Amendment No. 1 to the 2020 Summary Plan Description and Plan Document of the NECA-IBEW Welfare Trust Fund

WHEREAS, the Board of Trustees of the NECA-IBEW Welfare Trust Fund ("Fund") may, pursuant to the terms of the Summary Plan Description and Plan Document ("SPD"), amend to SPD;

WHEREAS, the Board of Trustees desires to amend the Plan as set forth below:

1. Effective July 1, 2021, the following sections of the SPD on page 48 thereof are amended to read as follows:

Death Benefits—Employees/Retirees Only

The Death Benefit, as shown in the in the applicable schedule in the "Schedules of Benefits" document, is paid to your beneficiary if you die from any cause while Eligible for benefits. Payment will be made in one lump sum to your beneficiary or beneficiaries, or in installments if requested by you or your beneficiary.

Benefits Payable

Except as specified below, benefits are payable to each beneficiary listed on, and in accordance with, the most current information on file at the Fund Office.

If you are married at the time of your death, your surviving spouse will automatically be your beneficiary (even if you named a different beneficiary on your beneficiary designation form submitted prior to your marriage). If you wish to name someone other than your surviving spouse while you are married, you must submit a new beneficiary designation form after you are married. You do not need to have spousal consent to name a beneficiary other than your spouse. Additionally, if no beneficiary is named, the Death Benefit will be paid to your surviving spouse. If you do not have a surviving spouse, and you have not named a beneficiary, the Death Benefit will be paid to your estate. Also, if you name a beneficiary, but he or she and any alternate beneficiary dies before you, the Death Benefit will be paid to your estate.

If you die within 31 days of the termination of your eligibility, the Death Benefit is still payable.

Designated Beneficiary

If you are married at the time of your death, your surviving spouse will automatically be your beneficiary (even if you named a different beneficiary on your beneficiary designation form submitted prior to your marriage). Also, if you get married, then any beneficiary designation that you previously completed and submitted is void. If you are not married or you named a new beneficiary other than your spouse after you were married, your designated beneficiary or beneficiaries for any Death Benefit will be the person or persons whom you designate in the last written notice on file in the Fund Office prior to your death. As explained above, if you wish for

your beneficiary to be someone other than your surviving spouse while you are married, you must submit a beneficiary designation form to the Fund Office after you are married. It will be your responsibility to notify the Fund Office, in writing and on such form as the Trustees prescribe, of the choice of beneficiary or beneficiaries and/or any change in beneficiary or beneficiaries. You may change your beneficiary or beneficiaries by filing a written notice on such form as the Trustees prescribe with the Fund Office. Any change in the beneficiary or beneficiaries will not become effective unless such change is received in the Fund Office prior to your death. If you fail to designate a beneficiary or beneficiaries, then any Death Benefit will be distributed as set forth above.

Effect of Divorce

In the event that your marriage is legally terminated by divorce, any prior beneficiary designation naming your former spouse as beneficiary (but not any other beneficiary designations) will be null and void. If you desire to retain your former spouse as beneficiary, you must complete a new beneficiary form after your marriage is legally terminated by divorce, listing such former spouse as beneficiary.

2. Effective July 1, 2021, the following sections of the SPD on pages 49-50 thereof are amended to read as follows:

Accidental Death and Dismemberment Benefits—Active Employees Only

If you die or suffer accidental Injuries that result in any of the losses described below, as a result of bodily Injuries sustained solely through purely accidental means, directly and independently of all other causes within 90 days following the date of such Injuries, benefits will be paid as explained in this SPD.

The full benefit for loss of life shall be payable to your applicable beneficiary (or beneficiaries) or designated beneficiary (or beneficiaries), as applicable, and the other benefits shall be payable under this benefit are payable to you.

The full benefit amount shown in the applicable schedule in the "Schedules of Benefits" document is paid for the loss of:

- Life;
- Two hands or feet or the sight of two eyes; or
- Any combination of one foot, one hand, or the sight of one eye.

One-half of the full benefit amount shown in the applicable schedule in the "Schedules of Benefits" document is paid for the loss of:

- One hand;
- One foot; or
- The sight of one eye.

Loss of hands or feet means severance at or above the wrist or ankle joint, respectively, and loss of sight means total and irrecoverable loss of sight.

If you suffer more than one of these losses because of any one accident, the Plan pays only for the loss for which the largest benefit is provided.

No payment will be made for any loss incurred wholly or partly, directly or indirectly, by:

- Disease, ptomaine, or bacterial infections, except pyogenic infection of a visible cut or wound accidentally sustained.
- Insurrection, participation in a riot, or war or any act of war, declared or undeclared.
- Military service for any country or organization.
- The claimant during the commission of an assault or felony.
- Medical or surgical treatment, except payment will be made for a death that is caused by negligence of an attending Physician.

If benefits are payable for loss of life, the Fund will have the right and opportunity to have an autopsy performed where it is not forbidden by law.

Accidental Death and Dismemberment Exclusions

No payment will be made for any loss incurred wholly or partly, directly or indirectly, by:

- Disease, ptomaine, or bacterial infections, except pyogenic infection of a visible cut or wound accidentally sustained.
- Insurrection, participation in a riot, or war or any act of war, declared or undeclared.
- Military service for any country or organization.
- The Participant during the commission of an assault or felony.
- Medical or surgical treatment, except payment will be made for a death that is caused by negligence of an attending Physician.

Retirees

Only active Employees are Eligible for Accidental Death and Dismemberment Benefits. Retirees are not Eligible for Accidental Death and Dismemberment Benefits.

3. Effective July 1, 2021, the following sections of the SPD on page 122 thereof are amended to read as follows:

Death Benefit Claims

The Death Benefit is paid to your applicable beneficiary (or beneficiaries) or designated beneficiary (or beneficiaries), as applicable, promptly upon submission of the appropriate application form provided by the Fund Office and upon receipt of a certified copy of the death certificate. Be sure to update your beneficiary information as you have changes in your life.

Generally, the Plan will make a decision on a Death Benefit claim and notify your beneficiary of the decision within 90 days of receiving the claim. If the Plan needs additional information to make a decision, your beneficiary will be notified as to what information must be submitted.

Your beneficiary will have up to 45 days to submit the additional information. Once the Plan receives the information, your beneficiary will be notified of the Plan's decision on the claim within the 90-day period.

If circumstances require an extension of time for processing the claim, your beneficiary will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

4. Effective July 1, 2021, the following sections of the SPD on page 122 thereof are amended to read as follows:

Accidental Death and Dismemberment Benefit Claims

The Accidental Death and Dismemberment Benefit is paid to you in the event of disability or to your applicable beneficiary (or beneficiaries) or designated beneficiary (or beneficiaries), as applicable, in the event of your death. Benefits are paid promptly upon submission of the appropriate application form provided by the Fund Office and upon receipt of a physician statement certifying your disability or a certified copy of your death certificate.

The Plan will make a decision on an Accidental Death and Dismemberment Benefit claim and notify you or your beneficiary of the decision within 90 days of receiving the claim. If the Plan needs additional information to make a decision, you or your beneficiary will be notified as to what information must be submitted. You or your beneficiary will have up to 45 days to submit the additional information. Once the Plan receives the information, you or your beneficiary will be notified of the Plan's decision on the claim within the 90-day period.

If circumstances require an extension of time for processing the claim, you or your beneficiary will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

5. Effective January 1, 2021, the following sections of the SPD on page 51-52 thereof are amended to read as follows:

Weekly Income Benefits—Active Employees with Base or Alternative Plan Coverage Only

If you become Totally Disabled while Eligible under the Base or Alternative Plan (including the Single Coverage Tier), a Weekly Income Benefit is payable for up to a maximum of 26 weeks per period of Disability. Totally Disabled or Total Disability means you are unable to engage in gainful pursuit within the electrical industry or usual occupation and are not Eligible for any salary continuation from an electrical Employer.Disabilities lasting 13 weeks or longer are subject to Utilization Review. The amount of your weekly benefit depends on how long you are Totally Disabled, as shown in the applicable schedule in the "Schedules of Benefits" document.

If you are Disabled for part of a week, youwill receive one-seventh of your weekly benefit for each day of Disability.

If you become Disabled while employed, or within 30 days of the date you were last Employed in the Industry, benefits will begin on the first day of Disability if the Disability is the result of an accidental Injury or on the eighth day of Disability if the Disability is due to a Sickness. If a Disability due to a Sickness lasts eight weeks, the Plan will retroactively pay benefits from, and including, the first week. If you become Disabled more than 30 days after you were last Employed in the Industry, your Disability will be considered to start on the first day of Hospital confinement. (This applies if your Eligibility has been extended due to your Hour Bank.)

You are not considered to be working in the electrical industry if you are making self-payments to the Fund, unless you provide written verification of employment on the date of the Disability from a Participating Employer. Upon receipt of written verification from the employer, you will be considered to be Employed in the Industry. Verification of employment will be confirmed by reviewing the employer's Monthly Payroll Reporting (MPR) for the period in question.

Successive periods of Disability are considered one period of Disability unless:

- You return to active full-time work and earn Eligibility for at least three consecutive months based on employer contributions.
- You are a non-bargaining member who works (as opposed to merely having hours reported on your behalf) 40 hours per week for three consecutive months.
- The Disabilities are due to unrelated causes and you return to active full-time work for at least one day between Disabilities.
- You return to work for at least 90 days if the successive periods of Disability are due to accidental Injuries.

Limitations

Weekly Income Benefits are not paid:

- If you are a Disabled Employee and are not under the care of a Physician.
- If treatment resulting from an Injury did not occur within 14 days of the date of the Injury.
- For any Disability due to work or pursuit of compensation or profit.
- For any Disability for which benefits are payable under any workers' compensation, occupational disease, or similar law.
- For any Disability for which you perform light-duty work.
- For any condition that does not meet the Plan's definition of Total Disability and cannot be verified by an examination by a Physician designated by the Trustees.
- For any period you are drawing a salary or unemployment benefits.

Termination of Benefits

Benefit payments will end after 26 weeks or upon recovery from Total Disability, if earlier.

Taxation of Weekly Income Benefits

As required by the Internal Revenue Service, Weekly Income Benefits are subject to withholdingfor federal income tax purposes.

Retirees

Only active Employees on either the Base or Alternative Plan (including the Single Coverage Tier) are Eligible for Weekly Income Benefits. Retirees are not Eligible for Weekly Income Benefits.

6. Effective immediately, the following sections of the SPD on page 10 thereof are amended to clarify that Home Health Care coverage includes Respiratory therapy as follows:

Home Health Care:

- The term "Home Health Care" will mean the services and supplies defined under "Home Health Care Plan" as defined below. Home Health Care must replace a needed Hospital stay,must be for the care or treatment of sick or injured Persons, and must be furnished by a Home Health Care Agency, in accordance with the Home Health Care Plan.
- "Home Health Care Agency" will mean a:
  - Hospital;
  - Visiting nurse association licensed by the state; or
  - Non-profit or public Home Health Care Agency or organization licensed as such by thejurisdiction in which it is located.
- "Home Health Care Plan" consists of these services and supplies:
  - Part-time nursing care provided by a registered nurse, a licensed public health nurse, orlicensed vocational nurse supervised by a registered nurse, not to exceed:
    - Two hours of nursing service in a 24-hour period; and
    - 60 visits per occurrence;
  - Part-time or intermittent home health aide services;
  - Physical, occupational, or speech therapy provided in the Eligible Person's home;
  - Physical, occupational, or speech therapy or the use of medical equipment provided on anoutpatient basis by either a Home Health Care Agency, Hospital, or other facility, if arranged with the Home Health Care Agency;
  - Medical supplies, drugs, and medications prescribed by a Physician or Surgeon, and related pharmacy and laboratory services, but only to the extent that they would havebeen covered in a Hospital; or
  - Respiratory therapy.
- Each visit from a Home Health Care Agency team of four hours or less is considered a single visit. The Eligible Person must be homebound to qualify for benefits under this definition, except if the patient is a minor child being cared for at home or in a daycare facility. If, under these latter circumstances involving a minor child, there is no practicable or economically feasible way, in light of the Eligible Person's particular circumstances, to transport the child to an outpatient

facility to receive speech therapy (and proof of such circumstances will be the burden of the Eligible Person to establish), the Fund will pay for the therapy to be provided in the home or daycare facility, but only up to the amount the Fund would have paid had the service been rendered at the outpatient facility.

7. Effective July 19, 2021, the following section of the SPD on page 5 thereof is amended to read as follows:

Allowable Charge:

- With respect to a network Preferred Provider Organization (PPO) provider, the term "Allowable Charge" is the negotiated fee/rate set forth in the agreement with the participating network professional provider, facility, or organization and the Plan.

- With respect to an out-of-network (non-PPO) provider, the "Allowable Charge" means the amount determined by the Board of Trustees (or organization designated by the Board of Trustees) that the Plan will pay for a particular service or supply, that is 130% of Medicare's Allowable Charges. Medicare Allowable Charges are the rates established and periodically updated by the Centers for Medicare and Medicaid Services for payment for services and supplies provided to Medicare enrollees.

  If Medicare Allowable Charge pricing is not available, then the Plan will use 100% of the PPO Allowable Charge for an out-of-network (non-PPO) professional provider (e.g., doctor) claims and 150% of the PPO Allowable Charge for an out-of-network facility (e.g., hospital) claims as the Allowable Charge. If neither Medicare Allowable Charge pricing nor PPO Allowable Charge pricing is available, then the Plan will use 25% of billed charges for out-of-network (non-PPO) professional claims and 50% of billed charges for out-of-network (non-PPO) facility claims as the Allowable Charge.

  Under no circumstances will the Plan pay an Allowable Charge for out-of-network services or supplies that is determined by any provider, facility, or other person or an organization other than the Board of Trustees (or organization designated by the Board of Trustees).

- The Board of Trustees has determined Allowable Charge to mean the amount most consistently charged by a licensed Physician or other professional provider for a given service. An Allowable Charge refers to a charge that is within the range of usual charges for a given service billed by most Physicians or other professional providers with similar training and experience in a given geographic area. When considering the range of usual charges, the Plan may consider discounted rates allowed by network providers as a basis for Allowable Charges.

- In no event will the Allowable Charge exceed the charges actually incurred.

8. Effective immediately, the following section of the SPD on page 64 thereof is amended to clarify that the following items are Covered Medical Expenses as follows:

45. Immunizations and Vaccinations.

9. Effective July 1, 2021, the following section of the SPD on page 54 thereof is amended to add the following paragraph and to read as follows:

Telehealth and Virtual Visits (During the Covid-19 Pandemic):

With the emergence of COVID-19, there is an urgency to expand the use of technology to help patients who need routine care and keep vulnerable patients and patients with mild symptoms in their homes while maintaining access to the care they need.

Through at least December 31, 2022, the Plan will cover telehealth services and Virtual Visits related to COVID-19 testing at no cost to you.

The Fund will also cover other telehealth services not related to COVID-19 testing according to standard Plan rules (i.e. deductible, copayments, and coinsurance). These additional benefits supplement the Fund's Virtual Visits through MDLIVE.

IN WITNESS WHEREOF, as authorized by the Board of Trustees, this Amendment No. 1 to the Fund's Summary Plan Description and Plan Document, 2020 Edition, is adopted on the ___ day of _____, 2021.

The Board of Trustees, by:

DocuSigned by:
Mark Kawolsky
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Chairman

DocuSigned by:
Jarrett Chm
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Secretary