NECA-IBEW Welfare Trust Fund

Supplemental Retirement Benefit Plan

2015 EDITION

SUMMARY PLAN DESCRIPTION

FOR RETIRED PARTICIPANTS AND DEPENDENTS

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

2015 Edition

Effective July 1, 2015

NECA-IBEW Welfare Trust Fund
2120 Hubbard Avenue
Decatur, IL 62526-2871
800-765-4239
www.neca-ibew.org

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Statement of Grandfathered Status

The Trustees believe that this Plan is a "grandfathered health plan" under the Affordable Care Act, which permits us to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, our Plan does not have to include certain consumer protections of the Affordable Care Act that apply to other plans (for example, providing preventive health services without any cost sharing). However, grandfathered health plans, like our Plan, must comply with other consumer protections in the Affordable Care Act (for example, the extension of coverage for dependent children to age 26).

Contact the Welfare Trust Fund Administrative Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

Table of Contents

Introduction

This booklet contains only highlights of certain features of the NECA-IBEW Welfare Trust Fund Supplemental Retirement Benefit Plan in effect as of July 1, 2015. Full details are contained in the Plan documents, Trust Agreements, insurance contracts and collective bargaining agreements that establish the Plan's provisions. If there is a discrepancy between the wording here and the Plan documents that establish the Plan, the language in the Plan documents will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time. This Summary Plan Description (SPD) booklet replaces and supersedes the prior SPD. If the Plan is amended or modified, you will receive written notice of such change.

The Plan's benefits are not guaranteed by the Board of Trustees, any participating employer, union, or any other individual or entity. Plan benefits may be provided only from the assets in the Plan that are collected and available for such purposes. The Board of Trustees reserves the right to interpret, amend, modify, or terminate all or a part of this Plan, and to take any action deemed desirable to preserve the Plan's financial stability.

Automated Information System

Please use the automated information system to confirm your eligibility and/or claim status rather than calling the Welfare Trust Fund Administrative Office. In order to obtain your information from the system, please be prepared to provide your unique ID number (which is located on your BlueCross BlueShield card.), the date of birth of the patient and/or the date of service of the claim you are inquiring about. The system is very efficient. To use the system:

- Dial 800-765-4239.
- When your call is answered, press the number nine (9) for eligibility status (it is not necessary to listen to the menu of options).
- The system will then tell you to press the number one (1) if you are a provider or to press two (2) if you are a participant.
- The system will then ask you to enter your unique ID number. You can find your unique ID number on your BlueCross BlueShield card and/or your Express Scripts card.
- Depending on your responses to the prompts, the system will supply you with the desired information on your eligibility or the status of claims on you and/or a family member.

Once the system has provided the information requested and you should still need to talk with a customer service please press six (6).

NECA-IBEW Website

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

Please check the website periodically for updates and enhancements, which will be posted as developments occur. Currently, the website gives you the opportunity to:

- Access an electronic version of this NECA-IBEW Welfare Trust Fund Supplemental Retirement Benefit Plan Summary Plan Description;
- Access the NECA-IBEW Welfare Trust Fund Base Plan Summary Plan Description;
- Access the NECA-IBEW Welfare Trust Fund Alternative Plan Summary Plan Description;
- Access the NECA-IBEW Welfare Trust Fund Plan Document;
- Access the NECA-IBEW Pension Trust Fund Summary Plan Description and Plan Document;
- Access current and past issues of the NECA-IBEW Welfare Trust Fund newsletters;
- Access information about your Health Reimbursement Account (HRA), including a list of eligible expenses, reimbursement forms and a link to the HRA Participant Portal to view HRA your balance, contributions and claim information;
- Access claim forms and other forms;
- Check on claims and eligibility status for you and your family;
- Find out more about your medical and prescription drug coverage; and
- Contact the Welfare Trust Fund Administrative Office.

Most information is accessible without logging onto the site; but, to check on claim and eligibility status, you must be a registered user.

Instructions for Registering on the Website

Please read all of the following instructions before you go to the website to register.

- Go to www.neca-ibew.org.
- Navigate to the blue login in box in the upper right corner of the page:
- **If you've already registered**, enter your "Username" and "Password" and click "Login;" or
- **If you've forgotten you login information**, click "Forgot Login," another page will open, and you can select "Request Username" or "Forgot Password";
- **If you're registering as a new user**, click "Register," another page will open, and you will need to fill in:
  - User Type (either Member or Dependent).
  - First Name.
  - Last Name.
  - Your Social Security Number.
  - Date of Birth.
  - Zip Code (five-digit number only).
- **Then click the "Submit" button**. This screen will allow you to enter the username and password of your choice. Remember, each person has to be logged in separately. If you log in, you will see only information that pertains to you. This screen will also request that you answer challenge questions. A successful response to a challenge question permits a resetting of your password in case you forget it.

This screen will also request that you answer challenge questions. A successful response to a challenge question permits a resetting of your password in case you forget it.

Once you have logged in, you will be at the benefits page where you can use the menu links to view specified information. You will be able to view claims data, eligibility and pension information, if it applies to you.

For HIPAA (Health Insurance Portability and Accountability Act) security, each family member needs to log in separately to view their personal information.

Points to Remember

- Information on the website is updated on a nightly basis.
- After you have viewed your personal information, there is a log out link at the top right of the page. This is to maintain the security of the website. In addition to this, at the bottom of each page, you can see a padlock, which verifies security.
- If you have unsuccessfully tried to log in three times and each attempt has failed, you will need to contact the Fund by e-mail at info@neca-ibew.org to have your password reset.

Overview of Plan Benefits

The NECA-IBEW Welfare Trust Fund Supplemental Retirement Benefit Plan provides health and welfare coverage for eligible retirees and their eligible dependents. There are two basic benefit programs:

- a self-insured benefits program for retirees and their eligible dependents who are not yet eligible for Medicare; and
- a fully insured benefits program for Medicare-eligible retirees over age 65 and/or their Medicare-eligible dependents over age 65, through an arrangement with the Transamerica Premier Life Insurance Company ("Transamerica").

Retirees and Their Eligible Dependents Who Are Not Yet Eligible for Medicare

If you and/or your eligible dependents are not yet eligible for Medicare Parts A and B, you have two coverage options. You may continue your Active coverage under the **Fund's Comprehensive Major Medical Benefits (Base Plan)** or you may elect coverage under the **Alternative Plan**. The Alternative Plan provides a lower level of coverage at a reduced cost.

You can elect coverage under the Alternative Plan at any time. However, once you do, you will not have the option of re-enrolling in the higher level of coverage under the Base Plan.

If you had Base Plan coverage while an Active employee, you may elect the Alternative Plan when you are initially eligible for retiree coverage—or at a later date.

If you were covered under the Alternative Plan as an active participant, you cannot elect base Plan coverage when you retire.

Retirees and Their Eligible Dependents Who Are Age 65 or Over and Eligible for Medicare

If you and/or your eligible dependents are age 65 or over and eligible for Medicare Parts A and B, you will receive your medical benefits through Transamerica. In addition to medical benefits, you will receive coverage for organ transplants and prescription drugs through the Welfare Trust Fund's self-insured benefits program.

You have the option to elect to receive your prescription drug coverage under either the Base Plan or the Alternative Plan. Compared to the Base Plan, the Alternative Plan provides a lower level of prescription drug coverage at a reduced cost. If you elect the Alternative Plan's Prescription Drug Benefit, you will not have the option, at any time, to re-enroll in the higher level of coverage under the Base Plan.

If you or your eligible dependents are enrolled in Medicare Parts A and B due to disability, you must submit your claims to the Welfare Trust Fund Administrative

Office for processing. Your claims will be coordinated with Medicare, in accordance with the Plan's and Medicare's coordination of benefits provisions. Benefits will be coordinated with Medicare based on a supplemental approach, whether or not you or your eligible dependents are actually enrolled in Medicare Parts A and B.

Summary of Benefits for Retired Employees and Eligible Dependents Not Eligible for Medicare Who Elect Base Plan Coverage

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

Death Benefits

Eligible Retired Employee *Only* $5,000

Comprehensive Major Medical Benefits

Benefits are payable at the Allowable Charge for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after you meet the calendar year Deductible. Comprehensive Major Medical Benefits pays benefits as shown on the following pages.

Annual Maximum ..... **No maximum**

Calendar Year Deductible
Individual $600
Family Maximum..... $1,800

Coinsurance (after Deductible, Plan pays)
PPO Provider ..... 90% of first $19,000 of Allowable Charges, 100% thereafter
Non-PPO Provider ..... 75% of first $7,600 of Allowable Charges, 100% thereafter

Calendar Year Out-of-Pocket Maximum (after Deductible)
Individual $1,900
Family Maximum..... $3,800

Non-Accident Emergency Room Deductible
Deductible ..... $60 per visit after first two visits per calendar year
(Does not apply to Calendar Year Deductible or Calendar Year Out-of-Pocket Maximum.)

Physician Office Visits
Copayment ..... $15 per visit
(Does not apply to Calendar Year Deductible or Calendar Year Out-of-Pocket Maximum.)

Chiropractic Treatment
Coinsurance Plan Pays 50%
Calendar Year Maximum ..... 48 visits
Calendar Year Out-of-Pocket Maximum ..... None

Temporomandibular Joint Dysfunction (TMJ)
Coinsurance (after Deductible, Plan pays).....75%
Lifetime Maximum $2,000
(For participants and dependents age 18 and over; no maximum for dependents under age 18.)

Testosterone Replacement Therapy
Calendar Year Maximum $2,500
(Requires verification of Medical Necessity and lab results showing deficiency.)

Growth Hormones
12-Month Maximum.....$15,000
Lifetime Maximum $50,000

Physical/Massage/Speech/Occupational Therapy
Physical/Massage Therapy Calendar Year Maximum .....48 visits
Speech Therapy Calendar Year Maximum .....48 visits
Occupational Therapy Calendar Year Maximum.....48 visits
(Limits are for eligible individuals six years of age and older; benefits for dependents younger than six years of age are unlimited as long as the dependent is making ongoing therapeutic progress.)

Hearing Aid Benefit
For participants and dependents ..... $1,250 per ear once every 5 years
EPIC Hearing Service Plan.....Access to discounts on hearing exams, hearing aid devices and hearing aid batteries

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, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Welfare Trust Fund Administrative Office is required for Medical Necessity; otherwise, benefits are not payable. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. You must contact the Welfare Trust Fund Administrative Office if you or your dependent is a candidate for transplant surgery before incurring any expenses.

Calendar Year Deductible ..... Comprehensive Major Medical Deductible of $600 per person

Coinsurance (after Deductible, Plan pays)
COE Facility .....90% of Covered Charges up to $19,000; 100% thereafter
Non-COE Facility ..... 50% of discounted charges, based on the negotiated COE fee

Calendar Year Out-of-Pocket Maximum
COE Facility $2,500
($1,900 Comprehensive Major Medical Out-of-Pocket Maximum plus $600 Deductible)
Non-COE Facility .....No Out-of-Pocket Maximum

Immunosuppressive Medications
Retail Pharmacy Prescription Drug Program
(Only if not available through Mail-Order Prescription Drug Program.)
Maximum Supply ..... 30-day supply
Copayment
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
Copayment
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 Calendar Year Deductible)

Behavioral Health Benefits

Behavioral Health Benefits apply towards the Comprehensive Major Medical Benefits Plan Year Annual Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefit Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).

You and your eligible dependents have access to up to three counseling sessions per year under the Member Assistance Program. Sessions are covered 100% by the Plan.

Prescription Drug Benefits

Prescription Drug Calendar Year Deductible..... $60 per person
Participating Retail Pharmacy (up to a 34-day supply)*
Generic..... $15 per prescription Copayment
Brand Name..... $20 per prescription Copayment**
Non-Participating Retail Pharmacy (up to a 34-day supply)* 50%
Mail-Order Prescription Drug Program (up to a 90-day supply)
Generic..... $25 per prescription Copayment
Brand Name..... $35 per prescription Copayment**
Specialty Medications..... 10% Coinsurance up to $380 per prescription fill***

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

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

*** If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name co-payments provided under the retail or mail order program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Welfare Trust Fund Administrative Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.

Summary of Benefits for Retired Employees and Eligible Dependents Not Eligible for Medicare Who Elect Alternative Plan Coverage

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

Death Benefits

Retired Employee *Only* $5,000

Comprehensive Major Medical Benefits

Benefits are payable at the Allowable Charge for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after you meet the calendar year Deductible. Comprehensive Major Medical Benefits pays benefits as shown on the following pages.

Annual Maximum ..... No maximum

Calendar Year Deductible

Individual $1,000
Family Maximum..... $3,000

Coinsurance Plan Pays (after Deductible)
PPO Provider ..... 70% of first $10,000 of Allowable Charges, 100% thereafter
Non-PPO Provider ..... 60% of first $7,500 of Allowable Charges, 100% thereafter

Calendar Year Out-of-Pocket Maximum (after Deductible)
Individual $3,000
Family Maximum..... $6,000

Non-Accident Emergency Room Deductible
Deductible .....$50 per visit after first two visits per calendar year
(Copayment does not apply to Deductible or Out-of-Pocket Maximum)

Physician Office Visits

Copayment ..... $20 per visit
(Copayment does not apply to Deductible or Out-of-Pocket Maximum)

Specialist Office Visits

Copayment ..... $40 per visit
(Copayment does not apply toward Deductible or Out-of-Pocket Maximum)

Chiropractic Treatment

Coinsurance Plan Pays.....50%
Calendar Year Maximum .....48 visits
Calendar Year Out-of-Pocket Maximum .....None

Temporomandibular Joint Dysfunction (TMJ)

Coinsurance Plan Pays 75%
Lifetime Maximum $2,000
(for participants and dependents age 18 and over; no maximum for dependents under age 18)

Testosterone Replacement Therapy

Calendar Year Maximum $2,500
(Requires verification of Medical Necessity and lab results showing deficiency.)

Growth Hormones

12-Month Maximum $15,000
Lifetime Maximum $50,000

Physical/Massage/Speech/Occupational Therapy

Physical/Massage Therapy Calendar Year Maximum ..... 48 visits
Speech Therapy Calendar Year Maximum ..... 48 visits
Occupational Therapy Calendar Year Maximum..... 48 visits
(Limits are for eligible individuals age 6 and older; benefits for dependents younger than age 6 are unlimited as long as the dependent is making ongoing therapeutic progress.)

Hearing Aid Benefit

For participants and dependents .....$1,250 per ear once every 5 years
EPIC Hearing Service Plan.....Access to discounts on hearing exams, hearing aid devices and hearing aid batteries

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, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Welfare Trust Fund Administrative Office is required for Medical Necessity; otherwise benefits are not payable. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. You must contact the Welfare Trust Fund Administrative Office if you or your dependent is a candidate for transplant surgery before incurring any expenses.

Calendar Year Deductible ..... Comprehensive Major Medical Deductible of $1,000 per person

Coinsurance Plan Pays
COE Facility ..... 70% of Covered Charges up to $10,000; 100% thereafter
Non-COE Facility .....50% of discounted charges, based on the negotiated COE fee

Calendar Year Out-of-Pocket Maximum
COE Facility $4,000
(Comprehensive Major Medical Out-of-Pocket Maximum of $3,000 plus $1,000 Deductible)
Non-COE Facility .....No Out-of-Pocket Maximum

Immunosuppressive Medications

Retail Pharmacy Prescription Drug Program
(only if not available through Mail-Order Prescription Drug Program)
- Maximum Supply.....30-day supply
- Copayment
  - 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
- Copayment
  - 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)

Behavioral Health Benefits

Behavioral Health Benefits apply towards the Comprehensive Major Medical Benefits Plan Year Annual Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefit Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).

You and your eligible dependents have access to up to three counseling sessions per year under the Member Assistance Program. Sessions are covered 100% by the Plan.

Prescription Drug Benefits

Prescription Drug Calendar Year Deductible.....None
Participating Retail Pharmacy (up to a 34-day supply)*
- Generic.....$25 per prescription Copayment
- Preferred Brand Name .....$40 per prescription Copayment
- Preferred Brand Name .....$50 per prescription Copayment**

Non-Participating Retail Pharmacy (up to a 34-day supply)* 50%
Mail-Order Prescription Drug Program (up to a 90-day supply)
- Generic.....$50 per prescription Copayment
- Preferred Brand Name .....$80 per prescription Copayment
- Non-Preferred Brand Name .....$100 per prescription Copayment**

Specialty Medications..... 10% Coinsurance up to $300 per prescription fill***

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

If a generic is available, you pay the non-preferred brand name Copayment **plus the difference in cost between the generic and non-preferred brand name prescription.

***If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name co-payments provided under the retail or mail order program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Welfare Trust Fund Administrative Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.

Summary of Benefits for Retired Employees Over Age 65 and Eligible Dependents Over Age 65 Eligible for Medicare Who Elect Base Plan Coverage

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

Death Benefits

Eligible Retired Employee Only $5,000

Medical Benefits

Retired Employees and their eligible dependents over age 65 that are eligible for Medicare are covered under an insured medical program through **Transamerica Premier Life Insurance Company** (see page 48). The Transamerica Medical Plan provides a benefit for eligible retirees for care received at skilled nursing facilities. The Transamerica Medical Plan pays in addition to Medicare, so a portion of your expenses will be covered from Days 1 – 365.

Note: There is no lifetime maximum under the Transamerica Medical Plan or the Welfare Trust Fund's Comprehensive Major Medical Benefits.

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, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Welfare Trust Fund Administrative Office is required for Medical Necessity; otherwise, benefits are not payable. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. You must contact the Welfare Trust Fund Administrative Office if you or your dependent is a candidate for transplant surgery before incurring any expenses.

Calendar Year Deductible ..... Comprehensive Major Medical Deductible of $600 per person

Coinsurance Plan Pays

COE Facility ..... 90% of Covered Charges up to $19,000; 100% thereafter
Non-COE Facility .....50% of discounted charges, based on the negotiated COE fee

Calendar Year Out-of-Pocket Maximum
COE Facility $2,500
($1,900 Comprehensive Major Medical Out-of-Pocket Maximum plus $600 Deductible)
Non-COE Facility .....No Out-of-Pocket Maximum

Immunosuppressive Medications

Retail Pharmacy Prescription Drug Program
(only if not available through Mail-Order Prescription Drug Program)
Maximum Supply.....30-day supply
Copayment
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
Copayment
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)

Behavioral Health Benefits

Behavioral Health Benefits apply towards the Comprehensive Major Medical Benefits Plan Year Annual Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefit Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).

You and your eligible dependents have access to up to three counseling sessions per year through the Member Assistance Program. Sessions are covered 100% by the Plan.

Prescription Drug Benefits

You have the option to elect to receive your prescription drug coverage under either the Base Plan or the Alternative Plan. Compared to the Base Plan, the Alternative Plan provides a lower level of prescription drug coverage at a reduced cost. If you elect the Alternative Plan's Prescription Drug Benefit, you will not have the option, at any time, to re-enroll in the higher level of coverage under the Base Plan.

Prescription Drug Calendar Year Deductible.....$60 per person
Participating Retail Pharmacy (up to a 34-day supply)*
Generic.....$15 per prescription Copayment
Brand Name .....$20 per prescription Copayment**

Non-Participating Retail Pharmacy (up to a 34-day supply)* 50%
Mail-Order Prescription Drug Program (up to a 90-day supply)
Generic .....$25 per prescription Copayment
Brand Name .....$35 per prescription Copayment**
Specialty Medications..... 10% Coinsurance up to $380 per prescription fill***

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

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

***If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name co-payments provided under the retail or mail order program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Welfare Trust Fund Administrative Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.

Summary of Benefits for Retired Employees Over Age 65 and Eligible Dependents Over Age 65 Eligible for Medicare Who Elect Alternative Plan Coverage

Accidental Death and Dismemberment, Weekly Income, Vision, and Dental Benefits are not provided for Retirees or eligible dependents.
Death Benefits
Eligible Retired Employee Only $5,000

Medical Benefits

Retired Employees and their eligible dependents over age 65 that are eligible for Medicare are covered under an insured medical program through **Transamerica Premier Life Insurance Company** (see page 48). The Transamerica Medical Plan provides a benefit for eligible retirees for care received at skilled nursing facilities. The Transamerica Medical Plan pays in addition to Medicare, so a portion of your expenses will be covered from Days 1 – 365.

Note: There is no lifetime maximum under the Transamerica Medical Plan or the Welfare Trust Fund's Comprehensive Major Medical Benefits.

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, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Welfare Trust Fund Administrative Office is required for Medical Necessity; otherwise, benefits are not payable. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. You must contact the Welfare Trust Fund Administrative Office if you or your dependent is a candidate for transplant surgery before incurring any expenses.

Calendar Year Deductible ..... Comprehensive Major Medical Deductible of $1,000 per person

Coinsurance Plan Pays
COE Facility ..... 70% of Covered Charges up to $10,000; 100% thereafter
Non-COE Facility .....50% of discounted charges, based on the negotiated COE fee
Calendar Year Out-of-Pocket Maximum
COE Facility $4,000
(Comprehensive Major Medical Out-of-Pocket Maximum of $3,000 plus $1,000 Deductible)
Non-COE Facility .....No Out-of-Pocket Maximum

Immunosuppressive Medications

Retail Pharmacy Prescription Drug Program
(only if not available through Mail-Order Prescription Drug Program)
- Maximum Supply.....30-day supply
- Copayment
  - 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
- Copayment
  - 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)

Behavioral Health Benefits

Behavioral Health Benefits apply towards the Comprehensive Major Medical Benefits Plan Year Annual Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefit Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and out-patient).

You and your eligible dependents have access to up to three counseling sessions per year through the Member Assistance Program. Sessions are covered 100% by the Plan.

Prescription Drug Benefits

You have the option to elect to receive your prescription drug coverage under either the Base Plan or the Alternative Plan. Compared to the Base Plan, the Alternative Plan provides a lower level of prescription drug coverage at a reduced cost. If you elect the Alternative Plan's Prescription Drug Benefit, you will not have the option, at any time, to re-enroll in the higher level of coverage under the Base Plan.

Prescription Drug Calendar Year Deductible.....None

Participating Retail Pharmacy (up to a 34-day supply)*
- Generic.....$25 per prescription Copayment
- Preferred Brand Name.....$40 per prescription Copayment
- Preferred Brand Name.....$50 per prescription Copayment**

Non-Participating Retail Pharmacy (up to a 34-day supply)*.....50%

Mail-Order Prescription Drug Program (up to a 90-day supply)
- Generic.....$50 per prescription Copayment
- Preferred Brand Name.....$80 per prescription Copayment
- Non-Preferred Brand Name.....$100 per prescription Copayment**

Specialty Medications..... 10% Coinsurance up to $300 per prescription fill***

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

** If a generic is available, you pay the non-preferred brand name Copayment **plus** the difference in cost between the generic and non-preferred brand name prescription.

*** If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name co-payments provided under the retail or mail order program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Welfare Trust Fund Administrative Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.

Plan Definitions

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

Allowable Charge:

- With respect to a network (PPO) provider, the term "Allowable Charge" is the negotiated fee/rate set forth in the agreement with the participating network professional provider, facility or organization and the Plan.
- With respect to an out-of-network (non-PPO) provider, the "Allowable Charge" means the amount determined by the Board of Trustees that the Plan will pay for a particular service or supply, as determined by the organization with which the Fund contracts to make such a determination. Under no circumstances will the Plan pay an Allowable Charge for out-of-network services or supplies that is determined by any provider, facility or other person or organization other than the Board of Trustees, or organization designated by the Board of Trustees.
- The Board of Trustees has determined Allowable Charge to mean the amount most consistently charged by a licensed physician or other professional provider for a given service. An Allowable Charge refers to a charge that is within the range of usual charges for a given service billed by most physicians or other professional providers with similar training and experience in a given geographic area. When considering the range of usual charges, the Plan may consider discounted rates allowed by network providers as a basis for Allowable Charges.

Behavioral Health Disorder: Any illness that is defined in the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or an addiction to alcohol, psychiatric drugs or medications, regardless of any underlying organic cause. This includes, among other things, autism, depression, schizophrenia and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods.

Substance abuse means a psychological and/or physiological dependence or addiction to alcohol, drugs or medications, regardless of any underlying physical or organic cause and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the DSM.

Coinsurance or Copayment: When the Plan pays a percentage of Covered Expenses and you pay the rest, this is called Coinsurance. A Copayment is the flat dollar amount that you are responsible for paying before the Plan begins to pay certain Covered Expenses.

Covered Medical Expenses or Covered Expenses: The Allowable Charges incurred for Medically Necessary covered medical services and supplies required for treatment. These must be recommended and approved by the attending physician and must be

consistent with the symptoms or diagnosis of the condition.

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

Experimental and/or Investigational: A service or supply is deemed to be Experimental and/or Investigational if:

- The service or supply is described as an alternative to more conventional therapies in the protocols or consent document of the healthcare provider that performs the service or prescribes the supply;
- The service or supply may be given only with the approval of an institutional review board, as defined by federal law;
- There is either an absence of authoritative medical, dental or scientific literature on the subject or a preponderance of the literature (published in the United States and written by experts in the field) shows that recognized medical, dental or scientific experts classify the service or supply as Experimental and/or Investigational or indicate that more research is required before the service or supply can be classified as equally or more effective than conventional therapies;
- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service or supply to be lawfully marketed and such approval has not been granted at the time the service or supply is prescribed or provided, or a current investigational new drug or new device application has been submitted and filed with the FDA (however, there are some exceptions); or
- The prescribed service or supply is available only through participation in Phase I or Phase II clinical trials, Phase III Experimental, research clinical trials or corresponding trials sponsored by the FDA, National Cancer Institute or National Institutes of Health.

The Trustees have broad discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. If your procedure is Experimental or Investigational, it may not be covered. If you are not sure if your procedure is Experimental or Investigational or if it is covered, you should call the Welfare Trust Fund Administrative Office before you have the procedure to make sure that it is covered.

Injury: Any damage to the body resulting from trauma from an external source.

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

- Provided by or under the direction of a physician or other duly licensed healthcare 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.

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 fact that a physician may provide order, recommend or approve a service or supply does not mean that the service or supply will be considered Medically Necessary for the medical coverage provided by the Plan. The Plan reserves the right to decline coverage for new Experimental and/or technologically innovative medical procedures that have not been historically covered, notwithstanding FDA and/or CMS approval of such treatment. The Trustees are the **final determiners** of Medical Necessity for benefits payable under this Plan.

Out-of-Pocket Maximum: The portion of Covered Medical Expenses that you must pay, after you meet any applicable Deductibles, before Covered Medical Expenses are paid at 100%.

Sickness: A Sickness includes:

- A condition when the body's organs do not function normally;
- A condition when a temporary ailment reduces the body's ability to function normally;
- Pregnancy; and
- A Behavioral Health Disorder.

Utilization Review: The cost management process that determines whether certain treatments are Medically Necessary. Currently, Hines and Associates, Inc. provides Utilization Review for medical care and behavioral healthcare. There is no requirement for a participant to call to obtain pre-approval for a hospital admission. However, transplant surgery and bariatric surgery must be pre-certified for Medical Necessity.

Eligibility Rules

Initial Retiree 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 Retirement Benefits for yourself and your eligible dependents. Please note that:

- If you elect COBRA Continuation Coverage under the Active Plan, you will lose any future right to receive Supplemental Retirement Benefits. COBRA Continuation Coverage is described in the Active Plan SPD.
- If you elect Supplemental Retirement Benefits, you will lose any future right to elect COBRA Continuation Coverage. However, your dependents may be eligible to elect COBRA Continuation Coverage from the Supplemental Retirement Benefit Plan if they experience a qualifying event while they are covered by the Supplemental Retirement Benefit Plan. See page 34.

You may be eligible for retiree benefits under the Supplemental Retirement Benefit Plan if you:

- Submit a written application to the Welfare Trust 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 Hour Bank.
- Are 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.
- Are eligible for Active benefits under the NECA-IBEW Welfare Trust Fund during the month in which you retire or the month immediately before you retire.
- 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 at least 45 of the last 60 months immediately before:

- The Welfare Trust Fund Administrative Office receives your retirement application; or
- Your entitlement to a Social Security Disability Award (a closed Social Security Disability Award with a specific starting and ending date does not qualify as a disability pension for these purposes) if you are retiring because of a total disability.

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 participating local union must verify, in writing, that you were seeking employment. This may help you 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 participating 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 at least 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.

Late submission of an initial application for benefits under the Supplemental Retirement Benefit Plan will not be accepted. You will not be entitled to apply at any other time for these benefits. For further information regarding eligibility, you may view and obtain a copy of the Plan Document at the Welfare Trust Fund Administrative Office or online at www.neca-ibew.org.

If a Medicare-eligible retired employee or the Medicare-eligible dependent of a retired employee elects Medicare Prescription Drug Coverage (Medicare Part D), the individual will not be entitled to Prescription Drug Benefits under the Fund. Additionally, your monthly premium for coverage under the Welfare Trust Fund will not be reduced as a result of not receiving Prescription Drug Benefits under the Fund. If you enroll for Medicare Prescription Drug Coverage and your Prescription Drug Benefits end,

you will have one opportunity to re-enroll for Prescription Drug Benefits if you subsequently drop Medicare Prescription Drug Coverage.

Retiree Opt-In/Opt-Out Option

New retirees who become eligible for the Supplemental Retirement Benefit Plan can opt out at the time of retirement and then opt back in at a later date, after providing proof of continuous coverage from the other plan they were covered under.

Opting Out of Retiree Coverage. When you are initially eligible and apply for retiree coverage, you will have the opportunity to postpone or suspend retiree coverage for yourself if you have other medical coverage available through your spouse's employer. This is a one-time only option. You are given the opportunity only once to postpone or suspend coverage and remain eligible for later coverage. To be eligible to postpone or suspend coverage until a future date, you must:

- Be a retiree who is eligible for coverage under the NECA-IBEW Welfare Trust Fund; and
- Be covered under another health plan (and provide proof of this other coverage); and
- Complete and file a form electing to postpone or suspend coverage.

If you want to postpone retiree coverage when you are initially eligible, you must make this election within 30 days of becoming eligible for retiree coverage. The application for retiree coverage will include a section about postponing or suspending coverage. If you elect to postpone or suspend retiree coverage for yourself, you must return the application to the Welfare Trust Fund Administrative Office by the deadline provided. If you do not file your election within the required time, you will not be permitted to defer coverage.

Resuming Retiree Coverage. To resume retiree coverage for yourself after opting out, you must:

- Have made a valid election to defer coverage;
- File an application with the Welfare Trust Fund Administrative Office within 30 days following the date the other coverage ends;
- Provide proof of continuous coverage by another plan since the date coverage under this Plan was postponed or suspended (if proof is not provided, you will not be eligible for coverage); and
- Make the required self-payment contributions for coverage at the rate in effect at the time coverage begins or resumes.

Coverage will begin or resume as of the first day of the month after your application for coverage is approved, provided the required self-payment contribution is made.

In the event that you die during a period of postponement or suspension of coverage, your surviving spouse may exercise your option to resume coverage under the Plan within 60 days of the retirees death, provided the surviving spouse is at least 55 years old.

Continuing Eligibility

Your Plan eligibility will continue for each month that your account linked to the automatic electronic fund transfer program has sufficient funds to cover your monthly self-contribution.

Before you and/or your dependents become eligible for Medicare, the Welfare Trust Fund Administrative Office will send you an enrollment package, which will include information on how to become covered under the Transamerica Medical Plan. Once you enroll in the Transamerica Medical Plan, you will receive a certificate of insurance providing detailed information about Transamerica's standard coverage. Transamerica will be responsible for answering questions, paying claims, and handling any appeals relating to its coverage for Medicare-eligible participants.

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
- Children, provided they are:
  - Under 26 years of age;
  - Over age 26, permanently and totally disabled and incapable of any gainful activity and/or self-sustaining employment due to a medically determinable physical or mental impairment that began before they attained age 26, which is expected to result in death or last for a continuous period of 12 months or more. However, if your disabled child loses eligibility for coverage because he or she becomes employed and self-sustaining, the child may again be considered a dependent if he or she once again becomes permanently and totally disabled and incapable of any gainful activity and/or self-sustaining employment due to a medically determinable physical or mental impairment;
  - Named under a Qualified Medical Child Support Order (QMCSO). A "QMCSO" is a medical child support order that:
    - Is made pursuant to a state domestic relations law (including a community property law) or certain other state laws relating to medical child support; and
    - Provides for child support or health benefit coverage for a child of a participant under a group health plan and relates to benefits under the plan.

In addition to children named under a QMCSO, children may include your:

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

To be considered your dependents, your adult disabled children over age 26 and your grandchildren under age 26 must also depend on you for more than 50% of their support and maintenance during the calendar year and have a principal place of residence with you for more than one-half of the calendar year. Legal guardianship is also required for grandchildren. If your adult disabled child who is age 26 or older or your grandchild does not live with you during the calendar year, they will still be considered your dependent children, provided:

- You are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or have lived apart from the child's other parent 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 custody or the custody of the child's other parent for more than one-half of the calendar year.

Your dependents' eligibility for coverage ends on the earliest of the:

- Date the Plan ends;
- Date you are no longer eligible;
- Last day of the month your dependent no longer meets the Plan's definition of dependent (for example, coverage for your enrolled eligible children will end on the last day of the month in which they turn age 26);
- Date coverage would end in accordance with other Plan provisions;
- Last day of the month that an order or decision of the court is entered with respect to a legal separation or, in the event that there is no court order or decision, the last day of the month the parties reach agreement on the terms of the separation; or
- Last day of the month in which the divorce decree is entered by the court and finalized.

Self-Contribution Amounts
Base Plan Coverage

When you elect coverage under the Supplemental Retirement Benefit Plan, you must pay for your coverage yourself through the electronic funds transfer program. The Supplemental Retirement Benefit Plan is funded by self-contributions. The Trustees reserve the right to modify the self-contribution rates at any time. For the Base Plan, if the effective date of your retirement was:

- Before January 1, 2002, the monthly self-contribution rate for single or family coverage 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.

Alternative Plan Coverage

You may elect coverage under the Alternative Plan when you are initially eligible for retiree coverage. If you elect coverage under the Alternative Plan, your monthly self-contribution rate is determined by the Board of Trustees. The rate is based on the same formula as that used for the Base Plan, but is adjusted for the Alternative Plan contribution rate.

Monthly Payments

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

Bank hours remaining in your account on the effective date of your retirement will be used in determining the initial self-contribution amount. Any hours worked before the effective date of your retirement, but reported to the Welfare Trust Fund Administrative Office after the effective date of retirement, will also be used to determine your future monthly retiree self-contribution rate. The first required self-contribution must be received in the month preceding the month for which coverage is desired.

If you are a disabled employee and you are eligible for Supplemental Retirement Benefit Plan coverage, you must retire at the time you receive your Social Security Disability award, and you may not run out the balance of your 21-month disability period before beginning your self-payments for Retiree benefits. Your coverage will begin on the effective date of your retirement, which is based on the disability date established in the Social Security Disability award letter.

Special Enrollment Rights Under the Health Insurance Portability and Accountability Act (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

You may also enroll yourself and your dependents in this Plan if you (or your dependents):

- Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP), but subsequently lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after it is determined that you (or your dependents) are eligible for such assistance.

To request special enrollment or obtain more information, contact the Welfare Trust Fund Administrative Office.

Termination of 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 your required self-contribution. **In addition, you may stop coverage at any time by contacting the Welfare Trust Fund Administrative Office. Once your coverage ends, it cannot be reinstated.**

If your coverage ends because you return to 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 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 spouse and/or dependents 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 and/or dependents want to continue coverage under the Supplemental Retirement Benefit Plan, he/she must make self-contributions the month following the month you last made self-contributions. Your spouse and/or dependents must use the automatic electronic fund transfer program. If your spouse remarries, his/her 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 Withdrawal of Local Union

Your eligibility will end on the 31st day following the date that the local union, which represented you as an Active employee for purposes of collective bargaining, withdraws from participation in the Trust Fund.

COBRA Continuation Coverage Self-Pay Rules

NOTE: Detailed information about COBRA Continuation Coverage is available from the Welfare Trust Fund Administrative Office or online at **www.neca-ibew.org**.

If you do not qualify for Supplemental Retirement Benefits or if you prefer, you may elect COBRA Continuation Coverage for yourself and your eligible Dependents who were covered under the 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 Retirement Benefits. For COBRA Continuation Coverage information, contact:

COBRA Continuation Coverage Department
NECA-IBEW Welfare Trust Fund
2120 Hubbard Avenue
Decatur, Illinois 62526-2871
800-765-4239.

If you elect COBRA Continuation Coverage, you will be entitled to the same type of coverage (Comprehensive Major Medical including Behavioral Health and Prescription Drug) that you had before the event that triggered COBRA, but you must pay for it. If there is a change in the health coverage provided under the Plan to similarly situated Active members, Retirees, and their families, that same change will be made in your COBRA Continuation Coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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. After 36 months, the employee will lose coverage unless he meets the Plan's initial eligibility requirements.

The Welfare Trust Fund Administrative Office will notify you and/or your Dependents of your COBRA Continuation Coverage rights by mail, sent to the last known address on file when you lose eligibility. Therefore, you should keep the Welfare Trust 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 Trust Fund Administrative Office. You and/or your Dependents may elect COBRA Continuation Coverage. You will then have 60 days from the date of the Welfare Trust Fund Administrative Office's notice to elect COBRA Continuation Coverage.

A qualifying event for a Dependent child occurs when he or she no longer meets the Plan's definition of Dependent. In addition, a qualifying event for a spouse and/or a Dependent child can occur upon your death (after regular eligibility is exhausted under your Hour Bank), upon divorce or legal separation, or when you become eligible for and enroll in Medicare.

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 any other qualified beneficiary who was covered by the Plan before the event that triggered COBRA Continuation Coverage. The eligible person must notify the Welfare Trust 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.

If a child loses Dependent status or you and your spouse divorce or get legally separated, **it is the responsibility of that individual** to notify the Welfare Trust Fund Administrative Office that a qualifying event has occurred within 60 days from the date they lose eligibility due to a qualifying event. The Welfare Trust Fund Administrative Office will advise that individual of his or her COBRA Continuation Coverage rights by letter. The Welfare Trust Fund Administrative Office will also provide written notification to individuals that are not entitled to COBRA Continuation Coverage. 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 Trust Fund Administrative Office does not receive the payment within the prescribed time limits).
- Enrolls in Medicare after electing COBRA Continuation Coverage.
- Becomes covered as an employee or Dependent under any group health plan.

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

Death Benefit

The Death Benefit, as shown in the *Summary of Benefits*, is paid to your beneficiary if you die from any cause while eligible for Plan benefits. Payment will be made in one lump sum to your beneficiary or beneficiaries or in installments if requested by you or your beneficiary.

Beneficiary Selection

Benefits are payable to each beneficiary shown on, and in accordance with, the most current information on file at the Welfare Trust Fund Administrative Office. You may change your named beneficiary by completing the required form and submitting it to the Welfare Trust Fund Administrative Office. Your requested change will become effective upon receipt of the form by the Welfare Trust Fund Administrative Office. If no beneficiary is named, benefits will be paid to your surviving spouse. If no spouse exists, the benefit will be paid to your estate. If your named beneficiary and any alternate beneficiary are deceased, then benefits will be paid to your estate.

Comprehensive Major Medical Benefits For Retirees and Eligible Dependents Not Yet Eligible for Medicare

How the Base and Alternative Plans Work

When you or your eligible dependent incurs Covered Medical Expenses due to a non-occupational Sickness or Injury that are in excess of the Deductible, the Plan reimburses you for a portion of the Covered Medical Expenses under the Comprehensive Major Medical Benefit. The Comprehensive Major Medical Benefit covers a wide range of services and supplies. How the Plan works is simple. Each calendar year, your benefits are administered based on the following Plan provisions:

- **Deductible:** You are responsible for meeting your Deductible (between January 1 and December 31) before the Plan begins to pay for Covered Medical Expenses. That means you or your dependent(s) must pay the first $600 per person or $1,800 per family ($1,000 per person or $3,000 per family for the **Alternative Plan**) 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 a Sickness or Injury not due to an accident, you are required to pay an additional $60 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 Coinsurance or Copayment 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 Copayment:** When you or a family member go to a physician's office, you pay a separate $15 Copayment ($20 for the **Alternative Plan**) for each office visit. This office visit Copayment is in addition to the calendar year Deductible and any other Coinsurance amounts you are responsible for paying. In addition, this office visit Copayment ***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 Copayment to your physician. Once a claim is submitted, the Welfare Trust Fund Administrative Office will deduct the Copayment from the amount that the Fund reimburses you.
- **Specialist Visit Copayment (Alternative Plan only):** When you or a family member go to a specialist's office, you pay a separate $40 Copayment for each office visit. This office visit Copayment is in addition to the calendar year Deductible and any other Coinsurance amounts you are responsible for paying. In addition, this office visit Copayment ***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 Copayment to your specialist. Once a claim is submitted, the Welfare Trust Fund Administrative Office will deduct the Copayment from the amount that the Fund reimburses you.

You do not pay your office visit Copayment directly to your physician or specialist. Once a claim is submitted, the Welfare Trust Fund Administrative Office will deduct the Copayment from the amount that the Fund reimburses you. Also remember that if you have a Health Reimbursement Arrangement (HRA), you can use the funds in your account to pay for your office visit Copayments. See page 59 for more information about how your HRA works.

- **Coinsurance:** 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 Allowable Charges for the duration of an Injury or illness. The Coinsurance percentage the Plan pays varies depending on whether you use a PPO or non-PPO Provider.

	Base Plan	**Alternative Plan**
PPO Provider	The Plan pays 90% of of Allowable Charges, which requires you to pay the remaining 10% of of Covered Medical Expenses, up to the Out-of-Pocket Maximum	The Plan pays 70% of of Allowable Charges, which requires you to pay the remaining 30% of of Covered Medical Expenses, up to the Out-of-Pocket Maximum
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 Plan pays 60%, which requires you to pay the remaining 40% of Covered Medical Expenses, up to the Out-of-Pocket Maximum

The above Coinsurance percentages apply unless specifically noted otherwise.

- **Calendar Year Out-of-Pocket Maximum:** After you or your dependent have met the Deductible and Copayment and/or Coinsurance amounts you pay for Covered Medical Expenses and reach the Calendar Year Out-of-Pocket Maximum, the Plan pays 100% of Allowable Charges for most Covered Medical Expenses incurred for the remainder of that calendar year (January 1 – December 31).

    - **Base Plan:** The Calendar Year Out-of-Pocket Maximum is $1,900, up to a family maximum of $3,800. Generally, covered individuals will not have to pay more than $2,500 (including the Deductible) in a calendar year. An entire family will not have to pay more than $5,600 (including the Deductibles) in a calendar year.

- **Alternative Plan:** The Calendar Year Out-of-Pocket Maximum is $3,000, up to a family maximum of $6,000. Generally, covered individuals will not have to pay more than $4,000 (including the Deductible) in a calendar year. An entire family will not have to pay more than $9,000 (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 Copayment or Coinsurance 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:

- Deductible for emergency room services;
- Copayments for office visits;
- Chiropractic treatment; and
- Organ transplant surgery performed at a non-Centers of Excellence Facility.

■ **Annual Maximum:** There is no annual maximum.

Note that some benefits and expenses may be covered differently or subject to benefit maximums. For more information, refer to the *Summary of Benefits* for the Base Plan and the *Summary of Benefits* for the Alternative Plan, beginning on page 7, as well as the specific benefit descriptions provided in this booklet.

Preferred Provider Organization

The Fund has entered into a contract with BlueCross BlueShield for the provision of its Preferred Provider Organization (PPO) network. The PPO network is comprised of physicians and hospitals, known as "PPO providers," that have agreed to provide discounts to Plan members. To find a PPO provider, call BlueCross BlueShield at 800-810-BLUE (2583) or use its Internet website **(www.bcbs.com).**

Covered Medical Expenses

The Plan pays benefits, based on Allowable Charges, for the following Medically Necessary Covered Medical Expenses.

1. Hospital expenses, including pre-admission testing for diagnostic purposes, 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, services of an anesthesiologist, pathologist, or radiologist, and emergency outpatient med-

ical care (including surgical procedures and emergency first-aid treatment) if due to bodily Injury or Sickness.

3. Outpatient surgery for procedures performed in the outpatient department of a hospital, ambulatory medical-surgical facility, or other facility approved by the Trustees.
4. Charges made by an emergency professional ambulance service for transportation to the nearest hospital or physician's office equipped to provide the required treatment for a life threatening Injury or Sickness. In the case of a terminal illness, routine ground ambulance service to and from a physician's office will also be covered. Any other transportation services are not covered.
5. Surgical expenses, including physician, surgeon, and assistant surgeon fees, within limits, when performed in a physician's office or on an outpatient basis (at a hospital, hospital approved ambulatory medical-surgical facility or other facility approved by the Trustees).
   - ❍ Charges made by a Physician, Surgeon, or Assistant Surgeon for professional services including Hospital visits while the Eligible Person is an inpatient. If two or more operations are performed through the same incision or body orifice, the benefit payable for the least costly operation will be one-half of the normal allowance for that procedure.
   - ❍ Charges made by a co-Surgeon are limited to not more than 50% of the Allowable Charge; 20% of the Allowable Charge for an Assistant Surgeon, for the operation performed. Charges incurred for a stand-by "Surgeon," even if the Hospital rendering care requires the services of a stand-by Surgeon, will not be paid under this Plan of benefits.
6. 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 lymph edemas.
7. Doctor's services in the office or hospital.
8. Initial doctor's exam for newborn, well baby care in the hospital.
9. Services of physiotherapists, speech therapists, registered nurses, nurse practitioners, legally licensed social workers, respiratory therapists (within guidelines), licensed practical nurses, and nurse aides (when trained nurses are not available), provided the services are not rendered by an eligible person's relative by blood or marriage or by someone who ordinarily resides in the eligible person's home.
10. Routine physical exams, including x-ray and laboratory testing (including pap smears) for participants and dependent spouses.
11. Radiology (x-ray), nuclear medicines, and radiation therapy.

12. Legend drugs and medicines requiring a prescription that are received during a hospital confinement and prescribed by the attending physician.
13. Blood or blood plasma and its administration and storage related to surgery.
14. Casts, splints, trusses, crutches, bandages, surgical dressings, oxygen, and rental of equipment for its administration.
15. Durable medical equipment, within the limits of the Plan, which is Medically Necessary for the treatment of a Sickness or Injury (for further information, you may view and obtain a copy of the Plan Document at the Welfare Trust Fund Administrative Office or online at www.neca-ibew.org.). This includes orthotic devices, which are covered once every three calendar years and hearing aids, which are limited to $1,250 per ear once every five years for participants and dependents age 18 and over; there is no limit for dependents under age 18.
16. Cardiac rehabilitation.
17. Home healthcare, not to exceed 60 days. For further information, you may view and obtain a copy of the Plan Document at the Welfare Trust Fund Administrative Office or online at www.neca-ibew.org.
18. Hospice care in a freestanding facility or an approved method of treatment for a terminally ill patient, including services of a physician, home healthcare services, emotional support services, homemaker services, bereavement services, and medications.
19. Well child care for routine office exams, inoculations, school physicals, athletic physicals, gynecological exams, and other kinds of well child care, as defined by the Plan.
20. Charges for vasectomies or sterilization procedures performed on a participant or a participant's dependent spouse when performed in a physician's office. Inpatient vasectomies or sterilization procedures, or outpatient procedures performed in an ambulatory medical-surgical facility, outpatient hospital setting, or similar setting are covered only when the attending physician certifies that the patient's health would be endangered if the procedure were performed in a physician's office. Expenses incurred for reversals of such vasectomies or sterilization procedures are not covered.
21. 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.
22. Colorectal cancer screening when recommended by a physician for an eligible person over age 50 once every 10 years, unless more frequent screening is Medically Necessary. Colorectal cancer screenings using molecular genetic techniques are not covered.
23. Testosterone replacement therapy, up to $2,500 per calendar year. However, to be considered a Covered Expense under the Plan, verification must be provided

of the therapy's Medical Necessity from the attending physician, including lab results showing a testosterone deficiency. Testosterone replacement therapy must be FDA-approved for the diagnosis.

24. Negative Pressure Wound Therapy (NPWT), which is also referred to as wound vac therapy.

25. Cancer prevention exams, tuberculosis exams, sickle cell anemia exams, and other types of physical exams or tests used to determine whether a person has a specific Sickness or disease.

26. Physician, laboratory, and/or medication expenses for weight control or treatment of obesity, when the condition is acute, as measured by generally accepted medical standards.

27. Pediatrician or neonatologist professional services.

28. Genetic counseling, including charges for Chorionic Villi Sampling (CVS), when prescribed by the attending physician as Medically Necessary.

29. Infertility treatment, including but not limited to in-vitro fertilization, low tubule transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, sperm washing, reversal sterilization procedures, and any testing done to monitor these artificial means of stimulating pregnancy. Charges for physician office visits and lab work are covered up to and just before any of the treatments described in the preceding sentence. Infertility treatment for any means of artificial treatment is not covered.

30. Intrauterine devices (IUDs) or similar devices, as well as medical services required to place or remove an IUD or similar device. The medical services are covered when they are Medically Necessary and provided by a PPO provider. The devices are covered when Medically Necessary.

31. Second surgical opinions (or third opinions if the second opinion does not confirm the need for surgery) performed by a board certified specialist, including any Medically Necessary x-ray and laboratory examination recommended by the physician providing the second opinion.

32. X-rays or laboratory examinations recommended by a physician in connection with the diagnosis of a non-occupational bodily Injury or Sickness.

33. Expenses due to a pregnancy or pregnancy-related condition for female participants and female spouses of participants. Dependent pregnancy and related services are not a covered expense. Termination of pregnancy is covered only when the attending physician certifies that the female participant's or female spouse's health would be endangered if the fetus was carried to term or that the child will be born with significant congenital deformities or defects, or that such termination is medically appropriate as a consequence of rape or incest.

34. Charges for the following additional services and supplies:

    a. Anesthesia and its administration.

    b. Artificial limbs and eyes to replace natural limbs and eyes lost.

c. Other appliances to replace physical organs or parts. For adults, only the initial charge for a prosthetic appliance will be covered. For children, charges for a replacement prosthetic device required due to growth will be covered.

d. Dental services when provided by a physician or dentist for treatment within two years of an Injury to the jaw or sound natural teeth. If the Injury occurs to an eligible dependent who is under 18 years of age and it is determined that dental services to treat the Injury should be delayed until the eligible dependent reaches full growth, the two-year limit does not start until the eligible dependent reaches age 18. In order for the treatment to be covered by the Plan, the dependent must still be eligible under the rules of the Plan when the treatment begins.

e. Temporomandibular Joint (TMJ) dysfunction syndrome treatment that is Medically Necessary, subject to the limitations listed in the *Summary of Benefits* on page 8.

35. Charges for routine foot care.
36. Acupuncture, subject to a 48-visit limit.
37. Bariatric surgery after Utilization Review by the case manager, if the participant meets industry standards for such surgery.
38. Private duty nursing, but only when the participant is in Hospice care.
39. Treatment for sleep apnea when Medically Necessary and prescribed by a medical doctor. Charges for oral appliances and home sleep studies that are prescribed by a dentist to treat mild to moderate sleep apnea are not covered.

The following services are also covered under the Plan's Comprehensive Major Medical Benefit, but with specific Coinsurance limitations and benefits maximums.

Chiropractic Treatment: Treatment from a chiropractor in connection with the detection, treatment, and correction of structural imbalance, subluxation, or misalignment of the vertebral column to alleviate pressure on spinal nerves, including x-ray and laboratory charges. The Plan covers 50% of the Allowable Charges for up to 48 visits in a calendar year. Expenses do not count towards the Out-of-Pocket Maximum.

Temporomandibular Joint Dysfunction (TMJ) Treatment: The Plan covers treatment of TMJ for surgery, appliances, or adjustment at 75% of the Allowable Charges, up to a $2,000 per person lifetime maximum for participants and dependents age 18 and over; there is no lifetime maximum for dependents under age 18.

Skilled Nursing Care/Skilled Nursing Facility or Subacute Care Facility

Note: This does not include nursing home care. See #23 on page 73 for more information.

Physical Therapy/Massage Therapy: The Plan covers up to 48 visits for physical therapy/massage therapy for patients age six or older. The Plan will cover unlimited

physical therapy visits for a patient under age six if the patient continues to make ongoing progress.

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

Occupational Therapy: The Plan covers up to 48 visits for occupational therapy for patients age six or older. The Plan will cover unlimited physical occupational visits for a patient under age six if the patient continues to make ongoing progress.

Outpatient Psychological Counseling: Family counseling is covered as Medically Necessary.

Hearing Benefit Program: The Fund, in partnership with EPIC Hearing Service Plan, assists active participants and pre-Medicare retirees* in locating hearing care professionals and, in most cases, reducing out-of-pocket expenses for hearing exams and hearing aid devices. Fund participants can save **approximately** 25-50% on major brand hearing instruments. In addition, EPIC has a discount program for hearing aid batteries. As a participant, you can have batteries shipped directly to your home, at a savings of over 40% from standard retail store pricing. To learn more, contact EPIC toll-free at 866-956-5400. Be sure to identify yourself or a family member as a participant in the NECA-IBEW Welfare Trust Fund.

Reminder: You can use the money in your HRA to pay for eligible hearing expenses, including:

- Hearing aids and hearing aid batteries.
- Special telephone equipment that lets a hearing-impaired person communicate over a regular telephone.
- Television equipment that displays the audio part of television programs, such as subtitles, for hearing-impaired persons.

* Medicare-eligible retirees can access the EPIC program, but benefit coverage is not provided by the Fund. Medicare-eligible retirees do not have hearing aid coverage.

Meniscal Allograft Transplants: Surgery in which a new meniscus (a cartilage ring in the knee) is placed into your knee. This procedure is done in cases of meniscus tears that are so severe that all or nearly all of the meniscus cartilage has to be removed. The new meniscus can help eliminate knee pain and possibly prevent future arthritis. The

Fund covers this type of surgery if you meet all of the following guidelines:

- You are under the age of 55;
- Pre-operative studies (MRI or previous arthroscopy) reveal the absence or near-absence of the meniscus;

- Degenerative changes in the surrounding articular cartilage must be absent or minimal; and
- Normal knee alignment and stability (i.e., intact or reconstructed ACL) or stability will be achieved concurrently with meniscal transplant.

Behavioral Health Benefits

The Plan provides Behavioral Health Benefits, which include treatment and services for mental health disorders and substance abuse (including alcoholism, chemical dependency, and drug addiction) recommended by the attending physician or a behavioral health practitioner, up to the limits shown on the applicable *Summary of Benefits*. Covered Expenses include the services of a physician, behavioral health practitioner, hospital, or other accredited treatment facility or recognized outpatient treatment program as determined by the Board of Trustees. Hospital expenses include room and board charges, medications, x-rays, lab/physician charges, and detoxification. Two days of partial hospitalization counts as one day of inpatient treatment.

The Plan provides participants and their covered dependents with access to a Member Assistance Program. Member assistance programs offer counseling and resources for when you need them most—whether you are going through a rough patch at home, stressed over work or finances, or looking to improve your work/life balance. Programs offer in-person or over-the-phone assistance, as well as referrals for child care, elder care, legal services and other services.

Through the Member Assistance Program, you and your covered dependents have access to up to three counseling sessions per year, covered at 100% by the Plan.

The Member Assistance Program is 100% confidential. No one from your union, the Fund or your employer will know that you contacted the program.

Organ Transplants

The Plan covers organ transplants. Pre-approval is required for Medical Necessity. Contact the Utilization Review Department immediately regarding organ transplants. Covered organ transplant surgeries 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, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants.

Organ procurement benefits are limited to a $20,000 maximum (payable at 100%, not subject to the Plan's Deductible). The Plan's individual Deductible applies. If you use a Centers of Excellence (COE) facility, the Plan's Coinsurance and Out-of-Pocket Maximums apply. However, if a COE facility is not used, the Plan only pays 50% of the discounted charges, based on the negotiated COE fee, and there is no Out-of-Pocket Maximum on the amount of expenses you are required to pay.

Extended Eligibility for Active Member Organ Donors. The Fund will freeze their Hour Bank and grant 21 months of eligibility due to disability to all active members who donate an organ either to a family member or to another participant covered under the Welfare Trust Fund. (Family members include a spouse, child, sibling, parent, grandchild, or grandparent.)

	Base Plan	**Alternative Plan**
Deductible	$600	$1,000
Copayment	The Plan covers 90% of Covered Charges up to $19,000 if a COE facility is used; 100% thereafter. If a COE facility is not used, the Plan covers 50% of the discounted charges, based on the negotiated COE fee.	The Plan covers 70% of $10,000 if a COE facility is used; 100% thereafter. If a COE facility is not used, the Plan covers 50% of the discounted charges, based on the negotiated COE fee.
Out-of-Pocket Maximum	$2,500, when COE facility is used If a COE facility is not used, there is no out-of-pocket maximum	$4,000, when COE facility is used If a COE facility is not used, there is no out-of-pocket 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 Copayment is the same as under the mail-order Prescription Drug Program. For up to a 30-day supply, with no maximum, your Copayment is:

- $25 per generic prescription; or
- $50 per brand name prescription.

Mail-Order Prescription Drug Program. For up to a 90-day supply of immunosuppressive medications, with no maximum, your Copayment 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 51.

Medical Exclusions and Limitations

Comprehensive Major Medical Benefits do not cover:

1. Dental work, except as specifically provided otherwise by the Plan.
2. Eye refraction (for fitting of glasses only) or eyeglasses and charges for the fitting of eyeglasses.
3. Dental prosthetic appliances and charges for the fittings of such appliances, except as otherwise covered under the Plan's Dental Benefits.
4. Any expenses incurred for pre-natal testing, including amniocentesis, when done to determine the sex of a child or without medical diagnosis.
5. Equipment that does not significantly enhance the medical management of patient care.
6. Equipment that is used solely as a patient comfort item.
7. Supplies or equipment for personal hygiene, comfort, or convenience such as telephones, televisions, cosmetics, guest trays, magazines, or beds or cots for family members or other guests.
8. Charges for a second surgical opinion from a physician affiliated with the physician rendering the first opinion.
9. Expenses incurred for physical exams not performed by a doctor of medicine, for a physician exam received in connection with an Injury or Sickness, or for a pre-marital or pre-employment exam.
10. Growth hormones, such as protropin, not to exceed $15,000 per year or $50,000 per lifetime, as within the guidelines established by the Trustees. In the case of a dependent child for whom growth hormones are deemed by medical opinion to be life essential and, in the medical opinion of an Independent Review Organization (IRO) selected by the Fund, are efficacious in continuing development of the child for a medically necessary reason, then the $50,000 lifetime maximum may be extended, in the discretion of the Appeals Committee, to a lifetime maximum of no more than $150,000.
11. Expenses incurred for stand-by surgeons.
12 Expenses incurred relating to organ transplants, except as specifically provided otherwise by the Plan:
    a. Unless there is medical documentation that conventional treatment could be unsatisfactory, unavailable, and/or more hazardous than a transplant;
    b. For any animal organ or mechanical equipment, device, or organ(s) except as otherwise specified by the Plan;

c. For any financial consideration to the donor other than for Covered Medical Expenses that are incurred in the performance of/or in relation to transplant surgery; and

d. That the patient may not be legally required to pay for.

13. Expenses incurred for a hospital confinement when the eligible person leaves the facility against the medical advice of the attending physician.
14. Any of the circumstances described in the Plan's general exclusions and limitations (see page 72).
15. Expenses related to sperm washing.
16. Weight loss programs.
17. Private duty nursing, except when the patient is in Hospice care.

Medical Benefits for Medicare-Eligible Retirees and Medicare-Eligible Dependents

Transamerica Medical Plan

Coverage for Medicare-eligible retirees over age 65 and/or their Medicare-eligible dependents over age 65 is fully insured through the **Transamerica Premier Life Insurance Company** (Transamerica) of Cedar Rapids, Iowa. Medicare-eligible retiree means an individual who is age 65 or older and enrolled in Medicare Parts A and B.

To be enrolled in the Transamerica 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 51. Before you and/or your dependent reach age 65 and become eligible for Medicare, the Welfare Trust Fund Administrative Office will send you an enrollment package. This package will include information on how to become covered under the Transamerica Medical Plan, as well as how to elect your prescription drug coverage. Once you enroll in the Transamerica Medical Plan, you will receive a certificate of insurance providing detailed information about Transamerica's standard coverage.

The Transamerica Medical Plan provides a **Skilled Nursing Facility Benefit** for care received at skilled nursing facilities for eligible retirees. The Transamerica Medical Plan pays in addition to Medicare, so a portion of your expenses will be covered from days 1 – 365.

Transamerica will be responsible for answering benefit questions, paying claims, and handling any appeals relating to Transamerica Medical Benefits for Medicare-eligible participants. If you have any specific questions about:

- Your retiree medical coverage, contact Transamerica at 800-752-9797;
- Submitting a claim or the status of a claim, contact Transamerica at 800-854-0186; or
- **Your premiums, contact the Welfare Trust Fund Administrative Office at 800-765-4239.**

Transamerica's 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 Transamerica Medical Plan coverage, contact the Welfare Trust Fund Administrative Office at 800-765-4239.**

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 Transamerica. All other benefits will be provided by the Fund on a self-funded basis.

Coordination of Benefits with Medicare

If you are disabled, you will be able to register for Medicare two years from your Social Security Entitlement date, regardless of your age.

Retirees and their eligible dependents who are enrolled in Medicare Parts A and B due to disability will submit their claims to the Welfare Trust Fund Administrative Office, which will be coordinated with Medicare, in accordance with the Plan's and Medicare's coordination of benefits provisions. Benefits will be coordinated with Medicare based on a supplemental approach whether or not the retiree or eligible dependent actually enrolls in Medicare Parts A and B, or Medicare+ Choice (Part C). This is how your benefits will work:

- You must satisfy the Plan Deductible.
- The Plan covers the Deductible and Copayments not covered by Medicare Part A.
- The Plan covers 20% of your Medicare-eligible expenses after the Medicare Part B calendar year Deductible is satisfied. Medicare-eligible expenses are healthcare expenses covered by Medicare to the extent recognized by Medicare. Charges not recognized as Medicare-eligible are not covered by the Plan.
- Each calendar year, the Plan covers the first three pints of blood that you require.
- The Plan covers transplant expenses approved by Medicare, but that exceed Medicare's limit for reimbursement, up to the Plan's calendar year and lifetime maximums.

If you have questions regarding the Plan's rules for coordinating benefits, call the Welfare Trust Fund Administrative Office. You will be furnished with an explanation of the coordination of benefits rules and upon request, you will also be provided with a written copy of the rules.

Organ Transplant Benefits

The Plan covers organ transplants. Pre-approval is required for Medical Necessity. Contact the Utilization Review Department immediately regarding organ transplants. Covered organ transplant surgeries 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, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants.

Organ procurement benefits are limited to a $20,000 maximum (payable at 100%, not subject to the Plan's Deductible). The Plan's individual Deductible applies. If you use a Centers of Excellence (COE) facility, the Plan's Coinsurance and Out-of-Pocket Maximums apply. However, if a COE facility is not used, the Plan only covers 50% of the discounted charges, based on the negotiated COE fee, and there is no Out-of-Pocket Maximum on the amount of expenses you are required to pay.

Extended Eligibility for Active Member Organ Donors. The Fund will freeze their Hour Bank and grant 21 months of eligibility due to disability to all active members

who donate an organ either to a family member or to another participant covered under the Welfare Trust Fund. (Family members include a spouse, child, sibling, parent, grandchild, or grandparent.)

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 Copayment is the same as under the mail-order Prescription Drug Program. For up to a 30-day supply, with no maximum, your Copayment is:
  - $25 per generic prescription; or
  - $50 per brand name prescription.
- **Mail-Order Prescription Drug Program.** For up to a 90-day supply of immunosuppressive medications, with no maximum, your Copayment is:
  - $25 per generic prescription; or
  - $50 per brand name prescription.

Prescription Drug Benefits

If you and/or your eligible dependents are eligible for Medicare and are covered under the Plan, you do not need to enroll for Medicare Prescription Drug Coverage. You will be covered under the Fund's Supplemental Retirement Benefit Plan, which includes prescription drug benefits, as long as you and/or your dependents remain eligible for Plan coverage and do not enroll for Medicare prescription drug coverage. The Plan's prescription drug benefits are described in the table on page 52.

If you or your eligible dependents enroll for Medicare Part D prescription drug coverage, you will not be eligible for prescription drug benefits through the Fund's Supplemental Retirement Benefit Plan. This will not affect your eligibility for Transamerica Medical Benefits; however, your monthly premiums for coverage through the Supplemental Retirement Benefit Plan will not be reduced even though you are not receiving prescription drug benefits through the Plan. This means you will be paying the same monthly premium to the Fund, but for less coverage. Plus, you'll have to pay a premium for Medicare's prescription drug coverage.

If you enroll for Medicare Part D prescription drug coverage, you will have one opportunity to re-enroll for prescription drug benefits through the Supplemental Retirement Benefit Plan if you subsequently drop Medicare's prescription drug coverage. Otherwise, your retiree coverage may not be reinstated unless you return to work and satisfy the eligibility requirements for Active coverage.

If you drop or lose your coverage under the Plan and you go 63 days or longer without prescription drug coverage that is at least as good as Medicare Part D prescription drug coverage, your monthly premium for Medicare Part D prescription drug coverage will increase. The increase will be 1% per month for every month that you were eligible but did not have coverage. For example, if you go 19 months without coverage, your monthly premium will always be 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare Part D prescription drug coverage. In addition, you may have to wait until the next open enrollment period (October 15 through December 7 each year) to enroll.

Retirees and eligible dependents who are age 65 or over and eligible for Medicare Parts A and B have a choice when electing prescription drug benefits to go along with the Medical Benefits provided through **Transamerica Premier Life Insurance Company.** You can choose either the Base Plan's prescription drug coverage or that of the Alternative Plan. The Alternative Plan's prescription drug benefits provide a lower level of coverage at a reduced cost. If you elect to receive prescription drug benefits under the Alternative Plan, you will not have the option, at any time, to re-enroll in the Base Plan and receive the higher level of coverage.

	Base Plan	Alternative Plan
Calendar Year Deductible	$60 You and your family members must satisfy the Deductible before the Copayments take effect.	N/A There is no Deductible Copayments take effect immediately.
Retail Pharmacy (up to a 34-day supply)*		
Generic	$15 per prescription	$25 per prescription
Brand Name	$20 per prescription**	N/A
Preferred Brand Name	N/A	$40 per prescription
Non-Preferred Brand Name	N/A	$50 per prescription**
Non-Participating Retail Pharmacy (up to a 34-day supply)*	50%	50%
Mail-Order Pharmacy (up to a 90-day supply)		
Generic	$25 per prescription	$50 per prescription
Brand Name	$35 per prescription	N/A
Preferred Brand Name	N/A	$80 per prescription
Non-Preferred Brand Name	N/A	$100 per prescription
Specialty Medications	10% Coinsurance up to $380 per prescription fill***	10% Coinsurance up to $300 per prescription fill***

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

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

***If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name co-payments provided under the retail or mail order program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Welfare Trust Fund Administrative Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.

Prescription Drug Benefits

Prescription Drug Benefits are available to all retirees and their eligible dependents, including Medicare-eligible retirees and dependents who receive their medical coverage through the Transamerica Premier Life Insurance Company, retirees who are not yet eligible for Medicare, and eligible dependents whether or not they are Medicare-eligible.

The Plan's prescription drug benefits are provided through Express Scripts. The Express Scripts program includes coverage for medications purchased at retail pharmacies or through a mail-order pharmacy. The prescription drug benefits also include a specialty medication program.

The retail pharmacy component provides access to a national network of participating retail pharmacies, which have agreed to provide discounts for our members. For a free listing of participating pharmacies, mail-order forms, and information regarding coverage for specific medications, contact Express Scripts at the telephone number stated in the Express Scripts information guide or through its website at www.express-scripts.com. For information about the Specialty Medication Program, visit www.accredo.com/Express-Scripts/.

Prescription Drug Calendar Year Deductible

Under the Base Plan, you and each of your family members must pay the first $50 of expenses incurred for prescription drugs dispensed at either a network retail pharmacy or through the mail-order facility (or a combination of the two) each calendar year. This Deductible is separate from the Comprehensive Major Medical Benefits Deductible. **Note: If you elect coverage under the Alternative Plan, there is no Prescription Drug calendar year Deductible.**

Retail Pharmacy Prescription Drug Program

Retail pharmacy Copayments are listed in the table below.

	Base Plan	**Alternative Plan**
Generic	$15 per prescription	$25 per prescription
Brand Name **Preferred** **Non-Preferred**	$20 per prescription*	$40 per prescription $50 per prescription*
Specialty Medication	10% Coinsurance up to $380 per prescription fill**	10% Coinsurance up to $300 per prescription fill**

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

**If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name co-payments provided under the retail or mail order program, as applicable. You may also prepay for your specialty medications

and send proof of payment listing the prescription to the Welfare Trust Fund Administrative Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.

The quantity of medication dispensed must be consistent with rational drug use, availability of product, and program economics, particularly for established drug regiments. You may obtain up to a 34-day supply at a retail pharmacy.

Network retail pharmacies 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 facility in order to be covered under the Plan. Maintenance medications are those medications that are taken for an extended period to treat a chronic condition, such as diabetes, arthritis, or heart disease.

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 Trust Fund Administrative Office. Claims for prescriptions filled at a non-participating retail pharmacy will be reimbursed at 50%.

Mail-Order Prescription Drug Program

Mail-order Copayments are listed in the table below. Note: If you elect **Alternative Plan** coverage, there is no calendar year Deductible to satisfy; the Copayments apply immediately. If you do not elect Alternative Plan coverage, you or your family members must first satisfy the Prescription Drug calendar year Deductible before the Copayments are effective.

	Base Plan	**Alternative Plan**
Generic	$25 per prescription	$50 per prescription
Brand Name **Preferred** **Non-Preferred**	$35 per prescription*	$80 per prescription $80 per prescription*
Specialty Medication	10% Coinsurance up to $380 per prescription fill**	10% Coinsurance up to $300 per prescription fill**

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

**If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name co-payments provided under the retail or mail order program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Welfare Trust Fund Administrative Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.

You may obtain up to a 90-day supply through the mail-order facility.

Maintenance Medications Reminder: You must have the third maintenance medication refill and all subsequent maintenance medication refills filled though the mail-order facility.

Preferred Drug Step Therapy Program

Some non-preferred medications are not covered under the Fund's prescription drug benefit unless you obtain approval through a coverage review. If you purchase a non-preferred medication, you will be responsible for the entire cost.

This requirement encourages you to try safer or more effective drugs before the Plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the Plan may require you to try Drug A first. If Drug A does not work for you and your doctor believes you should use a non-preferred medication, you or your doctor can request a coverage review by calling Express-Scripts toll-free at 800-417-1764. If, after review with your doctor, it is deemed appropriate, the Plan will then cover Drug B. This requirement to try a different drug first is called "Step Therapy." For more information, visit Express Scripts online at www.express-scripts.com. You can also call Express Scripts toll-free at 800-711-0917.

Specialty Medication Program

The Plan provides a separate specialty medication cost share tier for its pharmacy benefit program. If you were receiving specialty medications prior to January 1, 2013, you will continue to receive those medications at the retail and mail-order Copayment rates shown in the *Summary of Benefits*. If you began receiving specialty medications on or after January 1, 2013, you will be subject to the specialty medication cost share amounts shown in the *Summary of Benefits*. Prior authorization may apply. Visit www.accredo.com/express-scripts/ for more information.

Covered Medications

The following medications are covered when obtained at a network retail pharmacy or through Express-Scripts' mail order facility:

- All federal legend medications;
- Insulin;
- Insulin syringes and needles;
- Compound medication containing at least one federal legend ingredient;
- Oral contraceptives, contraceptive hormone patches and contraceptive devices;
- Diabetic diagnostics;
- Chantix and other oral smoking cessation medications;
- Erectile dysfunction medications (e.g. Viagra, etc.), limited to 10 pills per month; and
- Contraceptive intrauterine devices and similar devices due to Medical Necessity.

Exclusions

The Plan does not cover:

1. Any type of device, even if such device requires a prescription such as, but not limited to, therapeutic devices and artificial appliances; such devices do not include contraceptive devices.
2. Any charge for the administration or injection of any medication (other than insulin and other diabetic diagnostics).
3. Any prescription medication for which an eligible individual is entitled to receive reimbursement under any workers' compensation law or is entitled to receive reimbursement for without charge from a municipality, state, or federal program, including Title XVIII of the Social Security Amendment of 1965.
4. Any prescription filled in excess of the number specified by the physician or any refill after one year from the order of the physician.
5. Medications dispensed by a hospital, skilled nursing facility, or subacute rehabilitation facility where the individual is confined.
6. Any medication labeled "Caution-Limited by Federal Law to Investigational Use" or any Experimental or Investigational medication.
7. Any medication whose use is related to the restoration of fertility.
8. Any medication that is not Medically Necessary.
9. Fertility medications.
10. Hair loss products (e.g. topical Minoxidil, Rogaine, etc.).
11. Retin A, etc.
12. Over the counter medications, including smoking deterrents (such as Nicorette) and vitamins (whether prescribed or not).
13 Any of the circumstances described in the Plan's General Exclusions and Limitations section (see page 72).

Wellness Power: Wellness and Disease Management Benefits

The Fund provides wellness and disease management benefits for eligible participants and dependents, including health tools and access to healthcare professionals who can provide health advice and assistance. All NECA-IBEW Welfare Trust Fund participants, including retirees over age 65 and eligible dependents over age 18, can participate in the programs discussed in this section. Dependents under age 18 with diabetes and asthma can also participate in certain components of the program. Retirees over age 65, their spouses, and all covered dependent children are not eligible to earn HRA rewards.

To learn more about your wellness and disease management benefits, contact the Welfare Trust Fund Administrative Office.
The Wellness Coaching, NurseLine and Disease Management programs are administered by Nurtur.

Health Risk Assessment

A Health Risk Assessment is a confidential questionnaire designed by healthcare experts to help you evaluate your health and identify potential health risks before they become serious health problems. Once you complete the confidential questionnaire, healthcare professionals will review your answers and, if applicable, provide you with recommendations on how to enhance your health and wellbeing, so you can seek proper care and make necessary lifestyle changes.

The results of the Health Risk Assessment are confidential and are available only to you. Results are not available to the Welfare Trust Fund Administrative Office, your employer, or your union. Your Health Risk Assessment will not affect your eligibility or benefit payments. You can complete the assessment online or on paper.

All of your personal health information is completely confidential. The Fund's Wellness and Disease Management program meets all federal and state regulations, including those that are part of the HIPAA privacy regulations.

Wellness Programs

You and your eligible dependents have access to health improvement programs, which include interactive tools, resources, information, and online lessons, as well as access to healthcare professionals that can help you achieve and maintain a healthy, balanced lifestyle. The wellness programs offered include those related to weight loss, smoking cessation, exercise, stress relief, diabetes, heart health, and nutrition.

NurseLine

You and your eligible dependents have access to a 24-hour NurseLine. Just call 877-941-1692 to speak with a registered nurse any time you need health advice or assistance. The NurseLine can help you:

- Determine when to call 911 or emergency services;
- Find doctors and hospitals—anywhere in the country;
- Deal with minor health issues yourself;
- Better understand your symptoms and treatment options; and
- Make the most of your medications by learning about cost-saving options and how to avoid drug interactions.

Health Reference and Video Library

Nurtur's Health Reference Library contains over 3,900 articles for your information, as well as a Multimedia Encyclopedia, Spanish Encyclopedia, Care Guide, Wellness Tools and various health assessments. In addition, the video health library contains over 800 health and wellness videos.

Disease Management Programs

The Disease Management programs are designed to help you manage chronic conditions—Diabetes, Coronary Artery Disease, Heart Failure, Asthma, and Chronic Obstructive Pulmonary Disease—and reduce the risk of complications. If you have one or more of these chronic conditions, a healthcare professional will contact you to discuss the benefits of participating in a Disease Management program and help you learn about ways to modify your lifestyle for better health. They will also monitor your progress and work with you and your physician to make sure your treatment is appropriate.

Earning Health Reimbursement Arrangement Rewards

If you and/or your spouse are under age 65, you are eligible to receive rewards for participating in the wellness and disease management programs. When you or your spouse enroll and comply with the requirements of the programs, you will receive a reward in the form of a contribution to your Health Reimbursement Arrangement (HRA). To find out the current reward levels, please contact the Welfare Trust Fund Administrative Office at 800-765-4239. The Trustees reserve the right to modify the reward structure at any time. You can use your rewards to pay for healthcare expenses as defined by Internal Revenue Code (IRC) Section 213, including medical expenses and prescription medications that are not covered by the Fund.

Refer to the following section for more information about the Plan's HRA offering.

Health Reimbursement Arrangement (HRA)

The Plan includes a Health Reimbursement Arrangement (HRA). When you become eligible to participate, the Fund sets up and maintains an account for you and you can use the funds in the account to be reimbursed for eligible healthcare expenses, on a tax-free basis. See the Base Plan or Alternative Plan SPDs for more information about how the HRA works for Active participants.

HRA Eligibility

You are eligible to participate if you work under a collective bargaining agreement that allows for contributions to an HRA on your behalf. For non-bargained employees, there must be a written participation agreement allowing for contributions on your behalf.

If you are eligible, but elect not to participate in the Plan's Active or Retiree health benefit programs, you must be enrolled in another group health plan that covers at least 60% of eligible expenses in order to be eligible to participate in this Plan's HRA. A plan that covers at least 60% of eligible expenses is considered to have met the minimum value standard set by the Affordable Care Act.

If you opt out of the Plan's retiree health benefits coverage and you are covered by another group health plan, you must provide proof of the other coverage to the Plan. If you do not provide sufficient proof, or if your other group coverage does not meet the minimum value standard, there will be limits on the types of expenses that can be reimbursed to you by your HRA. You will only be able to use your HRA account to reimburse your expenses for Copayments, Coinsurance, Deductibles, expenses that are not essential health benefits, and premiums for the purchase of the other health plan.

While contributions are only made on your behalf while you are working for a participating employer, you do not have to be an active participant to use the money in your HRA. This allows you to use your HRA for reimbursement of future expenses, such as the cost of continued coverage when you are not working enough hours or after retirement (if you are eligible for retiree coverage). In addition, your HRA balance is available to your surviving spouse and dependent children in the event of your death, provided they were covered as dependents under the Plan.

You continue to be eligible to use your HRA for reimbursement of eligible healthcare expenses for three years from the date work hours were last reported (that is, when you left covered employment; this does not apply to retirement). In the event of your death, your surviving spouse will continue to be eligible for reimbursement of eligible expenses until the earliest of:

- The date your HRA account balance reaches zero;
- The date your HRA terminates; or
- If your HRA account is inactive for 36 months and your HRA account balance is $500 or less, then your HRA account will be terminated and your account balance

will be forfeited on the first day of the month following the 36-month period of inactivity.

If you participate in the HRA, you are now allowed, at least once a year, to permanently opt out of the HRA coverage and waive future reimbursements from the HRA. If you elect to opt out of the HRA Plan, you will forfeit any remaining money in your account on the date that your opt-out is effective.

The Affordable Care Act requires that you be allowed to choose to opt out to provide you with the choice of spending down your HRA balance or applying for a premium assistance tax credit in a Health Insurance Marketplace. If you have an account balance, you would not be eligible for the tax credit.

Your HRA Balance

Your HRA balance is the total of employer contributions made on your behalf for the HRA, minus a 5% administrative fee on each employer contribution, plus any interest earned, minus any reimbursements you request from your HRA. The amount available for reimbursement of eligible expenses is the amount credited to your HRA. Contributions made on your behalf will not be credited to your HRA until after they are received by the Fund, but always within 30 days after they are received. In other words, there may be a lag between the time contributions are required on your behalf and when they are available for you to use. Keep in mind that any unused amounts in your HRA at the end of a calendar year are carried over into the next year.

Unused balances remaining in your HRA at the end of a calendar year roll over into the next year, even into retirement. This allows you to save for future health expenses. Once you are no longer eligible for Plan coverage, your HRA may be carried forward for up to three years after your Plan coverage ends (for reasons other than retirement). Keep in mind, however, that no further employer contributions will be made to your account once you terminate covered employment. Your HRA balance will be carried forward until no balance remains or until three years after you are no longer covered under the Plan. During the three-year period, you may continue to use the money in your HRA for reimbursement of eligible healthcare expenses as long as a balance remains in your account.

In the event of your death, your surviving spouse continues to be entitled to reimbursements from your HRA account until the earlier of the date your HRA account reaches a zero balance, the HRA ends, or if the HRA account is inactive for 36 months and the HRA balance is $500 or less. Your other dependents covered under the HRA may continue participation in the HRA until the earlier of the date they no longer meet the Plan's definition of dependent, the date your HRA account reaches a zero balance, or the HRA ends. If you do not have any dependents, any amounts left in your HRA account will not be paid to any other individual. In this instance, all amounts remaining are forfeited and revert to the Plan to be used for administrative expenses. In no event will remaining assets be paid in cash to any person.

Your HRA account may be terminated for inactivity. If your HRA account is inactive for 36 months and your HRA account balance is $500 or less, then your HRA account will be terminated and your account balance will be forfeited on the first day of the month following the 36-month period of inactivity.

Reimbursable Expenses

You can use the money in your HRA to pay for eligible healthcare expenses incurred by you, your spouse and/or your eligible dependents. Please note that as with any Plan coverage, your spouse and/or your other dependents must meet the dependent for their expenses to be eligible for reimbursement. Any reimbursements you submit for your spouse's and/or your dependents' expenses will be charged against your HRA.

In general, healthcare expenses eligible for reimbursement include, but are not limited to:

- Hospital, doctor, and dentist bills;
- Prescription drugs;
- Amounts you pay for Deductibles, Copayments, and Coinsurance; and
- Premiums for group health plan coverage (provided premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars), COBRA Continuation Coverage, and Medicare Parts B, C, and D.

Following is a partial listing of the type of expenses that may be eligible for reimbursement from the Fund's HRA Plan. This list is based on IRC Section 213 and is taken from the Department of Treasury, Internal Revenue Service, *Publication 502, Medical and Dental Expenses*. Please note that not all IRC Section 213 expenses are eligible for reimbursement. For more detailed information, contact the IRS or visit www.irs.gov/pub/irs-pdf/p502.pdf.

- Acupuncture.
- Alcoholism, including inpatient treatment at a therapeutic center for alcohol addiction, including meals and lodging provided by the center during treatment.
- Artificial limbs.
- Artificial teeth, for other than cosmetic reasons.
- Birth control pills prescribed by a doctor.
- Breast reconstruction surgery following a mastectomy for cancer.
- Chiropractic care.
- Contact lenses needed for medical reasons, including cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner.
- Crutches (rental or purchase).
- Dental treatment, including fees paid to dentists for x-rays, fillings, braces, extractions, dentures, etc. (teeth whitening, as described later, is not covered).
- Diagnostic devices used in diagnosing and treating Illness and disease.

- Drug addiction for inpatient treatment at a therapeutic center for drug addiction, including meals and lodging at the center during treatment.
- Eye or vision correction surgery, including eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.
- Eyeglasses needed for medical reasons, including fees paid for eye examinations.
- Fertility enhancement to overcome an inability to have children, including:
  - Procedures, such as in vitro fertilization and temporary storage of eggs or sperm; and,
  - Surgery, including an operation to reverse a prior surgery that prevented the person from having children.
- Health institute if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or Illness of the individual receiving the treatment.
- Hearing aids, including batteries.
- Home Care (see Nursing services).
- Inpatient care at a hospital or similar institution if a principal reason for being there is to receive medical care; this includes meals and lodging (see Lodging).
- Laboratory fees for medical care.
- Legal abortion.
- Legal medical services provided by physicians, surgeons, specialists, and other medical practitioners.
- Lodging at a hospital or similar institution while away from home if:
  - The lodging is primarily for and essential to medical care;
  - The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to or the equivalent of a licensed hospital;
  - The lodging is not lavish or extravagant under the circumstances; and
  - There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

  Expenses for lodging cannot be more than $50 for each night for the individual receiving medical care and a person traveling with that individual. Expenses are not eligible if treatment is not received from a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital or if the lodging is not primarily for or essential to the medical care received.
- Medical supplies, such as bandages used to cover torn skin.
- Medicines that require a prescription by a doctor for use by an individual, including insulin.
- Mentally handicapped special home, which includes the cost of keeping a mentally retarded person in a special home, not the home of a relative. The stay at the mental health facility must be based on the recommendation of a psychiatrist to

help the person adjust from life in a mental hospital to community living.

- Nursing home medical care (including care in a home for the aged or similar institution), meals, and lodging if a principal reason for being there is to get medical care.
- Nursing services, including wages and other amounts paid for nursing services provided by a nurse licensed in the jurisdiction where services are provided.
- Operations or surgery, when legal and not performed for unnecessary cosmetic surgery. Cosmetic surgery is a non-covered expense.
- Service provided by an optometrist.
- Organ donors (see Transplants).
- Services provided by an Osteopath.
- Oxygen, including equipment to relieve breathing problems caused by a medical condition.
- Prosthesis.
- Psychiatric care, including the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care.
- Psychoanalysis (however, psychoanalysis that is part of required training to be a psychoanalyst is not eligible).
- Services provided by a Psychologist.
- Sterilization (a legally performed operation to make a person unable to have children).
- Smoking cessation programs (this does not include medications that do not require a prescription, such as nicotine gum or patches).
- Telephone special equipment that lets a hearing-impaired person communicate over a regular telephone, including teletypewriter (TTY) and telecommunications devices for the deaf (TDD), as well as equipment repair costs.
- Television equipment that displays the audio part of television programs, such as subtitles, for hearing-impaired persons (this is an adapter that attaches to a regular set or some of the costs associated with a specially equipped television that exceeds the cost of the same model regular television set).
- Therapy received as medical treatment (not including massage therapy).
- Transplants as a donor or possible donor of an organ.
- Vasectomy.
- Wheelchair used mainly for the relief of Sickness or disability, and not just to provide transportation to and from work; this includes the cost of operating and maintaining the wheelchair.
- Wig purchased upon the advice of a physician for the mental health of a patient who has lost all hair from disease.
- X-rays for medical reasons.

Expenses Not Eligible for Reimbursement

Expenses that are not eligible for reimbursement from the HRA (as defined by Section 213(d) of the Internal Revenue Code) include, but are not limited to:

- Long-term care services.
- Cosmetic or reconstructive surgery, or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an accident, trauma, or disfiguring disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to your or your dependent's inability to perform physical house work).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition, such as obesity.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Internal Revenue Code Section 213.
- Premiums paid through salary reduction contributions under the terms of the Internal Revenue Code Section 125 plan.
- Medical care expenses that you or your dependents are reimbursed or reimburs-

able for through another health insurance plan, other insurance, or any other accident or health plan. However, if only a portion of a medical care expense has been reimbursed elsewhere (e.g., because another health insurance plan imposes Copayment or Deductible limitations), funds in the HRA can be used to reimburse the remaining portion if it otherwise meets the requirements.

Claim and Reimbursement Procedures

You must submit a claim for reimbursement of any eligible expense. Claims can be submitted via the HRA Portal (https://necaibew.lh1ondemand.com), via the NECA-IBEW HRA mobile app powered by Evolution 1 (for both iPhone and Android devices), or by submitting a paper claim. When you use your Benny Card to pay for an expense, a claim will automatically be submitted for you within a few days; it is not necessary to submit a claim manually through the portal or with a paper claim form. If you, your spouse and/or your dependents are eligible for other coverage, you must include a copy of the Explanation of Benefits (EOB) from the other coverage as well as any EOB from this Plan. Only eligible expenses that have not been reimbursed, as shown on the EOB form, will be considered eligible for reimbursement.

You may submit eligible expenses for reimbursement at any time. The amount reimbursed for any eligible expense will not exceed your HRA balance at the time reimbursement is requested.

To receive reimbursement for an eligible expense, you must submit a written claim form within 12 months of the date the expense is incurred and in accordance with the Plan's claims procedures. If you fail to do so, your claim may be denied. In addition, any HRA payments that are unclaimed (e.g., uncashed checks) by the end of the year following the year in which the claim was incurred, will remain the property of the Fund.

By submitting a claim for reimbursement, you agree to accept and adhere to the following conditions:

- The eligible expense has not been otherwise reimbursed, nor will it otherwise be reimbursed, through any other source (including a Health Care Flexible Spending Account, if applicable);
- For premiums paid for other coverage, the eligible expense has not been paid or is not eligible for payment on a pre-tax basis; and
- The eligible expense has not been taken, nor do you intend to take it, as a tax deduction.

The following documentation, as applicable, is required to verify your claim as an eligible HRA expense:

- An itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge.

- An Explanation of Benefits (EOB) of any coverage (including any EOB from this Plan), plus original receipts verifying payment, when requesting reimbursement of the balance of charges for which coverage is available.
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums, and verification that the premium was not paid or eligible for payment under an IRC Section 125 plan. Additional documentation is also required for reimbursement of premiums under a qualified long-term care contract.
- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).
- An acceptable proof of payment, such as a copy of the front and back of a cancelled check or a copy of the front of a check, along with the corresponding bank statement, credit card statement or itemized sales receipt.
- Any additional documentation requested by the Plan.

HRA benefits are intended to pay benefits only for medical care expenses not previously reimbursed or reimbursable elsewhere. If a medical care expense is payable or reimbursable from another source, that other source will pay or reimburse before payment or reimbursement from the HRA. However, if the eligible expense is covered by both the HRA and by a health care Flexible Spending Account (FSA), then the funds in the HRA cannot be used as reimbursement of that expense until after the amounts available for reimbursement under the FSA have been exhausted.

Claim Submission

- Log on to the HRA Participant Portal (https://necaibew.lh1ondemand.com) to file a claim and to upload required documentation, or
- Log on to the mobile app (NECA-IBEW Benefits) to file a claim and to upload required documentation, or
- Use your Benny Card to pay for an HRA eligible expense, which will automatically file a claim (within a few days) for you and allow you to upload required documentation, or
- Mail a completed claim form and any required documentation to:

NECA-IBEW Welfare Trust Fund
Attn: HRA Dept.
2120 Hubbard Avenue
Decatur, IL 62526-2871

Note: The HRA is intended to qualify as a medical reimbursement plan under Internal Revenue Code Sections 105 and 106 and associated regulations and as a health reimbursement arrangement as defined under Internal Revenue Service Notice 2002-45. Reimbursements under the HRA are intended to be eligible for exclusion from your gross income under Internal Revenue Code Section 105(b).

Other Plan Features

Coordination of Benefits

If you or your dependents are covered by another health (medical and/or prescription drug) 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 claims to both plans. You will receive payment from our Plan (if appropriate) showing how your claim was calculated.

The amount charged by a healthcare provider to the other plan will be considered as the amount the healthcare provider accepts as payment in full for the service or supply. If such amount charged to the other plan differs from the charge reported to the Plan, allowable expenses for the service or supply will not exceed the lesser of the charges. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. The following four rules override any other plan rules:

- If the other plan does not have a coordination of benefits provision, that plan will be the primary plan and will pay benefits first.
- If your spouse is offered any comprehensive major medical coverage though his or her employer, your spouse must accept the coverage. This applies if your spouse works 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's 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.
- If an eligible dependent has primary coverage under a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), Preferred Provider Organization (PPO), or any other managed care program and voluntarily elects not to use the facilities or services of the HMO, EPO, or PPO, no benefits will be paid from this Plan. This rule also applies to dependent children whose coverage would be primary under the HMO, EPO, or PPO.

"Other plan" means any plan providing benefits or services for or by reason of medical, dental, or vision care or treatment for which benefits or services are provided by:

- Group blanket or franchise insurance coverage;
- Group BlueCross BlueShield coverage and other prepayment coverage;
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans, or any other arrangement of benefits for individuals or a group; or
- Any coverage under governmental programs, other than Medicaid, and any coverage required or provided by any statute.

"Other plan" also includes this Plan when an individual is covered as both an employee and a dependent, and when a child is covered as a dependent of more than one employee.

Our Plan will work with your other plan to coordinate your benefits based on our Plan. If the rules above do not apply to the situation, the first of the following rules that apply will establish the order:

- *Non-Dependent/Dependent.* The plan that covers a person as an employee, retiree, member, or subscriber (other than as a dependent) is primary and pays benefits first. (Except if the person is also a Medicare beneficiary and Medicare is secondary then the order of benefits is reversed).
- *Dependent child covered under more than one plan when the parents are married, not separated (whether or not they have ever been married), or a court decree awards joint custody (without specifying the responsibility for the child's healthcare coverage):*
  - The plan that covers the parent whose birthday falls earlier in the calendar year is primary and pays first.
  - If both parents have the same birthday, the plan that has covered one of the parents for a longer period is primary and pays first and the plan that has covered the other parent for the shorter period pays second.
  - If a court decree does not specify that one parent is responsible for the child's healthcare expenses or healthcare coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan is primary and pays first. If the parent with financial responsibility has no coverage for the child, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility is primary and pays first. However, this does not apply during any Plan year during which any benefits were actually paid or provided before the Plan had actual knowledge of the specific terms of that court decree.
- *Dependent child covered under more than one plan when the parents are not married, are separated (whether or not they ever were married), or are divorced and there is no court decree specifying responsibility for the child's healthcare coverage:*
  - The plan of the custodial parent is primary and pays first;
  - The plan of the custodial parent's spouse (if any) pays second;
  - The plan of the non-custodial parent pays third; and
  - The plan of the non-custodial parent's spouse (if any) pays last.
- *Dependent child covered under more than one plan when the parents are not married, are separated (whether or not they ever were married) or divorced and there is a court decree specifying responsibility for the child's healthcare coverage;*
  - The plan of the specified parent is primary and pays first;

- The plan of the custodial parent pays second; and
- The plan of the custodial parent's spouse pays last.

Exception: If the specified parent fails to provide the coverage mandated in the court decree, the custodial parent has no coverage and the custodial parent signs a "deadbeat parent" agreement. This Plan will pay the dependent claims at 50%. Scheduled Deductibles, Out-of-Pocket Maximums and Copayments apply.

- *Active/laid-off or retired employee.* The plan that covers a person either as an active employee (who is neither laid-off nor retired) or as that active employee's dependent is primary and pays first. If the other plan does not have this rule regarding active/laid-off or retired employees, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by the dependent/non-dependent rule rather than by this rule.
- *Continuation coverage.* If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member, or subscriber (or as that person's dependent) is primary and pays first. If the other plan does not have this continuation coverage rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan, and as a dependent of an active employee under another plan, the order of benefits is determined by the dependent/non-dependent rule rather than by this rule.
- *Length of coverage.* If none of the previous rules determines the order of benefits, the plan that covered the person for the longer period is primary and pays first.

Coordination with Medicare

Active employees and/or their eligible dependents who are also covered by Medicare will be covered by the Plan with this Plan paying benefits first. Then Medicare will determine what it will cover with respect to the remaining expense not covered by this Plan.

If you have questions regarding the Plan's rules for coordinating benefits, call the Welfare Trust Fund Administrative Office. You will be furnished with an explanation of the rules. You may request a written copy of the coordination of benefits rules.

Reimbursement, Subrogation, and Loan Agreements

The Plan can recover the amount of benefits it pays on your behalf for covered medical and prescription drug benefits resulting from a Sickness or Injury for which someone else (a third party) is legally responsible and required to pay (for instance, when the court requires a parent to be financially responsible for providing healthcare benefits and this Plan pays because the parent is not fulfilling his or her 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 available at the Welfare Trust Fund Administrative Office or online at www.neca-ibew.org.

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

The following section describes the rules that apply should another source, such as an automobile insurance company, be responsible for medical expenses that have already been reimbursed by the Plan. This may happen, for example, if you are in an automobile accident and receive medical treatment as a result. In the case of claims involving third-party liability, the Plan will pay benefits under the following conditions:

1. You and your dependents (and your attorney if you have one) must provide the Plan with written subrogation documents or loan agreements in which you and your dependents agree to repay the Plan the amount of benefits the Plan pays on a claim out of any recovery of expenses you receive. The Plan will not expect repayment of more than the benefits it pays on a claim or more than the amount you or your dependents receive. The Plan has the right, subject to written waiver by the Fund, to recover 100% of the amounts paid to your or your covered dependents' medical providers.
2. If you or your dependents receive payment from the responsible party and do not repay the Plan, the Plan has the right to withhold any future benefits to which you or your dependents may become entitled, based on claims for treatment received, until the proper amount has been repaid.
3. You and your dependents must sign an agreement not to assign any other person the right to recover the amount of the expense.
4. If a claim is for a minor child, the child's parent or guardian must sign the required documents on behalf of the child, including, but not limited to, the Subrogation Agreement.
5. If the responsible third party does not voluntarily pay for expenses and you or your dependents do not file suit against the party to recover expenses, you and your dependents must provide the Plan with a written agreement giving the Plan the right to file suit in your or your dependents' name to recover expenses the Plan paid on the claim. In the event the Plan files suit and makes a recovery, the Plan's expenses, costs and attorney's fees will be paid out of the recovery settlement. In the event you or your dependents file suit and make a recovery, the Plan will not be liable for any expenses incurred or attorneys' fees arising out of the litigation or recovery unless written authority from the Plan is first obtained.
6. If you or your dependents provide proof that is acceptable to the Trustees that you or your dependents have not received any recovery from a third party and that there is no possibility of any recovery, the Plan will pay Covered Expenses, but only after the subrogation documents or loan agreements are signed according to Plan procedures.

7. If you or your dependents receive any recovery, by way of judgment, settlement or for any other reason, from any other person or business entity, you and/or your dependents agree to hold such recovery in a constructive trust for the Plan and to reimburse the Plan in full, for any medical or disability expenses paid by the Plan.
8. The Plan's right to full recovery, either by way of subrogation or right of reimbursement, may be from funds you, your dependents or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, the underinsured motorist's insurance, any medical payments, and any no-fault or school insurance coverage paid or payable.
9. The Plan's right to recovery survives your death or the death of your dependent and beneficiary, and will automatically bind the decedent's successors, assignees, executor or estate.

Acceptance of benefits under this Plan indicates acceptance of these terms and conditions.

Recovery of Overpayments and Erroneous Payments

If the Plan makes an overpayment for an Allowable Expense (if the Plan pays more than the amount necessary), the Trustees have the right to recover the overpayment made on behalf of you, or your covered spouse or other covered dependents. This recovery may mean withholding future benefits. The Plan may collect any overpayments from one or more of the following, as determined by the Trustees:

- Any persons to whom or for whom the overpayments were made;
- Any insurance companies; and
- Any other organizations.

Provider Self-Audit Program

This Program is intended to encourage you and your dependents to review carefully the bills you receive 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 for refund 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.

General Limitations and Exclusions

The following list summarizes important limitations on benefit payments from the Plan. For a complete list, refer to the Plan Document. This list is in addition to any other limitations or exclusions listed throughout this booklet.

1. Any Injury, Sickness, or dental treatment of an eligible person that arises out of or in the course of any occupation or employment for wage or profit (i.e., for which the individual has received or is eligible to receive any benefits under a workers' compensation or occupational disease law). However, if a case is disallowed by the Industrial Commission, benefits may be payable under the Plan.
2. Any expense incurred after eligibility ends, except as specifically provided otherwise.
3. Any expense in excess of the Allowable Charge. Such excess charge is the responsibility of the eligible person.
4. Any expense or charge for services or supplies not recommended or approved by the attending physician or surgeon or not Medically Necessary in treating the Sickness or Injury.
5. Any expense or charge for services or supplies that is subject to the exercise of the Trustees' discretion to reasonably interpret the terms of the Trust, Plan, or Summary Plan Description (SPD) and that is deemed a non-Covered Expense or service.
6. Any expense or charge for a checkup, pre-marital exam, or routine physical exam for employment, except as specifically provided otherwise.
7. Any expense or charge for custodial care, except as specifically provided otherwise for hospice care or skilled nursing care.
8. Any loss, expense, or charge that results from cosmetic or reconstructive surgery except:
    - When such service is incidental to, or follows within two years of, surgery resulting from Injury, Sickness, or disease of the involved part while a person is eligible under the Plan.
    - When surgery is performed because of a congenital disease or anomaly that resulted in a functional defect as determined by the attending physician.
    - For corrective surgery for conditions that prevent an organ of the body from performing and functioning properly.
    - For breast reconstructive surgery following a mastectomy.
9. Any expense or charge in connection with dental work or surgery (including prescription drugs or vitamins for fluoride treatment), except as specifically provided otherwise.
10. Any expense or charge for failure to appear for an appointment as scheduled or for completion of claim forms.
11. Any expense or charge that an eligible person does not have to pay, except as

specifically provided otherwise..

12. Any loss, expense, or charge resulting from a claimant's participation in a riot or during the commission of an assault or a felony, except Injuries or Sicknesses that are the result of acts of domestic violence.
13. Any loss, expense, or charge that results from an act of declared or undeclared war or armed aggression.
14. Any loss, expense, or charge incurred while an eligible person is on active duty or in training in the armed forces, national guard, or reserves of any state of any country.
15. Any supply or equipment for personal hygiene, comfort, or convenience, except as specifically provided otherwise.
16. Special home construction to accommodate a medical condition.
17. Ambulance service, except as specifically provided otherwise.
18. Any service or supply received from a hospital that does not meet the Plan's definition of a hospital.
19. Any charge incurred for services or treatment rendered by a member of the eligible person's family.
20. Any charge incurred for treatment of a behavioral health disorder while confined in an institution operated by any government or government agency.
21. Any charge incurred for education, training, or room and board at an institution that is primarily an institution of learning or training.
22. Any charge incurred for special education, regardless of the type of education, purpose of education, recommendation of the attending physician, or the qualifications of the individual rendering the special education, except for approved educational programs for treating diabetic and cardiac patients.
23. Any expense or charge incurred by an eligible person confined in an institution that is primarily a place of rest, a place for the aged, or nursing home.
24. Any expense or charge incurred for treatment or consultation by a psychologist or social worker, unless such treatment or consultation is specifically recommended by a referring medical physician or such treatment or consultation is under the direct supervision of a medical physician. A psychologist or social worker must possess a master's or higher degree.
25. Any expense or charge incurred for treatment or consultation with a registered nurse, or certified addictions counselor, unless the professional has a master's degree in social work and the charge for such services are recommended by and/or under the supervision of a medical physician or psychiatrist.
26. Non-emergency care when traveling outside the United States.

If you have any concern about whether a particular expense is covered by the Plan, contact the Welfare Trust Fund Administrative Office at 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 their dependents become subject to special rules and limits including the following:

- Eligibility ends as of the 31st 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 31st 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

Most providers will file medical claims for you. You should encourage your provider to file claims as soon as possible. If you need to submit a health claim, your claim must:

- Be written or electronically submitted in accordance with HIPAA's EDI standards (oral communication is acceptable only for urgent care claims);
- Be received by the Welfare Trust Fund Administrative Office or authorized agent;
- Name a specific eligible person;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service, or product for which approval or payment is requested (post-service claims must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal Tax Identification Number (TIN); and
- When another plan is the primary payer, include a copy of the other plan's Explanation of Benefits (EOB) statement along with the submitted claim.

In the event of your death, your beneficiary should file a claim for death benefits as soon as possible. Various forms that may be needed for processing your claim may be printed by going to the Fund's website (www.neca-ibew.org). All claims should be submitted to:

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

All requested information should be submitted with claims. The employee's full name, address, and BlueCross BlueShield unique ID number (or your Social Security Number if you do not have a unique ID number) should be included on all claims. Claims submitted more than one year after the date incurred will be denied. In addition, if a claim is filed within 12 months, but additional information is requested and not received within that 12-month period, the claim may 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 Trust Fund Administrative Office. You may also check your claims through the Fund's website.

Death Benefit Claims

Death Benefits are paid to your designated beneficiary or beneficiaries promptly upon submission of the appropriate application form provided by the Welfare Trust 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.

Generally, the Plan will make a decision on a Death Benefit claim and notify your

beneficiary of the decision within 90 days of receiving the claim. If the Plan needs additional information to make a decision, your beneficiary will be notified as to what information must be submitted. Your beneficiary will have up to 45 days to submit the additional information. Once the Plan receives the information, your beneficiary will be notified of the Plan's decision on the claim within the 90-day period.

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

Healthcare Benefit Claims

All network and non-network providers should file medical claims with their local BlueCross BlueShield office. Network claims qualifying for benefits will be paid by BlueCross BlueShield. Non-network claims will be paid to the provider. No "up-front" payments should be made to network providers. You should wait until the claim has been processed by the Fund before making payment due to the fact that discounts and other factors may affect your balance due.

If a non-network provider refuses to file a claim with BlueCross BlueShield and/or insists you make either a partial or a full payment for services provided, you may be reimbursed for covered charges by sending an itemized bill and proof of payment to the Welfare Trust Fund Administrative Office.

You may periodically be required to complete an enrollment card, as requested. If you do not complete and return the card when requested, claims will not be paid until the card is returned. In addition, you and your dependents are required to complete and return an Accident Form for each accident before benefits will be paid relating to that accident.

Pre-Service Claims under the Pre-Admission Review Process

You are required to obtain pre-certification for transplant surgery and bariatric surgery. When pre-certification 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.

If your doctor recommends transplant surgery or bariatric surgery, you must call the Welfare Trust Fund Administrative Office at 217-875-2947 or 217-875-3017 before admission. You are encouraged to utilize a Centers of Excellence (COE) facility for transplant surgery. In addition to saving you money, COE facility doctors specialize in transplant surgeries and often surgeries performed at a COE facility have a higher success rate than those performed at a non-COE facility.

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

Medical 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.

Transamerica Medical Plan Claims

All claims for Medicare-eligible retirees and/or their Medicare-eligible dependents who are covered under the Transamerica Medical Plan are processed by Transamerica.

If you have questions about submitting a claim or the status of a claim, call Transamerica at 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 Transamerica, you must contact the Welfare Trust Fund Administrative Office at 800-765-4239.

Prescription Drug Benefit Claims

If you have your prescriptions filled at a pharmacy that does not participate in the retail pharmacy network, you must file a claim. Claims should be submitted to the Welfare Trust Fund Administrative Office and will be reimbursed at 50%, provided the prescription is a Covered Expense under the Plan.

Information regarding mail-order claims is available from the Welfare Trust Fund Administrative Office.

Health Reimbursement Account (HRA) Claims

You must submit a claim for reimbursement of any eligible expenses, as described on page 61. A request for reimbursement of an eligible expense is considered a claim. Claim decisions are subject to the Plan's claims procedures for post-service claims listed in this section.

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(s)s 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 Trust

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 (60 days for a claim for death benefits). 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 Trust Fund Administrative Office.

For purposes of the claim and appeal procedures, a claim denial (adverse benefit determination) includes:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit or your eligibility to participate in this Plan or a determination that a benefit is not a covered benefit;
- A benefit reduction resulting from the application of any pre-certification or Utilization Review decision, source-of-injury exclusion, network exclusion, other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate;
- The Plan's payment of less than the total amount of expenses submitted with regard to a claim, even where the Plan is paying the portion of the claim that is covered under the terms of the Plan; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

Generally, 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 healthcare claims;
- ***72 hours*** for urgent care healthcare claims; or
- Death and post-service healthcare 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 such 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 meeting at which the decision has

been reached.

The written notice of the decision on review will include:

- The specific reason(s) 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 broad 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 or administrative proceeding. You must follow and exhaust 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 designate someone as your representative at the meeting, the Fund will require a written authorization. If you decide to make a personal appearance or have someone do so on your behalf, it must be done at your own expense. The Trustees reserve the right to hold any meeting to consider appeals by telephonic conference call. Your right "to appear before" the Trustees considering the appeal in this instance is limited to participating in the telephone conference at the time the appeal is presented.

Authorized Representative

You must provide written authorization for a representative to act on your behalf to file a claim under this Plan. Authorization forms will be provided with the appeal form. The following individuals may be recognized as your authorized representative:

- Healthcare provider;
- Legal spouse;
- Dependent child age 18 or over;
- Parents or adult siblings;
- Grandparent;
- Court ordered representative, such as an individual with power of attorney for healthcare purposes or legal guardian or conservator; or
- Other adult.

No appointment of an authorized representative or assignment of benefits to another

person or entity provides the representative with any right to maintain an action in contract, tort, or as an ERISA benefit claim against the Fund or the Trustees for recovery of any amounts from the Plan. Any claim brought against the Plan for payment of benefits must be brought in the name of the eligible person upon whom services were performed.

Once you name an authorized representative, the Plan will route all future claims and appeals-related correspondence to your authorized representative and not to you. The Plan will honor the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization. However, you may revoke a designated authorized representative at any time by submitting a signed statement.

The Plan reserves the right to withhold information from a person who claims to be an authorized representative if there is suspicion about the qualifications of the individual claiming to be the authorized representative.

Important Information about the NECA-IBEW Welfare Trust Fund

The NECA-IBEW Welfare Trust Fund was 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, eligible retirees, and their eligible dependents. There is a list of participating local unions on page 91. For a list of participating employers, please contact the Welfare Trust Fund Administrative Office.

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 participating local unions. The Trustees collect, manage, and distribute the Fund's accumulated assets, determine benefits, and establish 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. 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 Sponsor and Plan Administrator. The 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 multiemployer groups representing participating employers in an area and representatives of participating local unions affiliated with the International Brotherhood of Electrical Workers that have become parties to the Fund Agreement and Declaration of Trust. The Board of Trustees is assisted in the administration of the Fund by an administrative manager.

Plan Identification Numbers. The Employer Identification Number (EIN) assigned by the Internal Revenue Service is 37-0738564. The number assigned to the Plan by the Plan Sponsor is 501.

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

Source of Contributions. The Fund receives contributions from employers pursuant

to written agreements requiring contributions to the Fund on behalf of employees. The contribution rate is set by the Trustees and contributions are paid monthly. Contributions are also received by the Fund from employees and retirees eligible to make self-payments.

Plan Funding. All Plan benefits are self-funded and administered directly by the Trust Fund, except for prescription drug benefits, which are administered by Express Scripts, the Wellness Coaching, NurseLine and Disease Management programs, which are administered by Nurtur, and the Transamerica medical benefits for Medicare-eligible retirees and their dependents.

Accumulation of Assets. All assets comprising the funds of the Plan are held in trust by the Board of Trustees pending payment of benefits and administrative expenses.

Plan Year. The Fund is maintained on a 12-month fiscal year basis ending each June 30. The Plan year is different from the 12-month administrative period, which is the calendar year (January 1 – December 31).

Plan Type. This Plan provides death, disability, disease management, health reimbursement account, medical, prescription drug, and wellness benefits for retired 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. In the event the Plan is terminated, any and all assets remaining after the payment of all obligations and expenses will be used in accordance with the purposes determined by the Trustees according to the Trust Agreement. However, any use of such assets will be made only for the benefit of the Plan participants who were covered under the Plan at the time of the Plan's termination.

Benefits Are Not Vested. You do not have a vested right to benefits under the Plan, and benefits may be amended or terminated at any time.

Plan Documents. Copies of the Trust Agreement, 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 Trust Fund Administrative Office or at the office of participating local unions. In addition, a complete set of these documents may be requested, in writing, from the Welfare Trust Fund Administrative Office. The Fund may charge a reasonable fee to cover the cost of reproducing documents. Requests for documents should be addressed to:

Plan Administrator
NECA-IBEW Welfare Trust Fund
2120 Hubbard Avenue
Decatur, IL 62526-2871
800-765-4239

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

NECA-IBEW Welfare Trust Fund's Privacy Policy. The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The official HIPAA Privacy Notice, which is distributed to all participants of the Plan, is summarized here.

The intent of HIPAA is to make sure that private health information that identifies (or could be used to identify) you is kept private. This individually identifiable health information is known as "protected health information" (PHI). The Plan will not use or disclose your PHI without your written authorization except as necessary for treatment, payment, Plan operations and Plan administration, or as permitted or required by law. What's more, the Plan will implement administrative, physical and technical safeguards to ensure that your PHI remains confidential, intact, secure and available only to authorized users. The Plan also will ensure that there are reasonable and appropriate security measures to protect electronic PHI, and ensure that any agent, including a subcontractor to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI.

The Plan also hires professionals and other companies to advise the Plan and help administer and provide healthcare benefits. The Plan requires these individuals and organizations, called "Business Associates," to comply with HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates (for example, Empire BlueCross BlueShield). That notice will describe your rights with respect to benefits administered by that individual/organization.

Under federal law, you have certain rights where your PHI is concerned, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, change or correct the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services, if you believe your rights have been violated.

If you have questions about the privacy of your health information or if you would like a copy of the official HIPAA Privacy Notice, please contact the Welfare Trust Fund Administrative Office.

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 Trust Fund Administrative Office. A copy is also posted on the NECA-IBEW website (www.neca-ibew.org). In addition, a copy may be requested, in writing, from the Welfare Trust 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
800-765-4239.

ERISA Rights

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 are entitled to the following rights.

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Welfare Trust Fund Administrative Office, 2120 Hubbard Avenue, Decatur, IL 62526-2871, and at other specified locations, such as worksites and union halls, 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 healthcare coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage, if it is elected (review this Summary Plan Description and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights).

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 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 latest summary annual report from the Plan and do not receive it 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, NW
Washington, DC 20210
866-444-3272

or

Nearest Regional Office:
Employee Benefits Security Administration
Chicago Regional Office
200 West Adams Street, Suite 1600
Chicago, IL 60606
312-353-0900

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, visit the EBSA's website at www.dol.gov/ebsa.

Nothing in this booklet is meant to interpret, extend, or change in any way the provisions expressed in the Plan Document. 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-payments.

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You can contact the Board of Trustees care of the NECA-IBEW Welfare Trust Fund Administrative Office:

NECA-IBEW Welfare Trust Fund
2120 Hubbard Avenue
Decatur, IL 62526-2871
800-765-4239
www.neca-ibew.org

Participating Local Unions

- Local 16
- Local 34
- Local 146
- Local 193
- Local 197
- Local 305
- Local 349
- Local 494
- Local 531
- Local 538
- Local 558
- Local 601
- Local 668
- Local 702
- Local 725
- Local 816
- Local 855
- Local 873
- Local 1701

NECA-IBEW
Welfare Trust Fund
2120 Hubbard Avenue
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