EUTF Supplemental Medical & Prescription Drug Plan

This EUTF supplemental plan provides reimbursement of eligible out-of-pocket medical expenses for active employee-participants who are primarily covered under a non-EUTF health plan. All covered services must first be paid by your primary medical and prescription drug plan prior to receiving any supplemental plan reimbursements for any copayment and/or coinsurance for eligible medical and drug expenses up to your plan year benefit maximums.

Schedule of Benefits	
Plan Year	July 1, 2020 through June 30, 2021
Plan Type	Group supplemental medical and prescription drug plan is a secondary payer.
Filing Deadline	The filing deadline is December 28, 2021 or 180 days after your termination date.
Plan Year Benefit Maximum	$2,750 per covered participant Prescription Drug Sublimit: $250
Prescription Drug Benefit	The maximum reimbursement for prescription drug copayment charges is $20 per 30-day supply, $40 per 60-day supply, and $60 per 90-day supply. Reimbursements for prescription drug copayment charges shall not exceed $250 per plan year per covered participant. Reimbursements for prescription drug copayments count towards the $2,750 Plan Year Maximum.
Eligible Medical Expenses	Those out-of-pocket medical, hospital and surgical expenses listed under Covered Expenses. Some exclusions apply (see plan exclusions list on next page).

Covered Expenses

The following medical, hospital, surgical care, physician and ancillary expenses are eligible under this supplemental plan:

Preventive Services

- Colorectal Screening
- Immunizations
- Newborn and Well-Baby Care
- Prostate Screening
- Routine Mammogram
- Routine Office Visit/Exam (One Per Year)
- Routine Pap Smear
- Routine Well-Woman Exam

Testing

- Allergy Testing
- Diagnostic Laboratory and Pathology
- Radiology, CT Scans, Ultrasound and Nuclear Medicine

Chemotherapy and Radiation Therapy

Hospital and Facility Services

- Ambulatory Surgical Center
- Birthing Center
- Emergency Room
- Inpatient Anesthesia Services
- Inpatient Hospital Room and Board
- Outpatient Hospital Ancillary Services
- Skilled Nursing Facility

Physician Services

- Consultations
- Office, hospital and emergency room visits
- Physician Assistants and Nurse Midwives working under the direct supervision of a physician
- Routine Obstetrical Care
- Surgeon, assistant surgeon and anesthesia

Other Services

- Ambulance
- Appliances and Braces
- Behavioral Health Services (In and Outpatient)
- Cardiac Rehabilitation (Short-Term)
- Dialysis and Related Supplies
- Durable Medical Equipment
- Home Therapies and Home Health Care
- Hospice Care
- Inhalation (or Respiratory) Therapy
- Injections
- Physical Therapy
- Prosthetics
- Speech Therapy
- Tissue and Organ Transplants

Plan Exclusions List

This EUTF supplemental plan does not pay for taxes, your primary group health plan's deductible or enrollment fees, services not specified as Covered Expenses, and services or benefits not paid by your primary group health plan. Any charges after reaching the plan maximum in your primary group health plan are excluded from reimbursement. Plan exclusions include but are not limited to the following:

- Acupuncture
- Aromatherapy
- Behavior testing
- Benefits not covered by your primary group health plan
- Biofeedback
- Bionic devices
- Blood or blood products
- Charges for donor sperm or ova
- Charges in excess of the eligible/allowable rates negotiated between any group health/medical plan and the provider or entity providing the service to the employee-beneficiary
- Chiropractic
- Complications of a non-covered procedure
- Cosmetic surgery
- Cost of storing or processing sperm
- Counseling for Bereavement, Genetic, Sexual Identification
- Custodial care
- Dental Care Services
- Disposable take home supplies
- Expenses or care for cosmetic surgery performed mainly to change a person's appearance
- Expenses or care that are not medically necessary or not prescribed by a licensed physician
- Expenses exceeding the maximum benefit amount allowed under this plan or your primary group health plan.
- Expenses incurred after your termination date of this plan
- Expenses incurred prior to your coverage effective date of this plan
- Expenses not listed (eligible) under Covered Expenses in this plan.
- Expenses paid or payable under any other source including insurance plan/policy
- Experimental or investigational services
- Eyeglasses; corrective lenses
- Fertility/Infertility
- Gender reassignment
- Government covered services (Medicaid, Medicare, QUEST)
- Group health plan deductibles that you have to satisfy in your primary group health plan
- Hair loss
- Hearing aids
- Homemaker services
- Hypnotherapy
- Massage therapy
- Naturopathy
- Oral travel immunizations/medications
- Over the counter drugs
- Personal convenience items
- Photo-refractive keratectomy
- Physical Examinations Related to
  - Employment
  - Insurance
  - Licensing
  - Court-order such as parole or probation
- Prescription drug charges in excess of the benefit maximum or annual prescription drug benefit maximum
- Provider is an Immediate Family Member
- Radial keratotomy
- Rest cure
- Reversal of voluntary sterilization
- Routine eye exams, eye exercises
- Routine foot care (unless medically necessary)
- Self-help or self-cure
- Services for which the patient has no responsibility to pay due to:
  - Military or service-related condition
  - Workers' Compensation liability
  - Automobile related condition
- Services not medically necessary
- Sleep therapy
- Stand-by time
- Transplants
  - Services for or transportation of a living donor
  - Mechanical or non-human organs
  - Organ purchase
- Travel and lodging cost
- Weight reduction programs
- Wigs