

**NECA-IBEW Welfare Trust Fund  
Supplemental Retirement Benefit Plan  
Summary Plan Description**

**2005 Edition**

**Effective January 1, 2005**

**NECA-IBEW Welfare Trust Fund**

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[www.neca-ibew.org](http://www.neca-ibew.org)

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## **Automated Eligibility System**

Please use the automated system when calling about eligibility. The system is very efficient. To use the system:

- Dial 1-800-765-4239;
- When answered, press the number nine (9) button for eligibility status (it is not necessary to listen to the selection of options):
  - The system will tell you to press the number one (1) button;
  - The system will again tell you to press the number one (1) button;
  - The system will then ask you to enter your Social Security Number;
  - Then the system will ask you to enter your birth date using eight (8) digits (Example: If your birth date is May 15, 1935, then enter 05151935);

At this point, the system will give you your eligibility status. If you are covered, the system will notify you of the date through which you are covered.

Please use this system for eligibility verification rather than calling the Welfare Fund Administrative Office.

If you return to work, this may affect your eligibility on the system. Therefore, in this instance, you should call a representative at the Welfare Fund Administrative Office.

## **NECA-IBEW Web Site**

The Web site is designed to be a resource for NECA-IBEW members, their families, and others requiring information about our organization or the benefits administration of the Welfare Trust Fund and Pension Trust Fund.

The IBEW-NECA Board of Directors and the Board of Trustees are dedicated to making the Funds friendly to participants. Please contact us with questions, for additional information, or if you have suggestions for other Web site features that might be helpful to you.

Currently, the Web site gives you the opportunity to:

- Access the NECA-IBEW Welfare Trust Fund Summary Document and Plan Document;
- Access the NECA-IBEW Pension Trust Fund Summary Document and Plan Document;
- Access the NECA-IBEW online newsletter; and
- Check on claim and eligibility status for you and your family.

Please check the Web site periodically for updates and enhancements, which will be posted as developments occur.

### **Instructions for Registering on the Web Site**

**PLEASE READ ALL OF THE FOLLOWING INSTRUCTIONS BEFORE YOU GO TO THE WEB SITE TO REGISTER.**

The following is a list of instructions for you and your family to follow, particularly the first time you access your file. To register, you will need to:

- Go to the Web site at [www.neca-ibew.org](http://www.neca-ibew.org).
- Click on the “member login” tab that appears at the top of the home page, which will allow you to register to view your eligibility.
- When the page for you to register opens, you will need to input your:
  - Social security number;
  - Date of birth; and
  - Temporary password, which is “ibew.”
- Hit the “SUBMIT” button.
- When the member login page comes up again, you will need to change your password.

- Enter a new password and confirm your password in the boxes provided on the page that says “new password” and “confirm password.”
- Hit the “SUBMIT” button.

To register with NECA-IBEW to view your “claims data,” you will need to:

- Go to the Web site at [www.neca-ibew.org](http://www.neca-ibew.org).
- Click on the “claims data” tab that appears at the top of the home page, which will allow you to view your claims data.
- When the page for you to register opens, you will need to input your:
  - Social security number;
  - Date of birth; and
  - Temporary password, which is “ibew.”
- Hit the “SUBMIT” button.
- When the member login page comes up again, you will need to change your password.
- Enter a new password and confirm your password in the boxes provided on the page that says “new password” and “confirm password.”
- Hit the “SUBMIT” button.

At this point, claims data information is shown. Please note that each participant is not listed by name but by date of birth.

### **Points to Remember**

- You are required to have a separate/different password for eligibility and claims information. If you are not eligible for benefits under the Plan, you will not be allowed to register on the Web site and view eligibility and/or claims data. You will get a message that your ID or password is not correct. This is because only eligible members are in the Web site database.
- Information on the Web site is updated on a weekly basis. This data information is verified on each page (claims and eligibility) after you log in.
- After you have viewed your personal information, there is a log out link at the bottom of the page. This is to verify that the Web site is secure. In addition to this, at the bottom of each page, you can see a padlock, which verifies security.
- If you have unsuccessfully tried three times to login and each attempt has failed, you will need to contact the Fund by e-mail at [info@neca-ibew.org](mailto:info@neca-ibew.org) to have your password reset.

**Summary of Benefits for  
Retired Employees and Eligible Dependents NOT Eligible for Medicare**

**Accidental Death and Dismemberment, Weekly Income, Vision, and Dental Benefits are not provided for Retirees or eligible Dependents.**

**Death Benefits**

Eligible Retired or Disabled Employee Only ..... \$2,500

**Comprehensive Major Medical Benefits**

Benefits are payable for the Usual, Customary, and Reasonable (UCR) Charges for Covered Medical Expenses that are Medically Necessary for the treatment of an illness or injury. **This Plan contains limitations for Preexisting Conditions, see page \_\_.** Comprehensive Major Medical Benefits are only paid after you meet the calendar year Deductible. Comprehensive Major Medical Benefits pays benefits as follows:

Lifetime Maximum ..... \$1,000,000

Calendar Year Deductible

Individual ..... \$500

Family Maximum ..... \$1,500

Co-Payment (after Deductible)

PPO Network Provider ..... 90% of first \$15,000 of UCR Charges, 100% thereafter

Non-PPO Network Provider ..... 75% of first \$6,000 of UCR Charges, 100% thereafter

Calendar Year Out-of-Pocket Maximum (after Deductible)

Individual ..... \$1,500

Family Maximum ..... \$3,000

Non-Accident Emergency Room Deductible.....\$50 per visit after first two visits per calendar year

..... Out-of-Pocket Maximum does not apply

The following benefits are paid at the Co-Payment rates and limits shown:

**Physician Office Visits**

Co-Payment ..... \$10 per visit  
(Co-Payment does not apply toward the calendar year Deductible or Out-of-Pocket Maximum)

**Mental Health Treatment Benefits**

**Inpatient Treatment**

Co-Payment ..... 75%  
Inpatient Treatment Maximum ..... 31 days per calendar year  
Calendar Year Out-of-Pocket Maximum ..... None

**Outpatient Treatment**

Co-Payment ..... 75%  
Outpatient Treatment Maximum ..... 30 counseling sessions per calendar year  
Calendar Year Out-of-Pocket Maximum ..... None

**Substance Abuse Treatment Benefits**

Inpatient and/or Outpatient Treatment Program Co-Payment ..... 75%  
Outpatient Treatment Non-Program Co-Payment ..... 50%  
Calendar Year Out-of-Pocket Maximum ..... None  
Inpatient Treatment Maximum:  
Dependent Children ..... 31 days per calendar year  
Adult ..... 31 days per lifetime

Mental health and/or substance abuse treatment requires pre-approval and Utilization Review. The Welfare Fund Administrative Office at 217-875-2947 or 217-875-3017 will handle all calls for eligibility and benefits. The Welfare Fund Administrative Office, in conjunction with the Utilization Review large case management provider, will handle the calls for the Fund. The Welfare Fund Administrative Office will also work with you for cases that may require some intervention or follow-up.

No payment will be made for detoxification only or when only part of the program is completed.

**Chiropractic Treatment**

Co-Payment ..... 50%  
Calendar Year Maximum ..... \$1,500  
Calendar Year Out-of-Pocket Maximum ..... None

**Temporomandibular Joint Dysfunction (TMJ)**

Co-Payment ..... 75%  
Lifetime Maximum..... \$1,500

**Respite Care**

Monthly Maximum..... 20 hours  
Maximum Benefit..... \$45 per hour

**Extended Care Facility**

Confinement Maximum..... 100 days

**Physical/Massage Therapy**

Calendar Year Maximum ..... 48 visits

**Speech Therapy**

Calendar Year Maximum ..... 48 visits

**Occupational Therapy**

Calendar Year Maximum ..... 48 visits

These limits for physical/massage therapy, speech therapy, and occupational therapy are for patients age six and older. Benefits for patients under age six are unlimited as long as the patient is making ongoing progress.

*Organ Transplant Benefits (Centers of Excellence)*

Transplant surgeries covered are those defined as non-experimental by the Centers for Medicare and Medicaid Services (CMS) for the condition being treated including, but not limited to: kidney, cornea, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-approval is required for Medical Necessity. Contact the Welfare Fund Administrative Office if you or a Dependent are a candidate for transplant surgery before incurring any expenses.

Calendar Year Deductible..... Comprehensive Major Medical Deductible of \$500 per person

**Co-Payment**

Centers of Excellence Facility..... 90% of Covered Charges up to \$15,000; 100% thereafter  
Non-Centers of Excellence Facility..... 50% of discounted charges, based on the negotiated COE fee

Calendar Year Out-of-Pocket Maximum

Centers of Excellence Facility ..... Comprehensive Major Medical Out-of-Pocket Maximum of \$1,500  
..... plus Deductible  
Non-Centers of Excellence Facility ..... No Out-of-Pocket Maximum

Lifetime Maximum ..... Comprehensive Major Medical Lifetime Maximum of \$1,000,000

Immunosuppressive Medications

Retail Pharmacy Prescription Drug Program

Covered only if not available through Mail-Order Prescription Drug Program.

Maximum Supply ..... 30-day supply

Co-Payment

Generic ..... \$25 per prescription

Brand Name ..... \$50 per prescription

Out-of-Pocket Maximum ..... Does not apply.

Mail-Order Prescription Drug Program

Maximum Supply ..... 90-day supply

Co-Payment

Generic ..... \$25 per prescription

Brand-Name ..... \$50 per prescription

Out-of-Pocket Maximum ..... Does not apply

Organ Procurement Benefit ..... \$20,000 maximum (payable at 100%) not subject to Deductible;  
..... included as part of the Comprehensive Major Medical Lifetime Maximum.

**Prescription Drug Benefits**

Prescription Drug Calendar Year Deductible ..... \$100 per person

Prescription Drug Calendar Year Maximum ..... \$15,000 per person

Co-Payment

Retail Pharmacy Prescription Drug Program \*

Generic ..... \$10 per prescription

Brand-Name ..... \$15 per prescription\*\*

Mail-Order Prescription Drug Program

Generic.....\$20 per prescription  
Brand-Name.....\$30 per prescription\*\*

\* For maintenance medications, only the original prescription and first two refills may be purchased through the Retail Pharmacy Prescription Drug Program. The third refill and all subsequent refills must be filled through the Mail-Order Prescription Drug Program.

\*\* If a generic is available, you pay the brand-name co-payment plus the difference in cost between the generic and brand name prescription.

**Summary of Benefits for  
Retired Employees Over Age 65 and Eligible Dependents Overage Age 65 Eligible for  
Medicare**

**Accidental Death and Dismemberment, Weekly Income, Vision, and Dental Benefits are not provided for Retirees or eligible Dependents.**

**Death Benefits**

Eligible Retired or Disabled Employee Only ..... \$2,500

**Comprehensive Major Medical Benefits**

Retired Employees and eligible Dependents over age 65 that are eligible for Medicare are covered under an insured medical program through Monumental Life Insurance Company (see page \_\_).

Note: There is no lifetime maximum under the Monumental Insured Medical Plan. However, the Plan's Comprehensive Major Medical Lifetime Maximum of \$1,000,000 applies to Organ Transplant and Prescription Drug Benefits.

*Organ Transplants Benefits (Centers of Excellence)*

Transplant surgeries covered are those defined as non-experimental by the Centers for Medicare and Medicaid Services (CMS) for the condition being treated including, but not limited to: kidney, cornea, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-approval is required for Medical Necessity. Contact the Welfare Fund Administrative Office if you or your Dependent are a candidate for transplant surgery before incurring any expenses.

**Co-Payment**

Centers of Excellence Facility ..... 90% of Covered Charges up to \$15,000; 100% thereafter  
Non-Centers of Excellence Facility ..... 50% of discounted charges, based on the negotiated COE fee

**Calendar year Out-of-Pocket Maximum**

Centers of Excellence Facility ..... \$1,500 Out-of-Pocket Maximum  
Non-Centers of Excellence Facility ..... No Out-of-Pocket Maximum

Lifetime Maximum ..... Plan's \$1,000,000 Lifetime Maximum

Immunosuppressive Medications

Retail Pharmacy Prescription Drug Program

Covered only if not available through Mail-Order Prescription Drug Program.

Maximum Supply ..... 30-day supply

Co-Payment

Generic ..... \$25 per prescription

Brand Name ..... \$50 per prescription

Out-of-Pocket Maximum..... Does not apply.

Mail-Order Prescription Drug Program

Maximum Supply ..... 90-day supply

Co-Payment

Generic ..... \$25 per prescription

Brand-Name ..... \$50 per prescription

Out-of-Pocket Maximum..... Does not apply

Organ Procurement Benefit .....\$20,000 maximum (payable at 100%);  
..... included as part of Plan's Lifetime Maximum

**Prescription Drug Benefits**

Prescription Drug Calendar Year Deductible ..... \$100 per person

Prescription Drug Calendar Year Maximum ..... \$15,000 per person

Co-Payment

Retail Pharmacy Prescription Drug Program \*

Generic ..... \$10 per prescription

Brand-Name ..... \$15 per prescription\*\*

Mail-Order Prescription Drug Program

Generic ..... \$20 per prescription

Brand-Name ..... \$30 per prescription\*\*

\* For maintenance medications, only the original prescription and first two refills may be purchased through the Retail Pharmacy Prescription Drug Program. The third refill and all subsequent refills must be filled through the Mail-Order Prescription Drug Program.

\*\* If a generic is available, you pay the brand-name co-payment plus the difference in cost between the generic and brand name prescription.

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## Health Plan Definitions

Here are a few definitions to help you understand the benefits in the Summary Plan Description that follows:

**Co-Payment:** That portion of covered medical, prescription drug, dental or vision expenses which you are obligated to pay.

**Covered Medical Expenses:** The Usual, Customary, and Reasonable Charges incurred for covered medical services and supplies required for your treatment. These must be recommended and approved by the attending physician.

**Deductible:** A fixed dollar amount per person or family of Covered Medical Expenses which you are obligated to pay each calendar year before Comprehensive Major Medical or Prescription Drug Benefits are payable.

**Medically Necessary or Medical Necessity:** A service or supply that is:

- Provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide and prescribe it;
- Necessary in terms of generally accepted American medical standards;
- Consistent with the symptoms or diagnosis and treatment of a sickness or injury;
- Not provided solely for the convenience of the patient, physician, hospital, health care provider, or facility;
- Appropriate, as defined by the Plan, given the patient's circumstances and conditions;
- Cost-efficient, as defined by the Plan, for the supply or level of service that can be safely provided to the patient; and
- Safe and effective for the sickness or injury for which it is used.

**Deleted:** Means the treatment, confinement, or services prescribed by a physician that is not of an experimental or investigational nature.

The Trustees, or their designee, determine if a particular service, supply, or procedure is Medically Necessary. The Trustees may rely on the advice of medical professionals retained by the Fund to make this determination. The Trustees are the **final judges** of Medical Necessity for benefits payable under this Plan.

**Deleted:** determine whether a particular service, supply, or procedure is Medically Necessary

**Out-of-Pocket Maximum:** The portion of Covered Medical Expenses that you must pay before Covered Medical Expenses are paid at 100%.

**Preexisting Condition:** A Preexisting Condition limitation applies for six months on any expenses related to treatment for a condition that started before you became eligible unless you provide acceptable proof of prior coverage to shorten or eliminate the delay in coverage.

You must submit a certificate of creditable coverage from your prior health care plan or insurance policy to prove that you are entitled to a credit for the time you were covered under the other plan or policy. A “break-in-coverage” means a period of 63 days or more between the date coverage ended under the other health care plan or insurance policy and your initial eligibility date under this Plan. The waiting period for your eligibility does not count towards the 63 days break-in-coverage. Your previous Employer, insurer, or plan is required by law to provide such a certification to you on request.

If there **has been** a break in coverage, no such credit will be provided for any periods of coverage before the break in coverage. A leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Rights Act will not be counted as a break in coverage.

If there has been **no** break in coverage, the maximum period of exclusion of coverage for Preexisting Conditions described in this section will be reduced by the period of time that you, your spouse and/or any of your Dependent children were covered under any health insurance policy or plan that provides reimbursement for hospital and medical expenses or provides hospital and medical services. This includes COBRA Continuation Coverage, or any group health care plan or insurance policy (whether or not it is Employer-sponsored), any individual health insurance policy or program, Medicare, Medicaid, military sponsored health care, program of the Indian Health Service, state health benefits risk pool, the Federal Employees health benefit program, a public health plan, and/or any health benefit plan provided under the Peace Corps Act.

Even if the Preexisting Condition limitation applies to you, it will not apply to pregnancy and high blood pressure prescription drugs. The Preexisting Condition limitation does not apply to children first placed in your home for adoption.

**Usual, Customary, and Reasonable (UCR) Charges:** Usual charge refers to the amount most consistently charged by a licensed physician or other professional provider to patients for a given service. A customary 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 within a given geographic area. This is referred to as UCR Charges.

The Fund will recognize for benefits only the amount of UCR Charges that it considers “reasonable” based on the resources available to the Trustees, the medical condition of the claimant and the locality in which services were rendered. The Trustees’ decision on UCR Charges and what is “reasonable” is **final** and **binding**.

**Utilization Review:** The cost management process that determines if your hospital visits are Medically Necessary. At this writing, the health care management company hired by the Trustees to handle Utilization Review is Hines and Associates, Inc. Hines and Associates, Inc. will provide guidance for medical treatment in those situations where the treatment will be lengthy or costly. There is no requirement for a participant to call to obtain pre-approval for a hospital admission, **except** for conditions involving mental health or substance abuse. In addition, transplant surgery must be pre-approved for Medical Necessity.

## Eligibility Rules

### Eligibility

If you retire from work under the NECA-IBEW Welfare Trust Fund and your regular Welfare Trust Fund benefits end in accordance with the Plan rules, you may elect COBRA Continuation Coverage or Supplemental Retiree Benefits for yourself and your eligible Dependents. Please note that if you elect:

- COBRA Continuation Coverage, you will lose any future right to Supplemental Retiree Benefits; or
- Supplemental Retiree Benefits, you will lose any future right to COBRA Continuation Coverage.

Under certain circumstances, your spouse or Dependent child will have COBRA Continuation Coverage rights. COBRA Continuation Coverage is described beginning on page \_\_.

To be eligible for the Supplemental Retirement Benefit Plan, you must:

- Apply for Retiree coverage. You must submit a written application to the Welfare Fund Administrative Office within 90 days of
  - The last day you work;
  - The date of the award letter, as it appears on the award letter;
  - The date of your Social Security Disability Award; or
  - The expiration of your accumulated bank hours.
- Be at least age 55 or totally disabled as defined by the Plan;
- Submit proof of retirement acceptable to the Board of Trustees. Proof of retirement means that you are eligible or have been awarded a retirement or disability pension from:
  - The National Electrical Benefit Fund;
  - Any other Pension Fund in which Union Trustees are selected by one or more Local Unions affiliated with the IBEW; or
  - The Social Security Administration. Entitlement to a Social Security Disability Award is considered a form of retirement and your Social Security entitlement date will be considered your retirement date. If you work past your Social Security full retirement age and are receiving Social Security benefits, you may provide other proof of retirement other than Social Security benefits. Such other proof must be submitted within 90 days of the award of a pension benefit.
- Be eligible for benefits under the NECA-IBEW Welfare Trust Fund during the month in which you retire or the month immediately before you retire.

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- Have been eligible for benefits under the NECA-IBEW Welfare Trust Fund (or working toward eligibility reinstatement at the rate of at least 80 hours per month) for 45 of the last 60 months immediately before:
  - The Welfare Fund Administrative Office receives your retirement application; or
  - If you are retiring because of a total disability, your entitlement to a Social Security Disability Award.

**Deleted:** you must be eligible for benefits provided by the NECA-IBEW Welfare Trust Fund (or working toward eligibility reinstatement at the rate of at least 80 hours per month) for 45 of the last 60 months immediately before

The 60-month period noted above may be extended by up to 30 months (to a maximum of 90 months). This period may be extended by one month for every month that no hours were reported on your behalf but during which you were seeking employment with a participating local union. Your local union must verify, in writing, that you were seeking employment. This may help you to meet the 45-month eligibility rule.

For example, if you only had 40 months of eligibility in the last 60 months before retiring but your local union verified, in writing, that you were unemployed and seeking employment for six of those last 60 months, the Fund will look at your last 66 months before retiring (adding one month for each month you were seeking employment). In this instance, since you were eligible for coverage for 46 of the last 66 months before retiring, you will meet this retiree eligibility requirement.

If you retired from a merged Fund and there was not sufficient time for you to accumulate the required 45 of the last 60 months of eligibility under the NECA-IBEW Welfare Trust Fund, you may be eligible for the Supplemental Retirement Benefit Plan if:

- The Trustees of the merged Fund verify that you were eligible under that Fund for 45 of the last 60 months before the effective date of your retirement; or
- You were eligible under the NECA-IBEW Welfare trust fund and the merged Fund for a combined total of at least 45 of the last 60 months before the effective date of your retirement.

### **Self-Contribution Amounts**

You must make self-contributions for the Supplemental Retirement Benefit Plan. If the effective date of your retirement was:

- Before January 1, 2002, the monthly self-contribution rate for single or family benefits is equal to:
  - 100% of the active Employee contribution rate multiplied by 160 for:
    - Retirees or surviving spouses who are younger than age 62; and
    - Surviving spouses of Early Retirees who are not yet eligible for Medicare.

- 75% of the active Employee contribution rate multiplied by 160 for:
  - Disabled Retirees who are younger than age 65 and not yet eligible for Medicare; and
  - Surviving spouses of deceased Medicare-eligible Retirees who are not yet eligible for Medicare.
- 50% of the active Employee contribution rate multiplied by 160 for:
  - Retirees or surviving spouses who are eligible for Medicare; and
  - Early Retirees who are between ages 62 and 65.
- On or after January 1, 2002, the monthly self-contribution rate is:
  - 100% of the active Employee contribution rate multiplied by 160 for:
    - Retirees between ages 55 and 61; and
    - Surviving spouses of Early Retirees who are younger than age 62 and not yet eligible for Medicare.
  - 75% of the active Employee contribution rate multiplied by 160 for:
    - Retirees between ages 62 and 64;
    - Surviving spouses of Retirees who are between ages 62 and 64 and not yet eligible for Medicare;
    - Surviving spouses of deceased Medicare-eligible Retirees who are not yet eligible for Medicare; and
    - Disabled Retirees who are younger than age 65 and not yet eligible for Medicare.
  - 65% of the active Employee contribution rate multiplied by 160 for:
    - Retirees age 65 and over;
    - Surviving spouses who are eligible for Medicare;
    - Disabled Retirees who are under age 65 and eligible for Medicare; and
    - Disabled surviving spouse who are under age 65 and eligible for Medicare.

The Trustees reserve the right to modify the Retiree self-contribution rates at any time.

You must make your monthly self-contributions for coverage under the NECA-IBEW Welfare Trust Fund using the automatic electronic fund transfer program. You will be required to submit the proper authorization forms to the Welfare Fund Administrative Office. Payments are withdrawn, directly from the account you designate, a month in advance.

## Initial Eligibility

You and your Dependents will become Eligible for benefits under the Supplemental Retirement Benefit Plan on the effective date of your retirement if you:

- Meet the Plan's eligibility requirements on page \_\_\_; and
- Submit a timely application.

Written applications must be submitted to the Welfare Fund Administrative Office within 90 days of:

- The last day you worked;
- The date of the award letter, as it appears on the award letter;
- The date of your Social Security Disability Award; or
- The expiration of your accumulated bank hours.

Bank hours remaining in your account on the effective date of retirement will be used in determining the initial self-contribution amount. Any hours worked before and received in the Fund Office after the effective date of retirement will also be used to determine future Retiree self-contributions. The first required self-contribution must be received in the month preceding the month for which coverage is desired.

Disabled Employees eligible for Supplemental Retirement Benefit Plan coverage must begin on the effective date of your retirement. However, please note that if your eligibility is continued under the Welfare Trust Fund Plan for active Employees for up to 21 months in the event of total disability when your hour bank reserves are exhausted, you may not begin self-contributions for Supplemental Retiree Benefits following the completion of the 21-month period.

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Late submission for initial application to the Supplemental Retirement Benefit Plan will not be accepted. You will not be entitled to apply at any other time for these benefits.

## Dependent Eligibility

Your Dependents are eligible for coverage when you are eligible for coverage. Your eligible Dependents include your:

- Spouse, provided you are not divorced or legally separated; and
- Unmarried children who:
  - Under age 19;

- Age 19 but less than age 25 before the end of the calendar year and enrolled as a full-time student in a secondary school, college, university, or trade school, or enrolled in such a school on a less than full-time basis if the student by reason of a physical, educational, or mental handicap, is not able to attend such school on a full-time basis. Verification of student status is required for each semester of study. Verification of student status for the:
  - Fall semester, qualifies the Dependent for coverage from June 1 through December 31; and
  - Spring semester, qualifies the Dependent for coverage from January 1 through May 31.
- To be covered for the summer months the student must be under age 25, have been full-time in the spring semester and pre-registered as full-time for the fall semester; or
- Overage age 19 and permanently and totally disabled and incapable of self-sustaining employment due to mental retardation or a physical handicap that began before the child attained age 19.

Unmarried children that do not live with you are eligible for coverage if, in addition to the above:

- You are divorced or legally separated from the child's other parent or you have lived apart at all times during the last six months of the calendar year;
- You and/or the child's other parent provide more than 50% of the child's support and maintenance during the calendar year; and
- The child is in your or the child's other parent's custody for more than one half of the calendar year.

Children include the following who receive more than one-half of their support from you:

- Biological children;
- Legally-adopted children, including children placed with you for adoption;
- Step-children;
- Foster children; and
- Grandchildren.

The number of stepchildren and foster children that can be considered your eligible Dependents under the Plan is limited to the first four children that become part of your household in the order in which each child becomes a part of your household.

### **Continued Eligibility**

Eligibility will continue each month using the automatic electronic fund transfer program. Before you and/or your Dependent become eligible for Medicare, the Welfare Fund Administrative Office will send you an enrollment package. This package will include information on how to become covered under the

Monumental Insured Medical Plan. Once you enroll in the Monumental Insured Medical Program, you will receive a certificate of insurance providing detailed information about Monumental's standard coverage. Monumental will be responsible for answering questions, paying claims, and handling any appeals relating to Retiree medical benefits for Medicare-eligible participants.

### **Termination of Employee Eligibility**

Your coverage will end on the last day of the month that your account linked to the automatic electronic transfer program does not have sufficient funds to cover the required self-contribution. **You may stop coverage at any time by contacting the Welfare Fund Administrative Office. Once your coverage ends, it cannot be reinstated.**

If your coverage ends because you return to active work, you must satisfy the requirements of the initial eligibility rules under the Welfare Trust Fund Plan for active Employees. If you want to keep Retiree coverage, you must make self-contributions for those months that you returned to active work but are not yet eligible under the Welfare Trust Fund Plan for active Employees.

### **Continuation of Coverage for Dependents of Deceased Eligible Retired Employees**

If you die while eligible for benefits under the Supplemental Retirement Benefit Plan, your:

- Dependent children may continue their coverage by electing COBRA Continuation Coverage; and/or
- Spouse may:
  - Make self-contributions for Supplemental Retirement Benefit Plan coverage for the duration of his/her lifetime; or
  - Continue his/her coverage for up to 36 months by electing COBRA Continuation Coverage, when permissible.

If your spouse wants to continue coverage under the Supplemental Retirement Benefit Plan, he/she must make self-contributions the month following the month you made self-contributions. Your spouse must use the automatic electronic fund transfer program. Your spouse can only make self-contributions for his/herself. **Your Dependent children will not be covered.** If the spouse of a deceased retired Employee remarries, the new spouse and any children born or otherwise of this marriage will not be covered.

### **Termination of Dependent Eligibility**

Your eligible Dependents benefits will end upon the earliest of the:

- Date the Plan ends;

- Date you cease to be eligible;
- Last day of the month your Dependent is no longer an eligible Dependent;
- Date coverage would end in accordance with other provisions of the Plan; or
- Last day of the month in which the account linked to the automatic electronic fund transfer program does not have sufficient funds to pay the required self-contribution.

Once coverage ends, it cannot be reinstated.

#### **Termination Due to Local Union Withdrawal**

Your eligibility under the Supplemental Retirement Benefit Plan will end on the 31<sup>st</sup> day following the date that the Union, which represented the Employee as an active Employee for purposes of collective bargaining, withdraws from participation in the Trust Fund.

## **COBRA Self-Pay Rules**

If you do not qualify for Supplemental Retiree Benefits or if you prefer, you may elect COBRA Continuation Coverage for yourself and your eligible Dependents who were covered under the regular Welfare Trust Fund when you retire from covered employment under the NECA-IBEW Welfare Trust Fund and your regular Welfare Trust Fund benefits end. You and each of your Dependents have an independent right to elect COBRA Continuation Coverage. You must self-pay for COBRA Continuation Coverage. It is important to remember that if you choose COBRA Continuation Coverage, you will lose any future right to Supplemental Retiree Benefits. For COBRA Continuation Coverage information, contact Robin Hamilton at:

NECA-IBEW Welfare Trust Fund  
2120 Hubbard Avenue  
Decatur, Illinois 62526-2871  
1-800-765-4239

A child born, adopted, or placed for adoption with an eligible person who is on COBRA may be added to the COBRA Continuation Coverage. That child will have the same COBRA rights as other qualified beneficiary who was covered by the Plan before the event that triggered COBRA Continuation Coverage. The eligible person must notify the Welfare Fund Administrative Office at the above address or phone number, as soon as possible after the birth or placement to add the child for coverage. Since COBRA Continuation Coverage premium self-payment amounts are established on a composite rate basis, there is no increase to the monthly amount. Like all qualified beneficiaries with COBRA Continuation Coverage, the child's continued coverage depends on the timely and uninterrupted payment of premiums on his or her behalf.

COBRA Continuation Coverage will count toward creditable coverage if you become covered under another group medical plan. You will receive an updated certificate of your length of creditable coverage under this Plan when your COBRA Continuation Coverage ends.

Every 12 months, the Trustees establish the monthly COBRA premium self-payment amount. A person who has a qualifying event, makes a timely election, and regularly pays the required monthly premium may self-pay for up to 36 months of COBRA Continuation Coverage.

The Welfare Fund Administrative Office will notify you of your COBRA Continuation Coverage rights by mail, sent to the last known address on file, when you retire. Therefore, you should keep the Welfare Fund Administrative Office informed of any changes in your address or the addresses of family members. You should also keep a copy of any notices you send to the Welfare Fund Administrative Office. You may elect COBRA Continuation Coverage, or if eligible, Supplemental Retiree Benefits. You will then have 60 days from the date of the Welfare Fund Administrative Office's notice to elect COBRA Continuation Coverage.

If you elect the Supplemental Retirement Benefit Plan and your child loses Dependent status or you divorce or legally separate from your spouse, **it is the responsibility of that individual** to notify the Welfare Fund Administrative Office that a qualifying event has occurred within 60 days from the date they lose eligibility for the Supplemental Retirement Benefit Plan. The Welfare Fund Administrative Office will advise that that of his or her COBRA Continuation Coverage rights by letter. The Welfare Fund Administrative Office will also provide written notification to individuals who are not entitled to COBRA. Such notice will explain why COBRA Continuation Coverage is not available.

An eligible individual who has a qualifying event **will** lose his or her right to COBRA Continuation Coverage before the end of the maximum 36-month period if he or she:

- Does not make a timely notice of his or her election for COBRA Continuation Coverage.
- Makes a timely election but does not pay the required premium (or the Welfare Fund Administrative Office does not receive the payment within the prescribed time limits.)
- Becomes entitled to Medicare after electing COBRA Continuation Coverage.

If COBRA Continuation Coverage ends before 36 months, you will receive written notice explaining why COBRA Continuation Coverage has ended, the date coverage end, and your rights, if any, to alternative coverage.

## **Death Benefit**

The Death Benefit is paid to your beneficiary if you die from any cause while eligible. Payment will be made in one lump sum to your beneficiary or beneficiaries.

### **Beneficiary Selection**

Benefits are payable to each beneficiary listed on, and in accordance with, the most current Basic Data Card that is kept at the Welfare Fund Administrative Office. A change in beneficiary can be made by completing a new Basic Data Card, which becomes effective upon receipt by the Welfare Fund Administrative Office. If no beneficiary is named, benefits will be paid to the surviving spouse. If no surviving spouse, then the benefit will be paid to the decedent's estate.

If there is a named beneficiary, but the beneficiary and the alternate beneficiary are both deceased, then benefits will be paid to the decedent's estate.

**Comprehensive Major Medical Benefits for  
Retired Employees and Eligible Dependents Not Yet Eligible for Medicare**

**How The Plan Works**

When you or your eligible Dependent incurs Covered Medical Expenses due to a non-occupational sickness or accident, which are in excess of the Deductible, the Comprehensive Major Medical Benefit reimburses you for a portion of the Covered Medical Expenses. Comprehensive Medical Benefits pay for a wide range of services and supplies. How the Plan works is simple. Each calendar year, Comprehensive Medical benefits work like this:

- **Calendar Year Deductible:** You are responsible for meeting your calendar year Deductible (between January 1 and December 31) before the Plan begins to pay for Covered Medical Expenses. That means you or your Dependent must pay the first \$500 of Covered Medical Expenses before the Plan pays benefits. The amounts you pay toward the annual deductible do not apply toward meeting the Plan's annual out-of-pocket maximum.
- **Emergency Room Deductible:** If you or your Dependents visit a hospital emergency room for treatment of injuries or illnesses not due to an accident, you are required to pay an additional \$50 Deductible for each visit after the first two visits in a calendar year. This Deductible is in addition to the calendar year Deductible and any other Co-Payment amounts you are responsible for paying. In addition, this emergency room Deductible *does not* apply towards meeting your calendar year Deductible or Out-of-Pocket Maximum and you must pay this Deductible even after you have met your Out-of-Pocket Maximum.
- **Office Visit Co-Payment:** When you or a family member goes to a physician's office, you pay a separate \$10 Co-Payment for each office visit. This office visit Co-Payment is in addition to the calendar year Deductible and any other Co-Payment amounts you are responsible for paying. In addition, this office visit Co-Payment *does not* apply towards meeting your calendar year Deductible or Out-of-Pocket Maximum and you must pay this amount even after you have met your Out-of-Pocket Maximum. Please note that you do not pay this \$10 copayment to your physician. Once a claim is submitted, the Fund Office will deduct the \$10 copayment from the amount that the Fund reimburses you.
- **Co-Payment:** Once you or your Dependents meet the Deductible, the Plan pays a percentage of Covered Medical Expenses and you pay the rest. Benefits are paid based on Usual, Customary, and Reasonable (UCR) Charges for the duration of an injury or illness. The Co-Payment percentage the

Plan pays varies depending on whether you use a PPO or non-PPO Provider. If you or your Dependent use a:

- **PPO provider**, the Plan 90% of UCR Charges, which requires you to pay the remaining 10% of Covered Medical Expenses, up to the Out-of-Pocket Maximum; or
- **Non-PPO provider**, the Plan pays 75%, which requires you to pay the remaining 25% of Covered Medical Expenses, up to the Out-of-Pocket Maximum.

The above Co-Payment percentages apply unless specifically noted otherwise.

- **Calendar Year Out-of-Pocket Maximum:** After you or your Dependent have met the Deductible and Co-Payment amounts you pay for Covered Medical Expenses, reach the calendar year Out-of-Pocket Maximum, the Plan pays 100% of UCR Charges for most Covered Medical Expenses incurred for the remainder of that Calendar Year (January 1 – December 31). The Calendar Year Out-of-Pocket Maximum is \$1,500, up to a family maximum of \$3,000. Covered individuals will not have to pay more than \$2,000 (including the Deductible) in a calendar year. An entire family will not have to pay more than \$4,500 (including the Deductibles) in a calendar year.

Please note that certain expenses are not subject to the Out-of-Pocket Maximum. This means amounts you pay for these expenses do not count towards meeting your Out-of-Pocket Maximum and you will continue to pay your Co-Payment percentage towards these expenses even once you reach your Out-of-Pocket Maximum. Expenses that are not subject to the Out-of-Pocket Maximum include:

- Emergency room Deductible;
- Office visit Co-Payment;
- Mental health and/or substance abuse treatment;
- Chiropractic treatment; and
- Organ transplant surgery performed at a non-Centers of Excellence Facility.

- **Lifetime Maximum:** The lifetime maximum for most Covered Medical Expenses is \$1,000,000 per person.

Note that some benefits and expenses may be covered differently or subject to benefit maximums. See the *Summary of Benefits* and specific benefit descriptions for more information.

### **Preferred Provider Organization**

A Preferred Provider Organization (PPO) is a group of physicians and hospitals that have negotiated a contract with the Fund to provide discounts to members. Physicians and hospitals that participate in the PPO network are known as PPO providers. BlueCross/BlueShield, the Plan's current PPO network, will answer your questions regarding whether your provider participates in their network. Call

BlueCross/BlueShield at 1-800-810-Blue (2583) for a list of participating providers or use their Internet Web site ([www.bcbs.com](http://www.bcbs.com)).

### **Covered Medical Expenses**

The Plan pays benefits, based on UCR Charges, for the following Covered Medical Expenses.

1. Hospital expenses, including pre-admission testing, room and board up to the semi-private room rate and intensive care. Federal law requires that the Plan pay hospital expenses for any hospital length of stay in connection with childbirth for a mother and/or the newborn child for at least 48 hours (following a vaginal delivery) or at least 96 hours (following a cesarean section). However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours, if applicable) following delivery.
2. Miscellaneous hospital charges, including services in an operating room and services of an anesthesiologist, pathologist, or radiologist.
3. Outpatient surgery for procedures performed in the outpatient department of a hospital, ambulatory medical/surgical facility, or alternative birthing center.
4. Emergency ambulance or lifeline service to the nearest hospital or physician's office equipped to provide required treatment for an injury or sickness, including terminal illnesses.
5. Surgical expenses, including surgeon and assistant surgeon fees within limits, and second surgical opinions for non-emergency operations. In addition, surgical expenses for reconstructive breast surgery and breast prosthesis following a mastectomy, including:
  - Reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
6. Doctor's services in the office or in the hospital.
7. Initial doctor's exam for newborn, well baby care in the hospital.
8. Services of physiotherapists, speech therapists, and registered nurses.

9. Diagnostic X-ray and laboratory testing, including pap smears.
10. Radium treatments and radioactive isotope therapy.
11. Legend drugs and medicines requiring a prescription that are not dispensed through the Retail Pharmacy Prescription Drug Program or Mail-Order Prescription Drug Program, which are covered under a separate Prescription Drug Benefit.
12. Blood or blood plasma.
13. Casts, splints, trusses, crutches, bandages, surgical dressings, oxygen, and rental of equipment for its administration.
14. Other durable medical equipment within the limits of the Plan. (For further information, you may view and obtain a copy of the Plan Document at the Welfare Fund Administrative Office.)
15. Cardiac rehabilitation.
16. Home health care. For further information, you may view and obtain a copy of the Plan Document at the Welfare Fund Administrative Office.
17. Hospice care in a freestanding facility or an approved method of treatment for a terminally ill patient.
18. Well child care for routine office exams, inoculations, and other kinds of well child care, before the child's second birthday.
19. Outpatient charges for vasectomies or sterilization procedures performed on you or your eligible spouse in a physician's office. Inpatient (or outpatient procedures not performed in a physician's office) vasectomies or sterilization procedures are covered only when the attending physician certifies that the patient's health would be endangered if the procedure were performed in an outpatient setting. Expenses incurred for reversals of such vasectomies or sterilization procedures are not covered.
20. Bone mass (bone density) measurement screening and repeat bone mass measurements when such tests are prescribed by the attending physician as Medically Necessary. Testing is covered once every two years, unless more frequent screening is Medically Necessary. Bone mass measurements by dual photon absorptiometry (DPA) are not covered.

21. Colorectal cancer screening when recommended by a physician for an eligible person over age 50 once every ten years, unless more frequent screening is Medically Necessary. Colorectal cancer screenings using molecular genetic techniques are not covered.

The following services are also covered under the Comprehensive Major Medical Benefits but with specific Co-Payment limitations and benefits maximums.

#### *Mental Health Treatment*

Inpatient treatment for mental and/or nervous disorders is covered at 75% of UCR Charges provided you contact the Welfare Fund Administrative Office at 217-875-2947 or 217-875-3017, and obtain pre-approval **before** any inpatient admission. Continued benefits while hospitalized must also be pre-approved by the Welfare Fund Administrative Office.

Outpatient Treatment is covered at 75% of Usual, Customary, and Reasonable Charges.

There is **no** Out-of-Pocket Maximum on your portion of the incurred charges for either inpatient or outpatient mental health treatment.

#### *Substance Abuse*

Inpatient and outpatient substance abuse treatment programs are both paid at 75% of UCR Charges. Inpatient Treatment is covered provided you contact the Welfare Fund Administrative Office at 217-875-2947 or 217-875-3017 and obtain pre-approval **before** admission as an inpatient. There is **no** Out-of-Pocket Maximum on the charges that you must pay. The Plan will not pay for more than 31 days per calendar year of treatment in a substance abuse program for Dependent children. In regard to you or your spouse, the Plan will not pay for more than 31 days of treatment in a substance abuse program during their lifetime. Non-program outpatient treatment is paid at 50%. Benefits are not payable for a detoxification-only program or for partial completion of a program.

#### *Chiropractic Treatment*

Treatment from a chiropractor, including X-ray and laboratory charges, is paid at 50% up to \$1,500 in a calendar year. Chiropractic charges, like all other charges are subject to UCR Charges. There is no Out-of-Pocket Maximum on the charges that you must pay.

### *Temporomandibular Joint Dysfunction (TMJ)*

Treatment of TMJ for surgery, appliances, or adjustment is paid at 75% of the UCR Charges up to \$1,500 in your or your Dependent's lifetime.

### *Respite Care*

The Plan will cover up to 20 hours per month for respite care. The maximum reimbursement will be \$45 per hour. These covered charges must be reviewed and approved, in advance, by the Welfare Fund Administrative Office. Respite care is designed to give relief to family members caring for an ill or disabled relative. It is strongly suggested that an RN or LPN provide this respite care.

### *Extended Care Facility*

The Plan will cover up to 100 days per confinement in an Extended Care Facility when the admission immediately follows an inpatient hospital stay. The patient must have potential for rehabilitation and would otherwise require continued confinement in a hospital. These covered charges must be reviewed and approved by the Welfare Fund Administrative Office.

### *Physical Therapy/Massage Therapy*

The Plan will cover up to 48 visits for physical therapy/massage therapy for patients age six or older. The Plan will cover unlimited physical therapy visits for patients under age six if the patient continues to make ongoing progress.

### *Speech Therapy*

The Plan will cover up to 48 visits for speech therapy for patients age six or older. The Plan will cover unlimited speech therapy visits for patients under age six if the patient continues to make ongoing progress.

### *Occupational Therapy*

The Plan will cover up to 48 visits for occupational therapy for patients age six or older. The Plan will cover unlimited physical occupational visits for patients under age six if they continue to make ongoing progress.

### *Organ Transplants*

The Plan will cover a lifetime maximum for transplants pursuant to the \$1,000,000 Lifetime maximum benefit for you and each of your Dependents. Pre-approval is required for Medical Necessity. Covered Transplants are transplant surgeries that are defined as non-experimental by the Centers for Medicare and Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, cornea, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. The Plan's \$500 individual Deductible applies. The Co-Payment is 90% of Covered Charges up to \$1,500 if a Center of Excellence (COE) facility is utilized; 100% thereafter. The Out-of-Pocket Maximum is the Plan's \$1,500 maximum plus the Plan Deductible. Organ procurement benefit is \$20,000 maximum (payable at 100%, not subject to the Plan Deductible) included as part of the Plan's Lifetime Maximum. If a COE facility is not used, the Plan pays 50% of the discounted charges, based on the negotiated COE fee. There is no Out-of-Pocket Maximum on the charges that you must pay if a Centers of Excellence facility is not used.

### *Immunosuppressive Medications*

- **Retail Pharmacy Prescription Drug Program:** Immunosuppressive medications are only covered at a retail pharmacy if they are not available through the Mail-Order Prescription Drug Program. The Co-Payment is the same as under the Mail-Order Prescription Drug Program. For up to a 30-day supply, with no maximum, your Co-Payment is:
  - \$25 per generic prescription; or
  - \$50 per brand-name prescription.
- **Mail-Order Prescription Drug Program.** For up to a 30-day supply of immunosuppressive medications, with no maximum, your Co-Payment is:
  - \$25 per generic prescription; or
  - \$50 per brand-name prescription.

### *Prescription Drugs*

The Plan covers most prescription drugs under separate Prescription Drug Benefits, as described beginning on page \_\_.

## **Comprehensive Major Medical Benefits for Medicare-Eligible Retirees and Medicare-Eligible Dependents**

### **Monumental Insured Medical Plan**

Coverage for Medicare-eligible Retirees over age 65 and/or their Medicare-eligible Dependents over age 65 is fully insured through the Monumental Life Insurance Company (Monumental) of Baltimore, Maryland. Medicare-eligible Retiree means an individual that is age 65 or older and enrolled in Medicare Parts A and B. To be enrolled in the Monumental Insured Medical Plan, you must be enrolled in Medicare Parts A and B. However, prescription drugs are covered under the Plan's Prescription Drug Benefit, as described beginning on page \_\_. Before you and/or your Dependent become age 65 and eligible for Medicare, the Fund Office will send you an enrollment package. This package will include information on how to become covered under the Monumental Insured Medical Plan. Once you enroll in the Monumental Insured Medical Program, you will receive a certificate of insurance providing detailed information about Monumental's standard coverage. Monumental will be responsible for answering questions, paying claims, and handling any appeals relating to Retiree medical benefits for Medicare-eligible participants. If you have any specific questions about:

- Your Retiree medical coverage, please contact Monumental at 1-800-752-9797; or
- Submitting a claim or the status of a claim, call Monumental at 1-800-854-0186.

Customer service representatives are available Monday through Friday from 8:30 a.m. to 6:00 p.m. eastern time. If you wish to terminate your Monumental Insured Medical Plan coverage, contact the Welfare Fund Administrative Office at 1-800-765-4239.

*Please note that it is possible that you and your spouse or other Dependents will be covered under different programs. Only Retirees and/or their Dependents eligible for Medicare will be insured through Monumental. All other benefits will be provided by the Fund on a self-funded basis.*

### **Organ Transplants**

The Plan will pay for organ transplants up to the Plan's \$1,000,000 lifetime maximum benefit for you and each of your Dependents. Pre-approval is required for Medical Necessity. Covered Transplants are transplant surgeries that are defined as non-experimental by the Centers for Medicare and Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, cornea, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. The Co-Payment the Plan pays is:

- If a Centers of Excellence facility is used, 90% of Covered Medical Expenses up to \$1,500; 100% thereafter; or
- If a Centers of Excellence facility is not used, 50% of the discounted charges, based on the negotiated COE fee; there is no Out-of-Pocket Maximum.

The Out-of-Pocket Maximum is the Plan's \$1,500 maximum. Organ procurement benefit is \$20,000 maximum (payable at 100%) included as part of the Plan's Lifetime Maximum.

#### *Immunosuppressive Medications*

- **Retail Pharmacy Prescription Drug Program:** Immunosuppressive medications are only covered at a retail pharmacy if they are not available through the Mail-Order Prescription Drug Program. The Co-Payment is the same as under the Mail-Order Prescription Drug Program. For up to a 30-day supply, with no maximum, your Co-Payment is:
  - \$25 per generic prescription; or
  - \$50 per brand-name prescription.
- **Mail-Order Prescription Drug Program.** For up to a 30-day supply of immunosuppressive medications, with no maximum, your Co-Payment is:
  - \$25 per generic prescription; or
  - \$50 per brand-name prescription.

## **Prescription Drug Benefits**

Prescription Drug Benefits are available to all Retirees and their eligible Dependents, including Medicare-eligible Retirees covered through Monumental Life Insurance Company, Retirees not yet eligible for Medicare, and eligible Dependents whether or not they are Medicare-eligible.

The Plan's Prescription Drug Benefits for Retirees and their eligible Dependents are provided through Medco Health Solutions, Inc. The Medco Health Program includes a:

- Retail Pharmacy Prescription Drug Program; and
- Mail-Order Prescription Drug Program.

The Retail Pharmacy Prescription Drug Program includes a network of participating pharmacies, which includes most pharmacies that have agreed to discounts for our members. For a free listing of participating pharmacies, Mail-Order Prescription Drug Program forms, and information regarding coverage for specific medications, contact Medco Health at the telephone number stated in the Medco Health information guide or through their Web site at [www.medcohealth.com](http://www.medcohealth.com).

### **Prescription Drug Calendar Year Deductible**

You and each of your family members must each pay the first \$100 of expenses incurred for prescription drugs dispensed through either the Retail Pharmacy Prescription Drug Program or the Mail-Order Prescription Drug Program (or a combination of the two) each calendar year.

### **Calendar Year Maximum**

The Plan covers a maximum of \$15,000 per person each calendar year for all prescription drugs purchased through the Retail Pharmacy Prescription Drug Program and the Mail-Order Prescription Drug Program combined.

### **Retail Pharmacy Prescription Drug Program**

Once you or your family member satisfies the prescription drug calendar year deductible, the Co-Payment for the remainder of the calendar year is:

- \$10 per generic prescription; or
- \$15 per brand-name prescription.

If you choose a brand-name medication when a generic substitute is available, you are required to pay the \$15 Co-Payment plus the difference in cost between the brand name and the generic substitute, except as noted on page \_\_. The quantity of medication dispensed must be consistent with rational drug use, availability of product, and program economics, particularly for established drug regimens. You may obtain up to a 34-day supply through the Retail Pharmacy Prescription Drug Program.

Maintenance medications are those medications that are taken for an extended period to treat a chronic condition, such as diabetes, arthritis, or heart disease. The Retail Pharmacy Prescription Drug Program will honor your initial maintenance medication prescription and the first two refills. The third maintenance medication refill and all subsequent refills must be filled through the Mail-Order Prescription Drug Program to be covered under the Plan.

#### *Non-Participating Network Pharmacy*

If you do not use a participating network retail pharmacy, you must file a prescription drug claim for reimbursement with the Welfare Fund Administrative Office. Claims for prescriptions filled at a non-participating retail pharmacy will be reimbursed at 50%.

#### **Mail-Order Prescription Drug Program**

Once you or your family member satisfies the prescription drug calendar year deductible, the Co-Payment for the remainder of the calendar year is:

- \$20 per generic prescription; or
- \$30 per brand-name prescription.

If you choose a brand-name drug when a generic drug substitute is available, you are required to pay the \$30 Co-Payment plus the difference in cost between the brand name and the generic substitute, except as noted on page \_\_. You may obtain up to a 90-day supply through the Mail-Order Prescription Drug Program.

**Maintenance Medications Reminder:** You must have the third maintenance medication refill and all subsequent maintenance medication refills filled through the Mail-Order Prescription Drug Program.

## **Brand-Name Medication Exceptions**

In general, if you choose a brand-name medication when a generic substitute is available, you are required to pay the brand-name Co-Payment **plus** the difference in cost between the brand name and the generic substitute. However, for certain medications, you will not be required to pay the additional amount.

You will only be required to pay the brand name Co-Payment (\$15 per 34-day supply for prescriptions filled through the Retail Pharmacy Prescription Drug Program or \$30 per 90-day supply for prescriptions filled through the Mail-Order Prescription Drug Program) for the following medications:

- Dilantin.
- Coumadin.
- Tegretol.
- Synthroid.
- Premarin.
- Theophylline products.
- Depakene.
- Celontin.
- Phenobarbital.
- Lanoxin.

The Trustees may update this list periodically. Please contact the Welfare Fund Administrative Office for a current list.

## **Covered Medications**

The following medications are covered when obtained through the Retail Pharmacy Prescription Drug Program or Mail-Order Prescription Drug Program:

- All federal legend medications;
- Insulin;
- Insulin syringes and needles;
- Compound medication containing at least one federal legend ingredient; and
- Oral prescription medications for smoking cessation.

## **Exclusions**

This Prescription Drug Benefit does not cover:

1. Injectable products (except insulin).
2. Diabetic diagnostics.
3. Rogaine, etc.
4. Nicorette or over-the-counter smoking deterrents.
5. Retin-A, etc.
6. Over-the-counter medications.
7. Investigational or experimental medications.
8. Therapeutic devices or appliances.
9. Anorexians.
10. Vitamins (prescription and over-the-counter).
11. Fertility medications.
12. Contraceptives.

## Other Features

### Coordination of Benefits

If you or your Dependents are covered by another medical plan, the combined benefits paid to you may not exceed 100% of the charges. If **you or a Dependent are** covered by another plan, you must **submit** your claim to both plans. You will receive payment (if appropriate) from our Plan showing how your claim was calculated.

If your spouse is offered any comprehensive major medical coverage through their employer, your spouse must accept the coverage. This includes spouses of retired and active participants that work full-time or part-time. If your spouse does not accept such other coverage, he or she will not be covered under this Plan.

No coverage of any kind will be provided by this Plan to a Dependent who has, or has available, any kind of medical coverage from his or her employer's plan unless that Dependent's employer plan provides the same maximum benefits to all its employees regardless of the coverage the employee (or the employee's dependents) may have in another plan.

Our Plan will work with your other plan to coordinate your benefits based on our Plan. The Plan has specific procedures that are followed to determine which plan pays first. If you have questions regarding the Plan's rules for coordinating benefits, call the Welfare Fund Administrative Office. You will be furnished an explanation of the rules. You may request a written copy of the coordination of benefits rules.

### Reimbursement, Subrogation, and Loan Agreements

This provision enables the Plan to recover the amount of benefits it pays on your behalf for Covered Medical Expenses resulting from an injury or sickness for which someone else (a third party) is legally responsible and required to pay. For example, treatment received because of a car accident, removal of breast implants, or when the court requires a parent to be financially responsible for providing health care benefits and this Plan pays because the parent is not fulfilling their responsibility. If this occurs, the Plan has special processing procedures for handling your claim, including completing subrogation and loan agreements. The Fund's right to reimbursement and subrogation is more fully explained in the Plan Document.

Please note that any injury, sickness, or treatment that arises out of or in the course of any occupation or employment for wage or profit is not a Covered Medical Expense and is not subject to this subrogation provision.

### **Recovery of Overpayments and Erroneous Payments**

Health care expenses are occasionally paid erroneously by the Plan or Fund Administrator (i.e., paid more than once or incorrectly under the Plan's terms, conditions, limitations, or exclusions). A retired employee, Dependent, or health care service provider receiving such an overpayment or erroneous payment must, upon discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. The Fund Administrator has no obligation to secure any other payment of the bill before refund by the retired employee, Dependent, or health care provider. A health care provider may not apply an erroneous or duplicate payment to the balance of another bill or towards a bill for any other Dependent.

The Plan has the exclusive right to choose who will repay it for an overpayment of erroneous payment (i.e., including, but not limited, to the retired employee, Dependent, health care service provider, another health benefit plan, or insurer). If the Plan elects to seek the refund from the retired employee or Dependent, recovery of the overpaid amount should be reimbursed in a lump sum or deducted from future claims presented for processing. Health care service providers accepting payment for services from the Plan, in consideration of such payments, further agree to submit all claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, CMS guidelines, HCPCS standards, or other standards approved by the Fund Administrator or insurer. Any paid claims not in accordance with the above provisions will be repaid to the Plan within 30 days of discovery or demand or incur a prejudgment interest rate of 1½% per month. Each participant hereby acknowledges by participation in the Plan that the Plan is entitled to litigation costs and actual attorney fees in the event it becomes necessary to institute suit to recover duplicate or erroneous payments or payments of improperly billed charges.

### **Provider Self-Audit Program**

This Program is intended to encourage you and your Dependents to review carefully your bills from professional care providers. A cash refund is available for discovering and arranging the recovery of overcharges made on your bills. The cash refund is 25% of the actual amount of the overcharge that the provider agrees is invalid. Overcharges of less than \$25 are not eligible under this Program. In addition, the maximum the Plan will pay you in a calendar year under this Program is \$500.

You must negotiate directly with the provider, within 45 days of receipt of your bill. The Fund will not get involved. To be eligible for the cash refund, you must have met your calendar year Deductible.

The Welfare Fund Administrative Office will be happy to furnish a list of suggestions to help you review your bills.

## General Limitations and Exclusions

For a complete list, refer to the Plan Document.

The following list summarizes the most important limitations on benefit payments from the Plan:

1. Expenses related to any accidental bodily injury sustained while working for compensation or profit.
2. Charges incurred after your eligibility ends, unless specifically provided otherwise.
3. Payments over the Usual, Customary, and Reasonable Charge.
4. Services or supplies not recommended and approved by an attending physician.
5. Services or supplies deemed not Medically Necessary, as defined by the Plan.
6. Any expense or charge for services or supplies that are:
  - a. Not provided in accordance with generally accepted professional medical standards;
  - b. For experimental or investigative treatment; or
  - c. Subject to the exercise of the Trustees' discretion to "reasonably interpret" the terms of the Trust or Plan and are thereby deemed non-covered expenses or services.
7. Preventative services or treatments, unless specifically provided otherwise.
8. Custodial care, except as hospice or respite care.
9. Cosmetic or reconstructive surgery, except for specific conditions described in the Plan Document.
10. Services, treatment, or surgical procedures related to non-acute obesity.

~~The Fund, notwithstanding approval from the FDA and/or CMS, reserves the right to decline coverage for new experimental and/or technological innovative medication procedures, which have not been historically covered by the Fund. The Trustees will retain independent professionals to determine benefits based upon independent evidence of medical effectiveness and Medical Necessity.~~

**Deleted:** Experimental (new and unproven) treatments.

11. Charges for which you are not legally responsible for payment.
12. Construction to an employee's home to accommodate a medical condition.
13. Supplies or equipment for personal hygiene, comfort, or convenience.
14. Elective eye surgery.

If you have any concern about whether a particular expense is covered by the Plan, contact the Welfare Fund Administrative Office at 1-800-765-4239.

### **Dental and Vision Benefits Coverage Run Out**

Benefits are extended under the Welfare Trust Fund Plan for active Employees for Dental and Vision Benefits as long as you continue to remain eligible based on your active hour bank. The Supplemental Retirement Benefit Plan does not include Dental and/or Vision Benefits.

### **Withdrawal of Local Union**

If a local union or employer ends participation in this Plan or a local union no longer provides in its collective bargaining agreement for the required employer contributions, the eligibility and benefit rights of those local union members, Retirees, and Dependents become subject to special rules and limits including the following:

- Eligibility ends as of the 31<sup>st</sup> day following the date contributions are no longer required regardless of any hour bank accumulation.
- All remaining hours accumulated in individual hour banks are canceled and no one has any rights to any of the Plan assets.
- Retiree eligibility ends as of the 31<sup>st</sup> day following the date contributions are no longer required because of the local union's termination. For this purpose, any Retiree who was a member of the terminating local union will be subject to this rule.

## **Claims and Appeals Procedures**

You should file claims for benefits as soon as possible. In the event of your death, your beneficiary should file a claim for death benefits as soon as possible. Claim forms are available from participating local unions, from the Welfare Fund Administrative Office and Chapter offices, and can be printed from the Fund's Web site ([www.neca-ibew.org](http://www.neca-ibew.org)). Call or write the Welfare Fund Administrative Office to obtain copies of appropriate forms. Claims (other than insured medical claims) should be submitted to:

NECA-IBEW Welfare Trust Fund  
2120 Hubbard Avenue  
Decatur, Illinois 62526-2871  
1-800-765-4239

All forms should be filled out completely. The retired employee's full name, address, and social security number should be included on all claims. Claims submitted one year after the date incurred would be denied. When filing a claim, please wait at least four weeks from the date you had the service performed before you contact the Welfare Fund Administrative Office. You may also check these through the Web site (see page \_\_).

### **Death Benefit**

The death benefit is paid to your designated beneficiary or beneficiaries promptly upon submission of the appropriate application form provided by the Welfare Fund Administrative 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.

The Plan will make a decision a Death Benefit claim and notify your beneficiary of the decision within 90 days of receiving a 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.

### **Monumental Insured Medical Plan**

All claims for Medicare-eligible Retirees and/or their Medicare-eligible Dependents who are covered under the Monumental Insured Medical Program are processed by Monumental. If you have questions

about submitting a claim or the status of a claim, call Monumental at 1-800-854-0186. Customer service representatives are available Monday through Friday from 8:30 a.m. to 6:00 p.m. eastern time. **If you want to terminate your coverage under Monumental, you must contact the Welfare Fund Administrative Office at 1-800-765-4239.**

### **Comprehensive Major Medical Benefits**

Application for Comprehensive Major Medical Benefits must include a completed and signed claim form from the claimant, and an itemized bill from the provider showing all information required by the Fund to consider charges. Please request that a diagnosis for each visit be itemized on the bills that you submit for payment.

All Covered Medical Expenses under current medical provisions will be paid to the providers. Only one claim form is required per year. However, if you should incur a new illness or injury, additional information may be required.

#### *Pre-Approval of Inpatient Treatment for Mental Health and Substance Abuse or Transplant Surgery*

If your doctor recommends inpatient treatment for mental health and/or substance abuse or transplant surgery, you must call the Welfare Fund Administrative Office at 217-875-2947 or 217-875-3017 before admission. If your doctor recommends transplant surgery, you will be encouraged to utilize a Centers of Excellence facility. In addition to saving you money, the doctors practicing at a Centers of Excellence facility specialize in transplant surgeries. Surgeries performed at a Centers of Excellence facility usually have a higher success rate than those performed at a non-Centers of Excellence facility.

#### *Pre-Service Claims under the Pre-Admission Review Process*

You are required to get pre-approval in advance of inpatient treatment for mental health and/or substance abuse or for transplant surgery. When pre-approval is required, the claim is considered a pre-service claim. The Plan will make a decision on your pre-service claim and notify you of the decision within a reasonable period appropriate to the medical circumstances, but no later than 15 days after receiving your pre-service claim. 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 original 15-day period. A decision will be made within 15 days of the time the Plan notifies you of the delay.

If the Plan needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have up to 45 days to submit the additional information. Once the Plan receives the information from you, you will be notified of the Plan's decision on the claim within 15 days.

### *Urgent Care Claims*

Urgent care claims are claims for medical care or treatment that would:

- Seriously jeopardize your life or health, as determined by a physician, if normal pre-service standards were applied; or
- Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a physician with knowledge of your condition.

If your claim involves urgent care, the Plan will make a decision on your urgent care claim and notify you of the decision as soon as possible, taking into account your medical needs, but no later than 72 hours after the Plan receives your claim.

If you do not provide sufficient information to determine whether or to what extent benefits are covered or payable for urgent care, the Fund Administrator or its designee will notify you as soon as possible, but no later than 24 hours after receipt of the claim, of the specific information necessary to process the claim. You must provide the specified information within 48 hours. If you do not provide the information, your claim will be denied.

### *Post-Service Claims*

Claims you submit after you have received the services are considered post-service claims. The Plan will make a decision on your post-service claim and notify you of the decision within 30 days of receiving a post-service claim. 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 original 30-day period. A decision will be made within 15 days of the time the Plan notifies you of the delay.

If the Plan needs additional information from you to make a decision, you will be notified as to what information must be submitted. You will have up to 45 days to submit the additional information. Once the Plan receives the information from you, you will be notified of the Plan's decision on the claim within 15 days.

## **Prescription Drug Benefit Claims**

When you go to a participating network pharmacy, Prescription Drug Benefits are obtained by showing the pharmacist your prescription drug ID card and paying the applicable Co-Payment. You must meet your prescription drug calendar year deductible before the Plan begins to pay Prescription Drug Benefits. If you go to a pharmacy that does not participate in the pharmacy network, you must file a claim. Claims for Prescription Drug Benefits obtained at a non-participating pharmacy are handled the same as Comprehensive Major Medical Benefits, see page \_\_ for more information.

Information regarding the Mail-Order Prescription Drug Program is available from the Welfare Fund Administrative Office.

### **If Your Claim is Denied**

If your claim is denied, in whole or in part, you (or your beneficiary) will receive notice of the denial of your claim within the appropriate period (as previously described) that provides the following information:

- The specific reason or reasons your claim was denied;
- Reference to the specific Plan provision(s) on which the denial was based;
- If an internal rule, protocol, or guideline was relied on in making the denial, a copy of the rule, protocol or guideline (or a statement that it is available upon request at no charge);
- If the determination was based on Medical Necessity, experimental/investigational exclusion, or similar exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms to your claim (or a statement that it is available upon request at no charge);
- A description of any additional information you need to submit to support your claim;
- An explanation of why the additional information is needed;
- An explanation of the Plan's appeal procedures and applicable time limits; and
- A statement of your right to bring a civil action under ERISA following an adverse benefit determination on appeal.

If you do not receive the notice within the appropriate periods (as previously described) and there has been no settlement on your claim, you should write to the Welfare Fund Administrative Office for information.

## Appealing the Denial of Your Claim

If your claim is denied, you are entitled to a full and fair review of your claim, known as an appeal. You or your authorized representative must submit your written appeal within 180 days of the denial of your claim. If your claim involves urgent care, you may make your request for review orally.

In making your appeal, you or your authorized representative will be entitled to submit additional proof that you are entitled to benefits and examine any document related to your claim that is in the possession of the Welfare Fund Administrative Office.

A decision on your appeal will be made as soon as possible and no later than:

- **30 days** of receiving your written appeal for pre-service claims; or
- **72 hours** for urgent care claims.

Post-service and death claims will be reviewed at the next regularly scheduled Claim Appeal Committee meeting. Meetings are held quarterly. If the Trustees receive the request for review of a post-service or death claim within 30 days of the next regularly scheduled Claim Appeal Committee meeting, the request for review may be considered at the second regularly scheduled Claim Appeal Committee meeting. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third regularly scheduled board meeting. You (or your beneficiary) will be advised in writing in advance if this extension will be necessary. Once a decision on review of the claim is reached, you (or your beneficiary) will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

The written notice of the decision on review will include:

- The specific reason or reasons the appeal was denied;
- A reference to the specific Plan provisions on which the denial was based;
- A statement that you (or your beneficiary) are entitled to receive reasonable access to and copies of all documents relevant to the claim upon request and free of charge;
- A statement of your right to bring a civil action under ERISA following an adverse benefit determination on review; and
- A statement about alternative ways to appeal the decision and referral to the Department of Labor or your state's regulatory agency.

The Trustees have discretionary authority to determine all benefit claim appeals and to interpret the Plan. The Trustees' decision on appeal will be given judicial deference in any later court action. You must

follow the Plan's claims and appeals procedures before you are permitted to bring any court action against the Plan.

You may appear before the Claim Appeal Committee, or may designate someone else to represent you at such a hearing. If you decide to make a personal appearance or have someone do so on your behalf, it must be done at your own expense.

## **Important Information about the NECA-IBEW Welfare Trust Fund**

The NECA-IBEW Welfare Trust Fund has been established to provide health and welfare benefits to eligible participants who have had contributions made to the Fund on their behalf by participating Employers. Participants in the Plan include eligible employees and their eligible Dependents, as well as eligible Retirees and their eligible Dependents.

The Trust Fund is operated under the direction of a Board of Trustees, some of whom are selected by the Employers and some of whom are selected by the unions. These Trustees collect, manage, and distribute the Fund's accumulated assets, determine the benefits, and establish the eligibility rules.

This Summary Plan Description has been prepared in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. It is intended to assist participants in understanding the benefits provided and the contract provisions governing the administration of the NECA-IBEW Welfare Trust Fund.

The following information is provided to help you identify this Plan and the people who are involved in its operations.

**Plan Name.** This Plan is known as the NECA-IBEW Welfare Trust Fund.

**Board of Trustees.** A Board of Trustees is responsible for the operation of this Plan. A complete list of members of the Board of Trustees is provided at the end of this booklet.

**Plan Sponsorship and Administration.** This Plan is administered by a joint labor-management Board of Trustees. The Board is comprised of individuals appointed by the Chapters of the National Electrical Contractors Association, Inc. or other multi-employer groups representing the participating employers in an area and representatives of local unions affiliated with the International Brotherhood of Electrical Workers that have become parties to the Fund Agreement and Declaration of Trust. An administrative manager assists the Board of Trustees in the administration of the Fund.

**Plan Identification Numbers.** The Employer identification number assigned by the Internal Revenue Service is 37-0738564. The number assigned by the Plan Sponsor is 501.

**Service of Legal Process.** Robert L. Williams is the Plan's agent for the service of legal process. If legal disputes involving the Plan arise, legal documents should be served upon Mr. Williams at the NECA-IBEW Welfare Trust Fund, 2120 Hubbard Ave., Decatur, IL 62526-2871 or upon any individual Trustee.

**Source of Contributions.** The Fund receives contributions from employers pursuant to written agreements requiring contributions to the Fund on behalf of employees. The Trustees set the contribution rate and contributions are paid monthly. Contributions are also received by the Fund from employees eligible to make self-contributions.

**Plan Funding.** All Plan benefits are self-funded and administered directly by the Trust Fund, except for:

- Prescription drug benefits, which are administered by Medco Health Solutions, Inc; and
- Comprehensive Major Medical Benefits for Medicare-eligible participants, which are insured through Monumental Life Insurance Company.

**Accumulation of Assets.** The Board of Trustees pending payment of benefits and administrative expenses holds all assets comprising the funds of the Plan in trust.

**Plan Year.** The Fund is maintained on a 12-month fiscal year basis ending each June 30.

**Type of Plan.** This Plan provides death, medical, and prescription drug benefits for Retirees. It also provides benefits for death, disability, medical, prescription drug, dental, and vision for active participants.

**Plan Amendment.** The Supplemental Retirement Benefit Plan is summarized and detailed in this booklet. The Trustees have the right to amend or terminate the Plan at any time in whole or in part in accordance with the Trust Agreement. You will be notified, in writing, of any Plan amendments.

**Obtaining Copies of Fund Documents.** Copies of the Trust Agreement, the Plan Document, and Amendments to those documents are available for review by participants. Participants may arrange to review and obtain these documents at the Welfare Fund Administrative Office or at the office of participating unions. In addition, a complete set of these documents may be requested, in writing, from the Welfare Fund Administrative Office. The Fund may charge a reasonable fee to cover the cost of reproducing documents. Requests for documents should be addressed to:

Board of Trustees  
NECA-IBEW Welfare Trust Fund  
2120 Hubbard Avenue

Decatur, IL 62526-2871

1-800-765-4239

**Obtaining Copies of NECA-IBEW Welfare Trust Fund's Privacy Policy.** A copy of the Fund's Privacy Policy is available for review by participants. Participants may arrange, by appointment, to review and obtain this document at the Welfare Fund Administrative Office. A copy is also posted on the NECA-IBEW Web site ([www.neca-ibew.org](http://www.neca-ibew.org)). In addition, a copy may be requested, in writing, from the Welfare Fund Administrative Office. The Fund may charge a reasonable fee to cover the cost of reproducing this document. Requests for the Privacy Policy should be addressed to:

HIPAA Privacy Officer

NECA-IBEW Welfare Trust Fund

2120 Hubbard Avenue

Decatur, IL 62626-2871

If any discrepancy exists between this booklet and the Plan Documents, the provisions of the Plan Documents will govern.

**Statement of Rights under the  
Employee Retirement Income Security Act of 1974 (ERISA)**

As a participant in the NECA-IBEW Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following rights.

**Receive Information about Your Plan and Benefits**

You have the right to:

- Examine, without charge, at the Fund Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, 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 (EBSA);
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (the Fund Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Fund Administrator is required by law to provide to each participant.

**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 and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.); and
- Reduce or eliminate exclusionary periods of coverage for Preexisting 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 ends.

You may also 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 Preexisting Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **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.

### **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 Fund 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 Fund Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a 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.

## Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the nearest office of the EBSA at:

*National Office:*

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.  
Washington, D.C. 20210  
1-866-444-3272

*Nearest Regional Office:*

Employee Benefits Security Administration  
Chicago Regional Office  
200 West Adams Street, Suite 1600  
Chicago, IL 60606  
1-312.353.0900

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the Web site of the EBSA at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**Nothing in this booklet is meant to interpret, extend, or change in any way the provisions expressed in the Plan. The Board of Trustees reserves the right to amend, modify, or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. In addition, the Board of Trustees reserves the right to instigate, increase, and/or decrease self-contributions.**

## Board of Trustees

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### Participating Local Unions

Local 16	Local 668
Local 34	Local 676
Local 146	Local 702
Local 193	Local 725
Local 197	Local 760
Local 305	
Local 308	Local 816
Local 349	Local 852
Local 429	Local 855
Local 443	Local 873
Local 531	Local 1316
Local 538	Local 1531
Local 558	Local 1701
Local 601	Local 1925