EUTF Supplemental Medical and Prescription Drug Plan

This EUTF supplemental plan provides reimbursement of eligible out-of-pocket medical and prescription drug expenses for active employee participants who are primarily covered under a non-EUTF group health plan (other than Medicare or Med-QUEST). 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, 2026 through June 30, 2027
Plan Type	Group supplemental medical and prescription drug plan is a secondary payer.
Filing Deadline	The filing deadline is December 27, 2027, 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:

Preventative 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

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

Chemotherapy and Radiation Therapy

Other Services
- Ambulance (ground and air)
- Appliances and braces
- Behavioral health services (inpatient 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

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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
- Bereavement counseling
- Biofeedback
- Bionic devices
- Blood or blood products
- Chiropractic services
- Complications of a non-covered procedure
- Cosmetic surgery or supplies (including wigs)
- Custodial care
- Dental care services
- Disposable take home supplies
- Expenses or care that are not medically necessary or not prescribed by a licensed physician
- Expenses (including prescription drug charges) exceeding this plan's benefit maximums
- Expenses incurred prior to your coverage effective date of this plan or after your coverage termination date of this plan
- Expenses not listed (or not eligible) under Covered Expenses in this plan
- Expenses paid or payable under any other source (including an insurance plan/policy or government program such as Medicare or Med-QUEST)
- Experimental or investigational services
- Eyeglasses or corrective lenses
- Fertility/infertility (including in vitro fertilization, the storage and processing of sperm, cost for donor sperm or ova, and voluntary sterilization reversal)
- Gender reassignment services
- Genetic counseling
- Hair loss treatment
- Hearing aids
- Homemaker services
- Hypnotherapy
- Massage therapy
- Naturopathy
- Oral travel immunizations/medications
- Over-the-counter drugs/products (including over-the-counter COVID-19 tests)
- Personal convenience items
- Photo-refractive keratectomy
- Physical examinations related to
  - Employment
  - Insurance
  - Licensing
- Court order such as parole or probation
- Provider is an immediate family member (i.e., parent, child, spouse, domestic partner, or yourself)
- Radial keratotomy
- Rest cure
- Routine eye exams or 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
- Sexual orientation counseling
- 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

Primary Plan Exclusions

- Services and expenses not covered by your health plan (including deductibles and cost exceeding the primary plan's eligible charge and/or benefit maximum)