The following definitions of terms are used in connection with the administration of the Health & Welfare Plan.

Accident

The term "Accident" shall mean an injury, such as a cut, break, sprain, bruise, or wound occurring from an unexpected, undesirable and unavoidable act. Intentionally self-inflicted injuries are excluded, unless the injury is a result of a "medical condition." A medical condition means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Ambulance Service

The term "Ambulance Service" shall mean charges for professional ambulance service to and from the Hospital.

Beneficiary

The term "Beneficiary" or "Beneficiaries" means any Eligible Dependent entitled to receive a benefit under the Plan or a person designated to be the recipient of any Death Benefit. The term "Beneficiary" is also used in the phrase "Qualified Beneficiary" to refer to an individual eligible for coverage under COBRA.

Covered Charges

The term "Covered Charges" shall mean only those charges made for services and supplies which the Trustees would consider to be reasonably priced (see UCR on page 9) and Medically Necessary in light of the Accident or Sickness being treated.

Creditable Coverage

The term "Creditable Coverage" means Creditable Coverage as defined in the Health Insurance Portability and Accountability Act ("HIPAA"). Generally, Creditable Coverage includes coverage under: 1) a group health plan (including Federal governmental and church plan); 2) hospital or medical service policy certificate or contract; 3) HMO contract; 4) Medicare; 5) Medicaid; or 6) State health benefits risk pool. Creditable Coverage may be used to reduce any Pre-Existing Condition Exclusion Period, as set forth on page **Error! Bookmark not defined.**.

Some examples of coverage that do NOT qualify as Creditable Coverage are:

A. Coverage under accident, disability income, liability, worker's compensation, automobile medical insurance and other types of insurance which is not considered to be general health insurance; and,

B. Health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, and plans under which health benefits are secondary or incidental; or,

C. Supplemental benefits such as Medigap or MedSupp insurance, TriCare supplemental programs and similar supplemental coverage under a group health plan.

Dental Treatment

The term "Dental Treatment" shall mean treatment rendered by a dentist, Physician or Surgeon for injuries to natural teeth, including the replacement of such teeth.

Developmental Care

The term "Developmental Care" means services, supplies or prescription drugs, regardless of where or by whom provided, which meet one of the following criteria:

A. Are provided to an Eligible Person who has not previously reached the level of development expected for his age in areas of major life activity such as intellectual; receptive and expressive language, learning, mobility, self-direction, capacity for independent living; or

B. Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or Sickness); or

C. Are educational in nature.

Eligible Dependent

The term "Eligible Dependent" shall mean the eligible Employee's legal Spouse including a same-sex spouse legally married in a state that recognizes same-sex marriage. It shall also include the eligible Employee's biological children, step-children, legally adopted children and children placed in the home prior to adoption through the end of the month in which they turn age 26.

The term "Eligible Dependent" shall also include the following:

A. A child over the age 25 who is 1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; 2) such incapacity commenced prior to age 19 and 3) the child remains chiefly dependent upon the eligible Employee for support and maintenance. The Plan will continue coverage for the child for as long as the eligible Employee's coverage remains in force and the incapacity continues, provided that proof of the incapacity is submitted to the Fund Office within 31 days of the date the child's coverage would otherwise terminate. The failure to submit proof of incapacity will result in termination of the child's coverage.

B. Children placed in the home by court order and enrolled in the Plan prior to January 1, 2011, shall be considered Eligible Dependents the same as biological or legally adopted children provided that they are dependent upon the eligible Employee for primary support and maintenance. Primary support and maintenance for the dependents referred to in this paragraph may be determined from the eligible Employee's latest federal tax return and by the eligible Employee's supplying an affidavit stating that the children are dependent upon

the eligible Employee for primary support and maintenance. The Trustees have the authority to request supporting documentation as necessary.

C. A child for whom you or your Spouse have the permanent or temporary legal guardianship or custody as those terms are defined under the laws of the state in which you reside. A child for whom you or your Spouse have custody under a guardianship will be considered a Dependent only if the court order granting the guardianship was issued by a juvenile court as a result of the court adjudicating that the child was a "child in need of services," as defined at Indiana Code 31-34-1-1, or similar statute if the guardianship proceeding occurred in another state. A child, including a grandchild, who is dependent not by birth or adoption, is not eligible for coverage as a Dependent unless both biological parents are deceased, or have permanently or by court order "legally relinquished all of their parental rights" in a court of law. "Legally relinquished all of their parental rights" means that the biological parents permanently, or temporarily (as determined by a court that such temporary custody would be in the child's best interest) do not have the:

1) Authority to consent to the child's marriage or adoption or authority to enlist the child in the armed forces of the United States;

2) Right to the child's services and earnings; and

3) Power to represent the child in legal actions and make other decisions of substantial legal significance concerning the child, including the right to establish the child's primary residence.

Notwithstanding the foregoing, in extreme instances in which neither the modification of an existing custody order nor the acquisition of a guardianship order is possible, the Board of Trustees, in its sole discretion, may opt to consider a child an Eligible Dependent where the child is a Participant's grandchild and the circumstances are such that the Board reasonably believes that, but for the inability to obtain judicial intervention, said child would be eligible for coverage under the terms of this Section,

In this subsection, a Dependent shall not be eligible for benefits if the Participant is awarded custody or guardianship exclusively for the purpose of obtaining health care coverage.

The Trustees have the authority to request supporting documentation as necessary. However, any child who is eligible for coverage under this Plan as an Employee is excluded from Dependent coverage.

Eligible Person

The term "Eligible Person" shall mean any person who is presently or may become eligible for benefits under this Plan in accordance with the Eligibility Rules adopted by the Trustees.

Eligibility Rules

The term "Eligibility Rules" shall mean the eligibility rules as established and adopted by the Trustees pursuant to the authority granted to them in the Trust Agreement.

Employee

The term "Employee" shall mean all employees employed by parties to the Trust Agreement establishing this Plan, represented by the Union and working for Employers, as defined herein, and in respect of whose employment an Employer is required to make contributions into the Trust Fund. However, excluding partners or sole proprietors, the term Employee shall also mean, employees of an Employer covered by the terms of a participation agreement which requires contributions to the Plan. The term "eligible Employee" means an Employee that has met the eligibility requirements set forth in the Rules of Eligibility herein.

Employer

The term "Employer" means all or any of the following:

A. An employer who is bound by the terms of a collective bargaining agreement with the Union providing for the establishment and maintenance of a Plan for payment of contributions to said Plan.

B. An employer who satisfies the requirements for participation as established by the Trustees. Such employer shall, by the making of a payment to the Trust Fund on behalf of an Employee, be deemed to have accepted, be bound by, and become a party to the Trust Agreement.

Family Unit

The term "Family Unit" shall mean the eligible Employee and all of the eligible Employees' Eligible Dependents. For the purpose of the Plan, the term "Family Unit" shall also include an Eligible Person without dependents.

Fund

The term "Fund" or "Trust Fund" shall mean the Electrical Workers Benefit Trust Fund.

Hospice

The term "Hospice" shall mean a licensed agency that provides counseling and medical services to the terminally ill and which meets all of the following tests:

A. Has obtained any required state or governmental Certificate of Need approval; and

B. Provides services on a 24 hour, seven day a week basis; and

C. Is under the direct supervision of a Physician; and

D. Has a nurse coordinator who is a Registered Nurse (RN); and

E. Has a social service coordinator who is licensed; and

F. Is an agency that has as its primary purpose the provision of Hospice services; and

G. Has a full time administrator; and

H. Maintains written records of services provided to the patient; and

I. Is licensed in the jurisdiction in which it is located, if licensing is required.

Hospital

The term "Hospital" shall mean any institution that meets ALL of the following requirements:

A. Maintains permanent and full-time facilities for bed care of five or more resident patients;

B. Has a legally qualified Physician in regular attendance;

C. Continuously provides 24-hour-a-day nursing service by a Registered Nurse;

D. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics or a place for drug addicts; and,

E. Is operating lawfully in the jurisdiction where it is located.

Hospitalization is referred to as a "Hospital stay" or "Hospital confinement."

Hospital Miscellaneous

The term "Hospital Miscellaneous" shall mean charges for the use of the operating room, drugs, medicines, blood and blood plasma (including administration thereof), x-ray examinations, laboratory tests, surgical dressings and medical supplies, anesthetic (including administration thereof in a Hospital by a Physician or Surgeon), radiation treatments, Physiotherapy, and professional Ambulance Service (except by railroad, ship, bus, airplane or other common carrier).

Hospital Room And Board

The term "Hospital Room and Board" shall mean charges for the average semi-private Hospital room rate. With regard to the Intensive Care, Coronary Care or Constant Care Units of the Hospital, the term "Hospital Room and Board" shall mean the average daily charge for those units.

Incurred Date of Claim

The term "Incurred Date of Claim" shall mean the first date on which an Eligible Person is under the care of a Physician or Surgeon and/or has incurred a Covered Charge which is payable by the Plan.

Medically Necessary

The term "Medically Necessary" means only those services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based upon the opinion of a qualified medical professional, to identify or treat an Eligible Person's Accident or Sickness and which:

A. Are consistent with the symptoms or diagnosis and treatment of the eligible individual's condition, disease, ailment, or injury,

B. Are appropriate according to standards of good medical practice,

C. Are not solely for the convenience of the Eligible Person, Physician or Hospital,

D. Are the most appropriate which can be safely provided to the Eligible Person,

E. Are not deemed to be Experimental or Investigative, and

F. Are not furnished in connection with medical or other research.

For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, facility, drug equipment, device, or supply) is considered to be "Experimental" or "Investigative" if the use is not yet generally recognized as accepted medical practice, or if the use of any such item requires federal or other governmental agency approval which has not been granted at the time the service or supply is provided, or if the service, supply or procedure is not supported by Reliable Evidence which shows that, as applied to a particular condition, it:

A. Is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty,

B. Has a definite positive effect on health outcome,

C. Over time leads to improvement in health outcomes under standard means of treatment under standard conditions of medical practice outside clinical investigatory settings (i.e., the beneficial effects outweigh the harmful effects), and

D. Is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment is not employable.

"Reliable Evidence" includes only the following:

A. Published reports and articles in authoritative medical and scientific literature,

B. The written investigational or research protocols and/or written informed consent used by the treating facility or another facility which is studying the same service, supply or procedure, and

C. Compilations, conclusions, and other information which is available and may be drawn or inferred from A or B above.

Consideration may be given to any or all of the following factors:

A. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, and

B. If Reliable Evidence shows that the treatment is the subject of ongoing Phase I, II or III clinical trials to determine its maximum tolerated dosage, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis, or

C. If Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis.

D. Final determination of whether the use of a treatment is Experimental or Investigative shall rest solely in the discretion of the Trustees.

Nursing Care

The term "Nursing Care" shall mean services of a Registered or Graduate Nurse other than a person who ordinarily resides in the treated individual's home, or who is a member of the treated individual's immediate family. The "immediate family" is considered for these purposes to be the Spouse, children, brothers, sisters and parents of such persons or their spouses.

Participant

The term "Participant" shall mean any Employee, former Employee of an Employer, or widow or widower, who is, or may become, eligible to receive any type of benefit from this Plan or whose benefit from this Plan or whose Beneficiaries may become eligible to receive any such benefit.

Physician or Surgeon

The term "Physician" or "Surgeon" shall mean a licensed medical doctor (MD) who performs a service which is payable under the Plan. Where group insurance law requires, “Physician” or “Surgeon” also includes any other provider who is a licensed practitioner acting within the lawful scope of his or her license, and performs a service which would be payable under the Plan if the

service were performed by an MD. A provider does not include a person who lives with, or is part of, the covered Participant's family.

Physician's Services

The term "Physician's Services" shall mean home, office and/or Hospital visits and other medical care and treatment rendered by a legally qualified Physician or Surgeon.

Physiotherapy

The term "Physiotherapy" shall mean treatment by a licensed or registered physiotherapist other than a person who ordinarily resides in the treated individual's home, or who is a member of the treated individual's immediate family. The "immediate family" is considered for these purposes to be the Spouse, children, brothers, sisters and parents of such persons or their spouses.

Sickness

The term "Sickness" shall mean any disease commencing after the effective date of coverage of the Eligible Person whose Sickness is the basis of the claim and resulting in a loss covered by the Plan. The term "Sickness" shall also include an illness not caused by an Accident.

Spouse

The term "Spouse" shall mean the eligible Employee's legal spouse. The term "Spouse" shall NOT include the divorced spouse of an eligible Employee.

Surgical Expenses

The term "Surgical Expenses" shall mean the fees charged by a legally qualified Physician or Surgeon for a surgical procedure, including the usual pre-operative and post-operative care. The surgical procedure may be performed in the patient's home, in the Hospital, in the doctor's office or elsewhere. Surgical Expenses are Covered Charges; to the extent the Surgical Expense meets the criteria for Covered Charges.

Trust Agreement

The term "Trust Agreement" shall mean the amended Agreement and Declaration of Trust establishing the Electrical Benefit Trust Fund effective May 3, 1949.

Trustees

The term "Trustees" shall mean the Employer Trustees and Union Trustees, collectively, as appointed pursuant to the terms of the Trust Agreement, as amended.

Union

The term "Union" shall mean the International Brotherhood of Electrical Workers ("IBEW") Local No. 481, affiliated with the American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO").

Usual, Customary And Reasonable Charge (UCR)

With regard to an Out-of-Network provider or an Out-of-Network Durable Medical Equipment purchase, the term "Usual, Customary and Reasonable Charge" (UCR) means that the charge, by any provider, for a service must be similar to all other like providers of the same service in that geographical area and which is no higher than the 90th percentile of prevailing health care charge data. The area reference is the zip code for the general level of charges being made by a Physician or Surgeon of similar training and experience. (See page 1 for relationship of Covered Charge and UCR).

With regard to an In-Network PPO Provider or In-Network Durable Medical Equipment purchase, UCR means the Allowed Charge as determined by the contracted PPO or any of the affiliated PPOs who may have an agreement with the contracted PPO (i.e. an Anthem or BCBS provider from another state).