 124 Health and Welfare Fund.

2. **Board of Trustees** A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Employers and the Union that have entered into collective bargaining agreements. The Trustees of this Plan are listed on page 65.

3. **Plan Sponsor and Administrator** The Board of Trustees is both the Plan Sponsor and Plan Administrator.

4. **Identification Numbers** The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

   The number assigned to the Board of Trustees by the Internal Revenue Service is 44-0569165.

5. **Agent for Service of Legal Process** The law firm of Arnold, Newbold, Sollars & Hollins, P.C. is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the law firm of Arnold, Newbold, Sollars & Hollins, P.C. or served upon any individual Trustee at the address shown on page ***i***.

6. **Source of Contributions** All contributions to the Plan are made by Employers in accordance with their collective bargaining agreements in effect from time to time with I.B.E.W. Local Union No. 124. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of participants working under the collective bargaining agreements. The collective bargaining agreements require contributions to the Fund at fixed rates per hour worked. Self-contributions are allowed under certain circumstances that are described on page eleven (11) of this booklet.

7. **Type of Plan** The Plan is maintained to provide medical, dental, vision, hearing, disability, and death benefits for Active and non-Medicare eligible Employees and their Dependents. The Plan benefits for participating Active and non-Medicare Retired Employees and their Dependents are shown in the Schedule of Benefits on pages 1 to 3 of this booklet. Plan benefits for Retired Employees and Dependents eligible for Medicare are outlined on page 45. All benefits are provided on a self-insured basis directly from the Fund's assets.

8. **Trust Fund** All assets are held in trust by the Board to provide benefits to covered Participants and their Dependents and defray reasonable administrative expenses. The Fund's assets and reserves are presently invested by a professional asset manager in insured savings accounts, certificates of deposit, U.S. Government Treasury Notes, preferred stocks, common stocks, and corporate bonds.

9. **Eligibility** The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits for Employees and Dependents are fully described in this booklet.

10. **Claims Procedures** The procedures to follow for filing a claim for benefits are set forth on page 50 of this booklet. If all or any part of your claim is denied, you may appeal that decision. See page 54 for an explanation of the procedures for appealing denied claims.

11. **Plan Year** The Fund's Plan (fiscal) Year for the purpose of maintaining records and filing various governmental reports is the twelve-month period beginning September 1 and ending August 31.

12. **Type of Administration** This Plan is self-administered and all benefits are provided from Fund assets.

13. **Collective Bargaining Provision** Such provisions are available upon written request to the Plan Administrator.

As of March 1, 2020, the Trustees of this Plan are as follows:

Union Trustees	Employer Trustees
Mr. John Fennesy, Chairman I.B.E.W. Local Union No. 124 Post Office Box 8727 Kansas City, Missouri 64114	Mr. Kenneth C. Borden, Secretary Chapter Manager Kansas City Chapter, N.E.C.A. 800 E. 101st Terrace Kansas City, Missouri 64131
Mr. Rudy Chavez I.B.E.W. Local Union No. 124 Post Office Box 8727 Kansas City, Missouri 64114	Mr. Michael Quarles 200 East 15th Avenue Kansas City, Missouri 64116
Mr. Todd Howerton 10835 Holmes Rd. Kansas City, Missouri 64131	Mr. Donald G. Laffoon Electrical Corporation of America Post Office Box 18070 Kansas City, Missouri 64133

XXIV. Statement of ERISA Rights

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

A. Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, such as worksites and union halls, all documents governing the Plan. These include 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 Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description/plan document. The Plan 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.

- Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should keep this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

- Be informed that the Plan complies with the non-discrimination requirements contained in the HIPAA regulations. These regulations state that a group health care plan may NOT establish eligibility rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) disability.

- Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse-midwife,

or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

■ Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to mastectomies shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

B. Continue Group Health Plan Coverage

You also have the right to:

■ 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/Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

■ Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:

— You lose coverage under the Plan;

— You become entitled to elect COBRA continuation coverage; or

— Your COBRA continuation coverage ceases.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. 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.

D. 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 Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in 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 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.

E. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or 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 (EBSA), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

For more information about your rights and responsibilities under ERISA:

- Call 1-866-444-3272;
- Visit www.dol.gov/ebsa; or
- Send electronic inquiries to www.askebsa.gov.