IBEW - NECA SOUTHWESTERN HEALTH AND BENEFIT FUND

SUMMARY PLAN DESCRIPTION (SPD)

Revised
September 1, 2023

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IMPORTANT NOTICES

LIFETIME AND ANNUAL LIMITS ELIMINATED

The lifetime and annual limits on the dollar value of Essential Health Benefits under the IBEW-NECA Southwestern Health and Benefit Fund no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. (Annual and Lifetime Limits still apply for certain non-Essential Health Benefits, as detailed below.) For more information contact Zenith American Solutions at 4101 McEwen Road, Suite 600, Dallas, TX 75244 or via telephone at (800) 527-0320.

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

Your enrollment in this plan is automatic once you have accumulated the required number of hours to be eligible for plan benefits. In addition, your eligible dependents up to age 26 will be automatically enrolled in this plan once you meet the plan's eligibility requirements. If you wish to enroll other dependents, you must submit an enrollment application. If you are declining enrollment for any of your dependents because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your dependents' other coverage). However, you must request enrollment within specified timeframes after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Typically, you have 30 days to enroll following the loss of other coverage, except you have 60 days from the date coverage is lost from a state Medicare program or state children's health insurance program. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Zenith American Solutions at 4101 McEwen Road, Suite 600, Dallas, TX 75244 or via telephone at (800) 527-0320.

GENERAL NOTICE

This Plan of benefits provided by the IBEW-NECA Southwestern Health and Benefit Fund (the "**Fund**") will not be deemed to constitute a contract of employment or give any employee of a Contributing Employer the right to remain in service of the Employer or to interfere with the right of the Employer to discharge any employee. These issues are generally covered by your collective bargaining agreement.

You must satisfy all of the eligibility provisions described in this summary plan description ("**SPD**") in order to be eligible for benefits under the Plan. Possession of this booklet does not automatically entitle you to Plan benefits.

The Fund's Board of Trustees ("**Board**" or "**Trustees**") has full and exclusive fiduciary authority in its sole discretion to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and other related matters. The Trustees also have full power and discretion to construe the provisions of the Agreement and Declaration of Trust for the Fund and the Fund's Rules and Regulations. Any such determination and any such construction adopted by the Trustees in good faith will be binding on all entities, members, and beneficiaries of the Fund.

The weekly accident and sickness benefits, comprehensive medical benefits, life insurance benefits, accidental death and dismemberment benefits, prescription drug, mental health, substance abuse, dental and vision benefits described in this SPD are not insured by any contract of insurance and there is no

liability upon the Fund's Trustees or any individual or entity to provide payment over and above the amount in the Plan available for such purpose (to the extent funded).

USE YOUR COMPUTER TO VISIT THE FUND'S WEBSITE

You may visit the Fund's website, https://inswhealth.zenith-american.com, at any time. When you use the website, you may check your eligibility, work history, claims status and download a printable copy of the latest version of the SPD and physician nomination forms. Our website also gives you links to the websites of Sav-Rx and Blue Cross Blue Shield.

Once you are online, go to the web address above. In the center of Zenith American Solution's main page, is a "Participant" button. Put your mouse's pointer over the Participant button and click once.

On the left side of the next website page, there is a "Participant Login" button. Click on this button once. Since your eligibility and claim information is kept strictly private, only you may have access to it.

Therefore, before you may view any specific information, you ***must*** enter your Username and Password.

To setup a Username and Password, you must complete an online registration by clicking on the "Register Form" link provided. If you have forgotten your Username and/or Password, click on the "Forgot Username/Password" and complete all of the requested information in order to obtain and/or reset this information.

HOW TO FILE A CLAIM

If you or your eligible Dependents become ill or injured and you believe you may be entitled to benefits under this Plan:

1. You should telephone the Fund Office at (972) 980-1123 or toll free at (800) 527-0320.
2. The Fund Office will tell you if you are eligible for benefits under this Plan.
3. The Fund Office will furnish you with a claim form.
4. You should complete the claim form on behalf of the person for whom the claim is being made.
5. Mail or bring the completed form and all bills pertaining to the claim to the Fund Office at the following address within 12 months of the date the expenses were incurred:

IBEW-NECA Southwestern Health and Benefit Fund
P.O. Box 819015
Dallas, Texas 75381-9015
Telephone: (972) 980-1123
Toll free: (800) 527-0320
FAX: (972) 341-8097
https//inswhealth.zenith-american.com

ALL ELIGIBLE EMPLOYEES ARE REMINDED THAT THEY MUST NOTIFY THE FUND OFFICE IN WRITING WHEN:

1. There is a change of address.
2. New Dependents are to be covered. (Provide certified copies of birth certificates/adoption papers/legal guardianship decree.)
3. There is a divorce/legal separation. (Provide court-certified divorce/legal separation decrees.)
4. There is a marriage. (Provide a certified copy of the marriage license.)
5. There is a death. (Provide a certified copy of the death certificate.)
6. A Dependent ceases to qualify as a “Dependent” (e.g., attains age 26).
7. A Dependent child reaches the limiting age of 26 and is either mentally or physically handicapped.

SUMMARY OF BENEFITS

AS OF SEPTEMBER 1, 2023

Life Insurance and Accidental Death & Dismemberment Benefits

Active Employees Only:

Life Insurance	$10,000
Accidental Death and Dismemberment Maximum Benefit..	$10,000

Eligible Dependents of Active Employees Only:

Life Insurance: Spouse	$3,000
Life Insurance: Children 15 days and older	$3,000

Weekly Accident and Sickness Benefit

Active Employees Only:

Weekly Benefit	$350
Waiting Period	Weekly Benefits begin on the 8th day of the disability
Benefit Duration..	Maximum of 26 weeks

Comprehensive Medical

Deductible Amounts

Overall Plan	$400 per Eligible Individual per calendar year; maximum of $800 per family
Additional Hospital Deductible	$200 per Hospital admission; waived when a PPO facility is used. This deductible does not apply if the Eligible Individual is readmitted to the same Hospital for the same injury, illness, or diagnosis in the same calendar year or for bona fide emergency services, as described below.

The Deductible Amount applies separately to all Covered Expenses incurred by or on behalf of each Eligible Individual covered under the Plan once during each calendar year (except as specified under the Family Limit). Expenses that are not Covered Expenses will not be applied toward satisfaction of the Deductible Amount. Expenses incurred toward satisfying the Deductible Amount in the last quarter of one calendar year may be applied toward the next year's Deductible Amount.

Coinsurance Amounts and Out-of-Pocket Maximums

If you receive Medically Necessary therapeutic treatment of an illness or injury by a Physician or covered facility for a covered expense, the Fund will, subject to the restrictions, limitations, and other terms and conditions hereafter stated, pay benefits as follows, up to the applicable maximums:

PPO Hospitals and Physicians	80% of the Reasonable and Customary Charges after the applicable Deductible Amounts; until the applicable out-of-pocket maximum is reached; 100% of the balance per Eligible Individual per calendar year;*
Maximum Individual annual Out-of-Pocket Expenses for Major Medical & Mental Health In-Network Claims (including the $400 deductible)	$4,400 (applies only to Essential Health Benefits & In-Network Claims. There are no limits on out-of-pocket expenses for non-Essential Health Benefits or non-network coverage);
Maximum Family Annual Out-of-Pocket Expense for Major Medical & Mental Health In-Network Claims (including the $800 deductible)	$8,800 (applies only to Essential Health Benefits & In-Network Claims. There are no limits on out-of-pocket expenses for non-Essential Health Benefits or non-network coverage);
Maximum Annual Out-of-Pocket Expense for Rx Prescription Drugs	$2,200 / individual and $4,400 / family. Where generic drugs are medically appropriate & available, brand name drugs are not Essential Health Benefits and thus are not subject to or counted against the Out-of-Pocket Maximums;
Non-PPO Hospitals and Physicians	55% of Reasonable and Customary Charges after the applicable Deductible Amounts (out-of-pocket limit does not apply; 55% is the maximum reimbursement amount; 100% reimbursement not available, regardless of out-of-pocket costs.) "Reasonable and Customary" for non-PPO facilities is capped at 200% of the Medicare allowable. The Plan pays 55% of this cap after the Deductible is met.

* ALL non-emergency hospitalizations **MUST** be pre-certified, and **ALL** emergency hospitalizations that continue after the completion of the emergency services must be certified by the close of business on the next business day following the completion of the emergency services (including stabilization and post-stabilization emergency services) covered by the No Surprises Act. Precertification for mental health and substance abuse is also required for partial hospitalization, residential treatment centers, and intensive outpatient treatment. Precertification is also required for outpatient medical services related to home health care, certain specialty drugs, intensive outpatient services, neurological services, and many more, as more fully set forth under "Outpatient Medical Benefits Requiring Precertification," below. Failure to properly pre-certify a non-emergency hospitalization or required outpatient procedure or treatment, or certify an emergency hospitalization by the close of business on the next business day following the completion of the emergency services **WILL** result in a 50% reduction in benefits up to a maximum penalty of $250 (or per BCBS provider sanction).

In addition to the above exclusions for non-network benefits and non-Essential Health Benefits (as defined the Affordable Care Act), please note that the out-of-pocket maximums and 100% reimbursement levels also do not apply to Excepted Benefits, such as dental and vision.

Moreover, if you have secondary medical insurance that would cover expenses you incur after you have incurred Covered Expenses that exceed the Maximum Individual annual Out-of-Pocket Expenses for Major Medical & Mental Health In-network claims of $4400 (including the $400 deductible) or that exceed the Maximum Family annual Out-of-Pocket Expenses for Major Medial & Mental Health In-network claims of $8800 (including the $800 deductible), then the Plan will not pay at 100% of such expenses, but will only reimburse for payments of 80%.

This 100% reimbursement provision also does **NOT** apply to expenses incurred in connection with:

- any penalties for failure to properly obtain advance approval from the Pre-Admission Review Program;
- dental and vision benefits; and
- organ transplants (unless deemed as Essential Health Benefit under Affordable Care Act standards).

These expenses are never payable at one hundred percent (100%).

Amounts counted toward satisfying the coinsurance limit in one calendar year cannot be applied to satisfy the coinsurance limit in any other calendar year. However, if the entire $4,400 individual or $8,800 family out-of-pocket maximum is satisfied in the last three months of a calendar year, the 100% reimbursement level may be carried over to the following calendar year for claims related to that same illness or injury incurred during the last calendar quarter that caused the maximum out-of-pocket limit to be reached.

Other Coinsurance Amounts:

Second Surgical Opinion	100% per occurrence after the Overall Plan Deductible Amount
Hospital Pre-Admission Diagnostic Tests and X-Rays	90% of the Reasonable and Customary Charges after the Overall Plan Deductible Amount until the applicable maximum out-of-pocket limit is reached; 100% of the balance per Eligible Individual per calendar year if performed within 14 days of the admission
Private Duty Nursing	80% of the Reasonable and Customary Charges subject to applicable Deductible Amounts until the applicable maximum out-of-pocket limit is reached; 100% of the balance per Eligible Individual per calendar year

Emergency Services

If you enter the emergency room of a Hospital in connection with a bona fide emergency situation, then any emergency room Physician Covered Expenses will be paid at the PPO reimbursement rate, whether or not the Hospital or individual emergency room Physicians (including any Physicians rendering treatment in

the emergency room in connection therewith, such as pathologists, radiologists and anesthesiologists) are members of the PPO network. However, if the Hospital or Physician is not a PPO Provider, all other non-network rules will continue to apply (200% of Medicare maximum. Reasonable and Customary rate; no out of pocket maximum, etc.). In addition, under such circumstances the $200 Hospital Deductible will be waived regardless of whether the Hospital is a PPO Facility. Finally, if used in connection with a bona fide emergency situation, all ambulance charges will be paid at the 80% PPO reimbursement rate. However, if the ambulance is not a PPO Provider, all other non-network rules will continue to apply (200% of Medicare maximum. Reasonable and Customary rate; no out of pocket maximum, etc.). For purposes of this Section, a "bona fide emergency" means a condition evidenced by sudden and unexpected symptoms of a disease or bodily injury severe enough to be, in the absence of treatment, either life threatening or likely to result in permanent disability. Examples of a bona fide emergency include serious breathing difficulties, caustic substance in the eyes, uncontrollable bleeding, major bums, sudden onset of severe chest pain, unconsciousness, shock, seizure, and sudden and severe spinal injuries.

Notwithstanding the above, effective as of September 1, 2022, all of the Plan's PPO Provider provisions (including billed amount; co-insurance percentage; crediting deductible, co-insurance, and out-of-pocket maximums; and prohibition against balance billing) will apply, even if the Provider is a Non-PPO Provider, if you obtain emergency services from an emergency dept of a hospital or emergency services in an independent freestanding emergency department. Emergency services are services performed with respect to an emergency medical condition, and include medical screening examination, ancillary services, and related treatment to stabilize the patient (regardless of whether furnished in the emergency department or after admitted to the hospital), and post-stabilizing services covered by the federal No Surprises Act.

If the Physician verifies that your condition is stable, recovering, and no longer life-threatening, and you are able to travel using nonemergency transportation or nonmedical transportation to an available PPO Provider located within a reasonable travel distance, you may, at no further expense to you, be moved to a PPO facility. If either (a) you are given a written notice pursuant to the No Surprises Act and elect not to be moved, or (b) you are given said written notice and provide written consent compliant with the No Surprises Act to continue to receive services from the Non-PPO Provider, then reimbursement for any remaining Covered Expenses for that confinement and any subsequent treatment by Non-PPO Providers shall be treated and billed as a Non-PPO expense, unless otherwise required by the federal No Surprises Act.

However, notwithstanding the above, a Non PPO Provider cannot balance bill for items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non PPO Provider previously satisfied the notice and consent criteria.

An emergency medical condition means a medical condition manifesting itself by, acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. This determination must be based on

the symptoms as they presented themselves at the time of the admission, and cannot be based solely on the basis of the final diagnosis or on diagnostic codes. In addition, denials of coverage cannot be based on imposing a time limit between the onset of symptoms and the presentation of the person to the emergency department, or because the person didn't experience a sudden onset of symptoms.

The emergency services must be provided without need for any prior authorization. The total cost-sharing requirement for the Eligible Individual shall be calculated by deeming the total medical bill to be the lesser of the billed amount or the Qualifying Payment Amount. The Qualifying Payment Amount is the medium contracted rate that the Plan has contractually agreed to pay a PPO Provider in the same insurance market for the same or similar items or services in the same or similar specialty or facility of the same or similar facility type, and provided in the same geographic region. The Plan shall calculate the Qualifying Payment Amount in accordance with the rules under the federal No Surprises Act.

Similarly, the amount the Plan will pay the Non-PPO Provider will be based on the lesser of the billed amount or the Qualifying Payment Amount, minus the amount payable by the Eligible Individual. If the Plan and the Non-PPO Provider cannot agree on this amount, it will be resolved by the Independent Dispute Resolution provisions of the federal No Surprises Act.

Other Non-PPO Services Where the Individual Had No Choice

Effective as of September 1, 2022, all of the PPO Provider provisions (including billed amount; co-insurance percentage; crediting deductible, co-insurance, and out-of-pocket maximums; and prohibition against balance billing) will apply, even if the Provider is a Non-PPO Provider, if you receive treatment performed in a PPO facility by a Non-PPO Provider, when you had no choice of provider, such as anesthesiology, radiology, pathology, neo-natal, laboratory, assistant surgeon, and ancillary physician services. This also includes Non-PPO services connected with PPO facility treatment, such as lab work being sent off site from a PPO facility to a Non-PPO lab, or scans or other imaging services being read off site by a Non-PPO radiologist.

Your total cost sharing requirement in these circumstances will be calculated by deeming the total medical bill to be the lesser of the billed amount or the Qualifying Payment Amount, as defined above. The Plan's payment obligation to the Non-PPO Provider is also as defined above.

These special No Surprises Act provisions will not apply, however, if you agree in writing to waive these PPO Provider provisions for the Non-PPO Provider, pursuant to the following rules:

(i) You must be informed of your rights in writing and give a voluntary, informed, written consent to waive these Non-PPO Provider balance billing protections.

(ii) The notice and consent must be provided in a form and manner specified by federal HHS guidance; must include a good faith estimate of the amount the Non-PPO Provider will charge; inform the Eligible Individual that he or she will be subject to the Plan's Non-PPO provisions and may be subject to balance billing; provide a list of PPO Providers at the facility who are able to furnish the items and services involved; and clearly state that consent to receive such items and services from the Non-PPO Provider is optional, and that you may instead seek the item or service from a PPO Provider and pay only PPO rates.

(iii) The notice and consent document must be provided separately from any other documents and not attached to or incorporated into any other document.

(iv) The notice and consent form must be furnished at least 72 hours prior to the date the item or service is to be furnished (in the case where the appointment for such item or service is scheduled at least 72 hours prior to such date), or on the date the appointment for such item or service is scheduled (in the case where the appointment is scheduled within 72 hours of such date). In all events, such notice and consent form must be furnished at least 3 hours prior to providing the item or service in question.

(v) This waiver is not available for items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology

(vi) This waiver is not available for items and services provided by assistant surgeons, hospitalists, and intensivists

(vii) This waiver is not available for diagnostic services, including radiology and laboratory services

(viii) Items and services furnished by a Non-PPO Provider cannot be waived unless there is a PPO Provider available who can provide such item or service at the same facility.

(ix) Items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished cannot be waived.

In addition, effective as of September 1, 2022, all of the PPO Provider provisions (including billed amount; co-insurance percentage; crediting deductible, co-insurance, and out-of-pocket maximums; and prohibition against balance billing) will apply, even if the Provider is a Non-PPO Provider, if you obtain services from an air ambulance provider. Your total cost sharing requirement will be calculated by deeming the total medical bill to be the lesser of the billed amount or the Qualifying Payment Amount, as defined above. The Plan's payment obligation to the Non-PPO Air Ambulance Provider is also as defined above.

A searchable list of PPO Network Providers can be accessed online at the BCBS website – www.bcbsil.com – For even more updated information, call the PPO Network phone number on your ID Card. You should be aware that medical providers are added and deleted from the list regularly, so you should check the lists of network providers immediately PRIOR to you obtaining medical treatment, if possible.

BCBS will update this PPO Provider directory every 90 days . You may also request updated PPO Provider information through a telephone call to the Fund Office or an electronic inquiry to BCBS, and the Fund Office or BCBS will use its reasonable efforts to respond within one business day. Effective as of September 1, 2022, if you reasonably relied on the latest PPO Provider directory information or a direct request to BCBS or the Fund Office that a Provider was a PPO Provider, but it turns out that the information was incorrect and the Provider was not a PPO Provider, your claim will nonetheless be treated as a PPO claim.

Effective as of September 1, 2022, the BCBS website will provide you with access to machine-readable files that contain information on PPO Provider rates and the Fund website will provide you with Non-PPO allowed amounts and billed charges.

Effective as of September 1, 2023, the BCBS website or the Fund website will provide you with price comparison information through an internet-based self-service tool (and in paper, upon request) for the 500 most common items and services, and effective as of September 1, 2024, with respect to all covered items and services. This price comparison tool will enable you to access cost-sharing information based on either billing codes or descriptive terms, for both PPO and Non-PPO Providers. You may also request this information (as of the effective dates stated above) via telephone call to the Fund Office.

If you are receiving services from a PPO Provider and are either (i) being treated for a serious and complex medical condition; (ii) receiving institutional or inpatient care; (iii) scheduled to undergo nonelective surgery (including receipt of post-operative care); (iv) are pregnant and being treated for the pregnancy; or (v) are terminally ill and receiving treatment for such illness, and the PPO contract is terminated with such Provider, you will be notified of such termination and will have the right to elect to continue your care with such Provider, at PPO rates, for up to 90 days (or, if earlier, the date you're no longer receiving such services from such Provider). The Provider cannot balance bill you for such treatment.

Lifetime Limits on Certain Covered Medical Benefits

Maximum Lifetime Benefits per Eligible Individual:

Sleep Apnea Diagnostic Testing	$3,000; must be referred by a Physician unrelated to the sleep center clinic
Hospice Care Charges	$7,500 for Hospice Care Covered Expenses
Bereavement Counseling	100% of Reasonable and Customary Charges up to $25 per session; ($200 aggregate lifetime limit)

Hospice Care Covered Expenses. If an Eligible Individual incurs Hospice Care Covered Expenses, the Fund will, subject to the calendar year Deductible Amount, pay 80% of the Reasonable and Customary Charges, up to a maximum of $7,500 for all Hospice Care Covered Expenses incurred by either the Eligible Individual or the Family Unit before the death of the Terminally Ill Patient. The 80% reimbursement rate applies whether the Hospice Care Covered Expenses are incurred at a facility that is a member of one of the Fund's PPO networks or not. The Fund will also, subject to the calendar year Deductible Amount, pay up to a maximum of $200 for Bereavement Counseling. The guidelines for Hospice Care Covered Expenses are as follows:

1. Confinement of a Terminally Ill Patient as an inpatient. The Plan will not pay for more than a total of 8 days of inpatient respite care.

2. Home Health Care furnished to the Terminally Ill Patient in the patient's home. The Covered Expenses for Home Health Care include the charges for the:

   a. Services of a home health aide;

   b. Professional services of a nurse;

   c. Physical therapy or other therapy;

   d. Nutrition counseling and special meals; and

   e. Medical Support.

3. Medical Social Services furnished to the Terminally Ill Patient or to the Family Unit.

4. Bereavement Counseling furnished to the Family Unit during the Bereavement Period. The Fund will not pay more than $25 for each session of Bereavement Counseling, up to a $200 lifetime maximum.

5. There will be no payment from the Fund if the participant uses a community hospice that does not charge for its services.

6. Hospice Care Benefits will be provided to Medicare eligible Retired Employees and their Medicare eligible Dependents only if Medicare is covering the Hospice stay. Medicare will be primary responsible for the charges for the Hospice stay in such situation and the Fund will supplement 80% of the cost that Medicare does not cover up to a maximum benefit of $7,500.

Hospice Care Definitions. The following definitions apply to Hospice Care Benefits:

1. The term "**Bereavement Counseling**" means counseling by a licensed or certified social worker or licensed pastoral counselor to assist the Family Unit in coping with the death of the Terminally Ill Patient.

2. The term "**Bereavement Period** means the 12-month period that begins on the date of the death of the Terminally Ill Patient.

3. The term "**Covered Expenses**" means, with respect to Hospice Care, only the:

    a. Exclusions and Limitations for Custodial Care do not apply;

    b. Medically Necessary Services include:

        i. Medical Social Services and Bereavement Counseling;

        ii. Palliative Care as well as treatment and diagnosis; and

        iii. Respite Care.

4. The term "**Essential Health Benefits**" means ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drug, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness care and chronic disease management, and pediatric services, as defined under the Affordable Care Act and as reasonably interpreted by the Board of Trustees.

5. The term "**Excepted Benefits**" means those benefits exempt from HIPAA and the Affordable Care Act, such as vision and dental benefits hereunder.

6. The term "**Family Unit**" means each member of the Terminally Ill Patient's family who is eligible for Plan benefits.

7. The term "**Hospice Care**" means care that:

    a. is furnished or arranged by a hospice that is approved by the Fund;

    b. is provided as a part of a coordinated plan of home and inpatient care designed to meet the special needs of the Terminally Ill Patient and the Family Unit due to the terminal illness;

    c. for the Terminally Ill Patient may include:

        i. Medical care;

        ii. Palliative Care;

        iii. Respite Care; and

        iv. Medical Social Services.

8. The term "**Medical Social Services**" means counseling furnished to the Terminally Ill Patient or to the Family Unit to assist each in coping with the dying process of the Terminally Ill Patient. The

counseling may be furnished by a social worker or a pastoral counselor but only if such person is licensed and practicing within the scope of his/her license.

9. The term "**Palliative Care**" means care that is rendered to relieve the symptoms or effects of an illness without curing the illness.

10. The term "**Respite Care**" means care that is furnished to a Terminally Ill Patient so that the Family Unit may have relief from the stress of caring for the Terminally Ill Patient.

11. The term "**Terminally Ill Patient**" means an Eligible Individual whose Physician has certified that the Eligible Individual is terminally ill and expected to live 6 months or less.

Preventive Care Services

Covered Expenses incurred for Preventive Care Services at a PPO Physician's office or PPO facilities will be covered at 100% of the Reasonable and Customary Charges for such services and the Deductible Amount will not apply.

Covered Expenses incurred for Preventive Care Services at a non-PPO Physician's office or non-PPO facility will be subject to the Deductible and then covered at 55% of the Reasonable and Customary Charges for such services.

"Preventive Care Services" include only medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law: (a) evidence-based items or services that have in effect a rating of :"A" or "B" in the current recommendations of the United States Preventive Services Task Force; (b) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; (c) with respect to infants, children and adolescents, evidence- informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and (d) with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. For avoidance of doubt, these services include HRSA required preconception and prenatal care for Dependent children, even though childbirth itself is not covered for non-spousal Dependents. The list of preventive women's health services can be found at www.hrsa.gov /womensguidelines.

Mammography Screening Benefits

Mammography screening benefits that constitute Preventive Care Services will be covered as outlined above under "Preventive Care Services."

Mammography Screening............................	100% of Covered Expenses per Eligible Individual; Overall Plan Deductible Amount is waived. Covered Expenses include (i) a baseline mammogram once between the ages of thirty-five (35) and thirty-nine (39), (ii) one baseline mammogram every calendar year for women age forty (40) and above, and (iii) any other mammogram without regard to age, if: the mammogram is recommended by a Physician; or the Eligible Individual, her mother or sister has had a history of breast cancer.

Prostate Examination Benefits

Prostate Examination benefits that constitute Preventive Care Services will be covered as outlined above under "Preventive Care Services." If you are over the age of forty (40) and you incur Covered Expenses as a result of either a routine digital rectal prostate examination or a prostate-specific antigen ("PSA") blood test, then such expenses will be covered as follows, provided the examination is performed no more often than once each calendar year:

Prostate Examination	Maximum of 100% per Eligible Individual; Overall Plan Deductible Amount is waived

Colonoscopy Coverage

Coverage of colorectal cancer screening tests, also known as a Screening Colonoscopy, including Colonguard, constitute Preventive Care Services and will be covered as outlined above under "Preventive Care Services." In contrast, a Diagnostic Colonoscopy is considered medical treatment (not Preventive Care) and is covered under the regular medical benefits provisions of the Plan and subject to the normal Deductible and Copayment rules.

A Diagnostic Colonoscopy is where you have a past or present history of gastrointestinal symptoms or disease, intestinal bleeding or anemia, polyps or cancer. It also includes procedures after a positive stool test or an abnormal barium enema or colonography. A Screening Colonoscopy, on the other hand, is a routine test provided to you after age 45, no more than once every five years, in the absence of signs or symptoms.

If polyps or lesions are discovered and removed during a Screening Colonoscopy, then the procedure is still considered Preventive Care and will be covered at 100%, with no Deductible, if a PPO Provider is used (regular Deductible and Copayment applies is a non PPO Provider is used).

Effective as of April 1, 2017, the Plan will also cover Virtual Colonoscopies as follows. A Virtual Colonoscopy is a medical imaging procedure which uses x-rays and computers to produce two- and three-dimensional images of the colon from the rectum to the small intestine, and displays them on a screen. It is used to diagnose colon and bowel disease, and is performed via computed tomography (CT) or with magnetic resonance imaging (MRI). The Plan coverage will be as follows:

Virtual Diagnostic Colonoscopy: If you have a past or present history of gastrointestinal symptoms or disease, intestinal bleeding or anemia, polyps or cancer or other testing indicators as referenced above, then the normal Medical Plan rules for PPO and non PPO coverage will apply to the Colonoscopy. If lesions or

polys are found in the Virtual Diagnostic Colonoscopy and the Physician has to perform a separate procedure to remove the same, this will be covered in the same way as other medical procedures under the Plan, and will be subject to the Plan's normal cost-sharing rules.

Virtual Screening Colonoscopy: If you undergo a Virtual Colonoscopy after age 45, no more than once every five years, in the absence of any signs or symptoms, the Plan will consider this a Preventive Care service and it will be covered as outlined above under "Preventive Care Services." If lesions or polyps are found in the Virtual Screening Colonoscopy, and the Physician has to perform a separate procedure to remove the lesions or polyps, this will also be covered as Preventive Care as long as such procedure is performed within one year of the discovery of the lesions or polyps by the Virtual Screening Colonoscopy. A procedure performed after this one year limit will be subject to the normal Plan rules for Medical (versus Preventive) Care.

Other Plan Benefits Limited by Time Period

Hearing Aids	Maximum of $2500 per hearing aid; limited to 2 hearing aids per Eligible Individual in a 5-calendar-year period after the Overall Plan Deductible Amount
Chiropractic and/or Acupuncture Care	Maximum of 52 treatments or visits per Eligible Individual per calendar year after the Overall Plan Deductible Amount

Supplemental Accident Benefits

Supplemental Accident	If an Active Employee or his Dependent sustains an accidental injury while covered under the Plan, the Plan will pay 100% of the first $300 for Reasonable and Customary Charges actually incurred per Eligible Individual per occurrence provided charges for the treatment are incurred within 90 days from the date of the accidental injury. No Deductible Amount or Coinsurance will apply to this benefit. Professional medical treatment as used herein will mean only: (i) medical or surgical treatment by a Physician, (ii) room and board and other necessary services furnished and billed by a Hospital, excepting personal services such as charges for television, telephone and the like, (iii) services of a Registered Nurse for private duty nursing, (iv) laboratory and X-ray examinations, (v) local ground and air ambulance service, (vi) prescription drugs, (vii) surgical dressings, casts, splints, trusses, braces and crutches, and (viii) treatment by a dentist, Physician or dental surgeon of a fractured jaw or injuries to natural teeth, including their replacement.

Eligible Employees and Their Dependents Who Are Eligible for Medicare

If an Eligible Individual who is eligible for Medicare receives Medically Necessary treatment by a Physician or covered facility for a non-occupational bodily injury or sickness, the Plan will, subject to the limitations and conditions herein, pay the following benefits. Benefits will be reduced, if necessary, so that

the sum of benefits under the Plan and Medicare won't exceed the benefits that would have been payable under the Plan in the absence of Medicare. In determining benefits payable under Medicare, all benefits to which you're entitled under Medicare will be included, whether or not you've registered for Part A or enrolled in Part B of Medicare (or Medicare + Choice). Medicare is always primary, unless otherwise required by law.

Medicare Supplement Benefits for Retired Employees and Dependents Age 65 and Over

Hospital Deductible	100% of Medicare Part A eligible deductible expenses up to 365 days. Only deductibles are covered; no other benefits will be paid.
Skilled Nursing Facility	100% of the Medicare deductible for days 21-100 of confinement will be paid, but no other benefits will be paid.
Physician Fees	20% of Medicare allowable Charges, except for any expense covered by Medicare after the Eligible Individual or Covered Person satisfies the Medicare Part B calendar year deductible. If the medical service is not covered by Medicare, then this Plan does not cover the outpatient medical treatment, office visit, lab, physician's fees, etc. If the medical service is allowed by Medicare, then the Plan will cover 20% of the Medicare allowable, subject to the above limitations.
In-Hospital Nursing	70%; 3 shifts per day; 30 days per calendar year (after you satisfy the Medicare Part B calendar year deductible).
Blood	after you satisfy the deductible, 20% of Reasonable and Customary Charges after the first 3 pints.
Prescription Drugs	Medicare Part D Employer Group Wrap Plan ("EGWP") administered by United Healthcare and Sav-Rx (you will be **ineligible** for prescription coverage under the Fund if you opt out of the Plan's Part D coverage or if you enroll in any other coverage, including an individual Medicare Part D prescription drug plan).

Mental Health and Substance Abuse Benefits

The Fund has an administrative services contract with Blue Cross Blue Shield to provide referrals and treatment for inpatient and/or outpatient mental health and substance abuse. Referrals and benefits are also provided for stress-related problems and smoking cessation (up to four counseling sessions for smoking cessation, to be treated as Preventive Care).

Whenever you or one of your Dependents is in need of inpatient or outpatient care and/or treatment as a result of one of the situations mentioned above, you should contact Blue Cross Blue Shield at (800) 851-7498 or www.bcbsil.com. A Blue Cross Blue Shield representative will refer you to one of its providers.

To the fullest extent permitted by the Mental Health Parity Act, a Blue Cross Blue Shield representative must also pre-certify all inpatient (acute and rehab) mental health and substance abuse services, including services at residential treatment centers. In addition, the following outpatient mental health and substance abuse services require precertification by Blue Cross Blue Shield: Outpatient Electroconvulsive Therapy; Intensive Outpatient Programs; Repetitive Transcranial Magnetic Stimulation; Partial Hospitalization; and Psychological and Neuro Psychological testing.. Failure to pre-certify results in a 50% reduction in benefits, up to a maximum $250 penalty (or per BCBS provider sanction). Applied Behavior Analysis (ABA) for Autism Spectrum Disorder Diagnosis will be covered, subject to the standard medical necessity review, including reviewing the relevant medical records and treatment plan.

Covered mental health and substance abuse services are subject to the same overall combined deductibles and coinsurance rates and out-of-pocket maximum that apply to the Fund's comprehensive medical benefits. There are no stand-alone separate deductibles, coinsurance or maximum out-of-pocket limits for mental health and substance abuse benefits. This means that the same $400 individual (and $800 family) deductible applies to covered mental health and substance abuse benefits as also applies to comprehensive medical benefits. In addition, in-patient mental health and substance abuse benefits are subject to the Fund's $200 non-PPO hospital deductible. After meeting applicable deductibles, just like comprehensive medical benefits, PPO services will be covered at the 80% coinsurance rate, up to the annual combined Major Medical / Mental Health out-of-pocket maximum of $4,400 individual and $8,800 family (including deductible), after which in-network care is paid at 100%. Non-PPO services will always be covered at the 55% of reasonable and customary cost coinsurance rate; there is no out-of-pocket maximum. "Reasonable and Customary" for Non-PPO facilities is capped at 200% of the Medicare allowable. You are also responsible for any charges over the reasonable and customary limit.

In addition to the general limitations on covered services discussed in this SPD, the following mental health and substance abuse benefits are **NOT** covered by the Fund:

1. Lifestyle and well-being programs that are primarily educational (e.g., stress management, weight control, marriage enrichment, smoking cessation, diet programs, financial counseling, vocational counseling, wellness programs) (some of these items may be covered under Preventive Care Services).

2. Services for primary V code conditions as listed in the Diagnostic and Statistical Manual- 4th Revision or its successor.

3. Custodial care or rest cures.

4. Treatment initiated primarily as the result of criminal behavior, or court-ordered treatment that is not determined by the Fund or its delegate to be Medically Necessary.

5. Any diagnostic category that is primarily physically based, including, but not limited to, the following: delirium, dementia, and amnesic and other cognitive disorders; learning disorders; mental retardation; dyslexia; oppositional defiant disruptive disorders; conduct disorders; and chronic pain disorders.

6. Services rendered on an experimental or research basis and not recognized by AMA as a general accepted medical practice.

7. Disability and workers' compensation cases.

8. Light therapy; biofeedback therapy.

9. Sleeping disorders.

10. Therapy related to sex change or transformations.

11. Medical-surgical care, including without limitation: (i) provided outside of a recognized alcoholism, other drug abuse, or psychiatric unit, or (ii) for medical conditions related to alcoholism, other drug abuse, or mental illness (e.g., medical intervention as the result of an attempted suicide).

12. Treatment that is not expected to materially improve the patient's condition or symptoms, including intractable personality disorders.

Dental Benefits

See below for a description of dental benefits offered under the Fund.

Vision Benefits

See below for a description of vision benefits offered under the Fund.

Teladoc

You have access to board certified doctors, by phone, on-line video, or mobile app, 24 hours /day, 7 days/week through Teladoc. Just call 1-800-835-2362. Or go on-line at Teladoc.com or Teladoc.com/Mobile. Consultations are free.

You can either obtain an immediate on-demand consult 24/7, or you can choose to pre-schedule a consult between 7:00 A.M. - 9 P.M., 7 days a week. A Teladoc physician can diagnose, recommend treatment, and prescribe medication for many medical issues. They can also interact with your primary care physician. Teladoc should not be used for emergency issues.

You must enroll with Teladoc in order to use this program. Go to www.teladoc.com or call 1-800-835-2362 to enroll.

Outpatient Medical Benefits Requiring Precertification

- **Coordinated Home Care (including nurse, social worker, physical therapy, occupational therapy, and speech therapy and private duty nursing)**
- **Select High-Cost Specialty Drugs managed through the Medical Benefit (SRU Drugs)**
- **Air Ambulance, fixed-wing, unless emergency services is needed**
- **Home Health Hospice Care**

- **Home Hemodialysis**
- **Home Infusion Therapy**
- **Lipid Apheresis**
- **Outpatient Surgical Procedures on Orthognathic surgery (Oral / Maxillofacial surgery); Mastopexy (Breast Lift); and Reduction Mammoplasty (Breast Reduction)**
- **Outpatient Gastroenterology, including Gastric Electrical Stimulation**
- **Outpatient Wound Care Services, including Hyperbaric Oxygen (HBO2) Therapy**
- **Outpatient Neurology Services, including Sacral Nerve Stimulation; Vagus Nerve Stimulation; and Deep Brain Stimulation**
- **Outpatient Transplant Evaluations and Transplants**
- **Ear, Nose & Throat Services (including Cochlear Implant; Bone Conduction Hearing Aids; and Nasal and Sinus Surgery)**
- **Surgical Deactivation of Headache Trigger sites**
- **Orthopedic Stem-Cell Therapy**
- **Functional Neuromuscular Electrical Stimulation**

BENEFIT PAYMENT EXAMPLE

Surgical Admission assuming Hospital charges of $16,000
and Physicians charges of $3,000

HOSPITAL CHARGES

	In-Network	Out-of-Network
Original Bill	$16,000	$16,000
Repriced Bill	$13,000	(N/A) $16,000
Reasonable and Customary Charges	(N/A) $13,000	$13,000
Calendar Year Deductible	$ 400	$ 400
Hospital Deductible	(N/A) $ 0	$ 200
Reimbursement	80%	55%
Total Plan Payment	$10,080	$ 6,820
Your Payments		
Deductibles	$ 400	$ 600
Coinsurance	$ 2,520	$ 5,580
Charges in excess of Reasonable & Customary	(N/A) $ 0	$ 3,000
Total	$ 2,920	$ 9,180

PHYSICIANS CHARGES

	In-Network	Out-of-Network
Original Bill	$3,000	$ 3,000
Repriced Bill	$2,400	(N/A) $ 3,000
Reasonable and Customary Charges	(N/A) $2,400	$ 2,400
Calendar Year Deductible	(paid above)	(paid above)
Reimbursement by Plan	$1,920	$ 1,320
Your Payment	$ 480	$ 1,680
Your Total Payments (Hospital and Physician Charges	$3,400*	$10,860

The above example assumes a 18.75% discount on the Hospital and Physician bills negotiated through the PPO organization. This amount may differ from time to time based on the actual surgical procedure and the number of days spent in the Hospital.

As you can see, you and the Fund both share significantly in the benefit from the use of PPO providers. In addition, if you utilize the Plan's PPO providers you will not be responsible for the difference between what the Physician charges and the Plan's allowable amount. Please use the Plan's PPO networks when and where they are available to you.

*Please note that for In-Network charges for Major Medical / Mental Health Essential Health Benefits, the maximum out-of-pocket charges that you are responsible for is $4,400 (including the calendar year Deductible Amount). Once you reach the out-of-pocket limit of $4,400, then the Fund will pay 100% of any remaining in-network charges for Major Medical / Mental Health Essential Health Benefits. There is no out of pocket limit for Out-of-Network charges or charges for non-Essential Health Benefits.

COMPREHENSIVE MEDICAL BENEFITS

FREQUENTLY USED TERMS

The following are definitions to some frequently used terms in connection with the medical benefits offered under the Plan.

1. The term "**Ambulatory Surgical Facility**" means a permanent public or private facility which:

    a. Has an organized staff of Physicians;

    b. Is equipped and operated mainly for the purpose of performing surgery;

    c. Has continuous service of Physicians and nurses whenever a patient is in the facility; and

    d. Does not provide services or other accommodations for patients to stay overnight.

2. The term "**Eligible Individual**" means an individual who is eligible for benefits under the Fund.

3. The term "**Hospital**" means a legally operated institution that meets either of these tests:

    a. Is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Healthcare Organizations, or

    b. Is supervised by a staff of Physicians, has 24-hour-a-day nursing service and is primarily engaged in providing either:

        i. General inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control; or

        ii. Specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, or under its control, or through a written agreement with a specialized provider of these facilities.

    c. In no event will the term "Hospital" include a nursing home or institution or part of one which:

        (i) is primarily a facility for convalescence, nursing, rest, or the aged;

        (ii) furnishes primarily domiciliary or custodial care, including training in daily living routines;

        (iii) is operated primarily as a school; or

        (iv) primarily provides care for drug addicts or alcoholics.

4. The term "**Intensive/Cardiac/Neonatal Care Unit**" means a unit or part of a Hospital separate from normal Hospital room and board accommodations that:

    a. is reserved exclusively for the temporary intensive care (other than normal care for post-operative patients) of critically ill patients who are under continual supervision or

observation of Physicians and/or specially trained registered graduate nurses on a 24-hour basis, and

b. within such unit or part there is maintained the necessary equipment, drugs and supplies for such care of critically ill patients.

5. The term "**Medically Necessary**" means services or supplies which, as determined in the sole direction of the Board of Trustees or its delegate, are:

a. provided for the diagnosis or treatment of a medical condition;

b. proper for the symptoms, diagnosis or treatment of a medical condition;

c. performed in the proper setting or manner required for a medical condition; and

d. within the standards of generally accepted health care practice.

6. The term "**Physician**" means:

a. legally licensed doctor of medicine ("M.D."), doctor of osteopathy ("D.O."), dentist, podiatrist, chiropractor, or ophthalmologist acting within the scope of his practice.

b. Any other legally licensed practitioner of the healing arts who renders services within the scope of his or her license and is determined to qualify as a "Physician" by the Board or its designee.

c. This term does not include a resident physician; an intern; or a person in training.

The Plan shall not discriminate with respect to participation under the Plan or coverage against any healthcare provider acting within the scope of his or her license or certification under applicable state law.

BENEFITS

The Plan offers a preferred provider organization (PPO) to you and your dependents whenever you need medical care. A PPO is a network of Hospitals, Physicians, labs, and pharmacies. When you use a provider that is a part of the network, you get a higher level of benefits than you would by going to a provider outside of the network. In addition, by utilizing network providers, you have access to the reduced fees that your respective network has negotiated. Thus, you not only receive a higher benefit percentage, but the covered charges themselves should be reduced. It is your responsibility to make sure that a provider or facility is currently in the network.

MATERNITY BENEFITS

If an Eligible Individual (other than a Dependent child) incurs Covered Expenses as a result of pregnancy, childbirth or related medical conditions while covered hereunder, the Plan will pay benefits in accordance with the Plan's general benefit rules, including Covered Expenses for the Hospital's routine nursery and the pediatrician's Hospital Covered Expenses. However, no benefits will be payable in connection with a surrogate pregnancy. In addition, the Plan does not cover expenses related to an elective abortion, except as follows:

1. The mother's life would be endangered if the fetus were carried to term.

2. Medical complications arise from an abortion.

3. The mother's mental and emotional health would be seriously threatened as a result of delivering and caring for a severely physically handicapped or retarded infant, provided test confirm the condition of the fetus.

4. A viable birth is not probable.

The separate Deductible Amount for the child will be waived for Covered Expenses incurred during the time of birth for a well newborn. However, any Covered Expenses incurred after the date of the newborn's discharge will be subject to all applicable Plan Deductibles.

Except as required by law (such as certain prenatal care that qualifies as Preventive Services), no benefits will be payable for the pregnancy of a Dependent child other than as a result of Complications of Pregnancy as that term is defined by the Plan.

The Plan does not pay for expenses related to the maternity care and delivery expenses associated with a pregnant Dependent Child. The exclusion of maternity care for a pregnant Dependent Child does not apply to the extent the expenses qualify as prenatal and postnatal office visits or Health Reform mandated services, but the exclusion does apply to maternity services that are not office visits and not mandated such as ultrasounds and delivery expenses.

Certain prenatal care/maternity related preventive care expenses are payable for all females (as listed on the government websites at http://www.hrsa.gov/womengudelines/ or http://www.healthcre.gov/law/about/provisions/services/lists.html including but not limited to routine prenatal obstetrical office visits, screening for gestational diabetes, HPV testing staring at age 30, rental of breastfeeding equipment and necessary supplies after delivery, and in conjunction with birth, coverage for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period. These services are covered without cost sharing for a female when obtained from in-network providers.

Prenatal services not covered under the women's preventive/wellness coverage include, but are not limited to lab & radiology services, delivery and high-risk prenatal services. While obstetrical ultra sounds may be part of routine prenatal care, they are not included under the health reform law and a Copayment, Coinsurance of deductible may apply for these services. For all females, prenatal and postnatal visits obtained from an in-network provider are payable at no cost to you. Normal plan cost-sharing still applies to all other maternity related services including ultrasounds and delivery fees.

Pregnancy-related care is covered for a female Employee, Retiree, and Spouse only. No coverage is provided for certain maternity or delivery expenses of Dependent Children. This exclusion of maternity care for pregnant Dependent Child does not apply to prenatal and postnatal care office visits and certain other preventive screening services mandated by health reform such as breast pump and supplies needed to operate the pump and lactation counseling. No coverage for ultrasounds and other pregnancy related services or delivery expenses for the pregnant Dependent Child and their baby.

ORGAN OR TISSUE TRANSPLANT BENEFITS

The Plan covers eligible services directly related to non-experimental transplants of Human organs or tissue including bone marrow, stem cells, cornea, heart, intestine, islet tissue, kidney, liver,

lung(s), pancreas, bone, tendons or skin, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.

Organ/tissue Procurement is payable to a maximum of $50,000 per patient per transplant. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. Transport fees are only payable when the organ/tissue is transported within the United States or Canada.

The Plan covers reasonable and necessary medical expenses a donor incurs (when the Plan also covers the recipient), which are payable without any Deductibles and Coinsurance applicable to those expenses.

Reasonable and necessary medical expenses incurred by a donor who is not covered by this Plan, are payable without any Deductibles and Coinsurance applicable to those expenses, but only to the extent the donor is not covered by the donor's own insurance or health care plan; and further, charges that exceed the donor's insurance coverage will be covered by this plan without any Deductibles or Coinsurance applicable to those expenses.

Transplant services including pre-transplant workup tests are subject to precertification by the Fund's Utilization Review firm.

Benefits are payable only if services are provided in a PPO Hospital or Health Care Facility and the participant uses Blue Cross Blue Shield Case Management.

TRANSPLANT RELATED TRAVEL BENEFIT

The Plan will pay transplant-related travel benefits when the Fund's Utilization Review firm approves them. The Maximum Plan Benefit for transplant related travel expenses, including transportation, lodging and meals for the patient and one family member or companion is $10,000 per transplant. Reimbursement is available (at 100%) for round trip "coach" airfare, car rental and up to a maximum of $250 per day for lodging and meals received during the pre-operative work-up, transplant operation and post-transplant treatment phases. Receipts are required when submitting lodging, meals and travel expenses for payment consideration. This travel benefit is available only when the transplant occurs in a contracted network facility (PPO facility). The following expenses are not covered: telephone calls, personal care items such as shampoo, entertainment expenses, alcohol/tobacco, souvenirs and expenses for persons other than the patient and his or her designated family member or companion.

See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions section of the SPD below. The Fund does not cover donor expenses unless the person who receives the donated organ/tissue is covered by this Plan.

TRANSPLANT (ORGAN AND TISSUE) EXCLUSIONS

The Plan does not cover expenses for Human organ, tissue transplants, or both, that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs/medicines and all complications thereof. The Plan covers only those transplant services described above.

The Plan does not cover:

1. Expenses related to non-Human (Xenografted) services, except heart valves.

2. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except heart valves, kidney dialysis , and a ventricular assist device (VAD) (that is a mechanical pump used to assist a damaged or weakened heart in pumping blood) only when used as a bridge to a heart transplant or for support of blood circulation post-cardiotomy (following open-heart surgery) or for destination therapy (permanent mechanical cardiac support only if there is approval from the FDA for that purpose, and the device is used according to the FDA- approved labeling instructions).

3. Donor expenses, unless the Plan covers the person who receives the donated organ/tissue.

ORGAN AND TISSUE TRANSPLANT DEFINITIONS

The term "**Transplant**" *or* "**Transplantation**" means the transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

The term "**Xenographic**" *or* "**Xenotransplant**" refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human).

EXTENDED BENEFITS

If an Active Employee or his Dependent is Totally Disabled (as defined below) on the date his coverage terminates, benefits are extended to apply to Covered Expenses incurred after termination for continued treatment of the injury or sickness causing such total disability, but in no case will benefits be payable for expenses incurred after recovery from total disability or more than twelve (12) months following the date coverage terminates, whichever occurs first. This extension of benefits will cease to apply on the date the Eligible Individual becomes covered under any other group plan.

Exception. This extension is not applicable to a Total Disability caused by pregnancy or resulting childbirth, miscarriage or abortion, except in connection with:

1. surgical operations for extra-uterine pregnancy or in connection with inter-abdominal surgery;

2. pernicious vomiting; and

3. toxemia with convulsions.

For the purpose of this subsection, an Active Employee will be deemed to be "Totally Disabled" if he is prevented by sickness or injury from performing any and all of the usual duties of his occupation. A Dependent will be deemed to be Totally Disabled if he or she is prevented by sickness or injury from engaging in any and all of his or her usual activities.

COMPREHENSIVE MEDICAL BENEFITS COVERED EXPENSES

Subject to the maximums, restrictions, limitations, and conditions specified herein, the Plan provides benefits only for "**Covered Expenses**." Covered Expenses only include charges for the following Medically Necessary services and supplies performed or provided by a Physician, Hospital, intensive/cardiac/neonatal care unit, or Ambulatory Surgical Facility that are certified by the attending Physician to be necessary for treatment of a non-occupational injury or illness, to the extent that the charges do not exceed Reasonable and Customary Charges generally made in the same locality under similar conditions. Items included under Limitations and Exclusions, below, are not considered Covered Expenses. When two (2) or more alternative courses of treatment are available and medically appropriate to the illness or injury, Covered Expenses are limited to those for the least expensive course of treatment.

A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made, is rendered or obtained.

COVERED HOSPITAL EXPENSES

Subject to the Deductible Amounts, room and board Covered Expenses made by a Hospital (excluding that part of the Hospital's charge for a private room in excess of the Hospital's average charge for semi- private room accommodations; in the event the Hospital does not have semi-private room accommodations, 90% of the private room rate will be recognized).

Covered Expenses for other Hospital services and supplies necessary for treatment of injury or sickness furnished during a Hospital stay resulting in a room and board charge, or emergency treatment of an accidental bodily injury or a surgical operation requiring Hospital facilities even though no room and board charge is incurred. Newborn nursery charges are also included.

90% of Covered Expenses for charges for pre-admission X-rays and laboratory tests in the Hospital's outpatient department will be covered, provided that a scheduled confinement starts within 14 days following administration of such tests. Benefits will still be payable at 90%, provided the admission is postponed or canceled for one or more of the following reasons:

- The test shows the condition requires medical treatment prior to admission.
- A medical condition develops that delays the admission.
- A Hospital bed is not available on the scheduled date of admission.
- The test indicates that, contrary to the attending Physician's expectation, the admission is not necessary.

If you receive care in an Intensive/Cardiac/Neonatal Care Unit, the full cost of care in such unit will be considered a Covered Hospital Expense.

OTHER COVERED EXPENSES

1. Physicians', Physician's Assistants', or nurse practitioners' Covered Expenses for medical or surgical services. The term "Physician's Assistant" means a licensed professional who has received specialized training to perform certain tasks usually performed by a Physician, and who is under the direction of a supervising Physician. However, assistant surgeon charges are only covered if:

a. the assistant surgeon is needed for a covered surgical or obstetrical service; and

b. the assistant surgeon's duties are not routinely available from a Hospital intern, resident, Physician's Assistant, or full-time salaried Physician.

2. Covered Expenses for private duty nursing services rendered by a Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Licensed Practical Nurse (LPN), but only including those services which require the skills, training, and knowledge of a licensed nurse.

3. Speech therapy by a qualified speech therapist to restore speech loss, or correct impairment, due to (1) a congenital defect for which corrective surgery has been performed, or (2) an injury or sickness.

4. Treatment by a nurse practitioner.

5. Treatment by a physiotherapist.

6. Transportation by ground ambulance or commercial air to and from the nearest facility able to provide necessary medical treatment when prescribed by a Physician. Air ambulance will be provided only when required by the attending Physician.

7. Anesthetics and their administration.

8. X-ray and laboratory examinations.

9. X-ray and radium treatments and treatments with other radioactive substances.

10. Blood and blood plasma.

11. Oxygen and rental of equipment for administration of oxygen (letter of medical necessity not required).

12. Durable Medical Equipment, including rental of a wheel chair, hospital-type bed or other durable equipment used exclusively for treatment of injury or sickness, provided that the Physician certifies in writing its Medical Necessity. Such certification is not an automatic approval, however, and is still subject to all the requirements hereof.

    The term "Durable Medical Equipment" means equipment that can withstand repeated use; is primarily and customarily used for a medical purpose; is not generally useful in the absence of an injury or sickness; is not disposable or non-durable; and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, electric hospital beds with safety rails, and electric and manual wheelchairs. Letter of medical necessity is not required for apnea monitors, blood sugar monitors, nebulizers, oximeters, oxygen and supplies, and ventilators.

    Durable Medical Equipment, such as that listed in this paragraph, must be the least expensive of appropriate treatment or equipment. If rental of the equipment is for an extended period of time, Covered Expenses will be the lesser of the Reasonable and Customary Charges for the purchase or the anticipated rental cost.

13. Casts, splints, trusses, braces, crutches, surgical dressings and electronic pacemakers (letter of medical necessity not required).

14. Artificial limbs, eyes and larynx. Covered Expenses for an eligible prosthesis will be covered for the initial purchase. Covered Expenses for replacements thereof will be covered by the Plan if such replacement is determined to be necessary by a qualified medical consultant selected by the Board of Trustees. The term "prosthesis" means an artificial device to replace a missing part of the body.

15. Covered Expenses incurred in connection with the purchase of hearing aids, fittings and repairs and replacements, not to exceed a total payment in five (5) years of five thousand dollars ($,5000) for two (2) hearing aids or two thousand five hundred dollars ($2,500) for one. The total payment for each hearing aid during such five (5) year period is limited to five thousand dollars ($5,000) after the overall deductible is met.

16. Immunizations given because of exposure to an illness of a life-threatening nature.

17. Sleep disorder studies, up to a lifetime maximum of $3,000, but only if referred by a Physician not related to the sleep center clinic.

18. One-hundred percent (100%) of Covered Expenses for a second surgical opinion, after the Deductible Amount has been satisfied.

19. Covered Expenses for claims that have been denied by a workers' compensation court or an administrative judge, provided that the individual signs a subrogation/reimbursement agreement with terms acceptable to the Fund whereby he or she agrees to reimburse the Fund from any settlement or recovery he or she may obtain in connection with such claims.

20. Diabetes self-management training is covered upon any of the following occurrences:

    a. The initial diagnosis of diabetes.

    b. A significant change in symptoms or condition that requires changes in the Eligible Individual's self-management regime, as diagnosed by a Physician.

    c. The prescription of periodic or episodic continuing education as warranted by the development of new techniques and treatment for diabetes.

    d. The need for a caretaker or a change in caretakers for the person with diabetes necessitates diabetes management training for the caretaker.

21. Self-injectables that are properly precertified, including, but not limited to Imitrex, Lovenox, Insulin, Glucagon, and Bee Sting Kits, will be covered by the Plan's Prescription Drug Program; provided that such treatments are subject to all of the limitations and exclusions that apply to the Plan's comprehensive medical benefits as described above under the heading COMPREHENSIVE MEDICAL BENEFITS and elsewhere in this SPD.

22. Extraction of impacted wisdom teeth if performed by a licensed oral surgeon and other medically necessary surgery to the jaw. Treatment related to the temporomandibular joint is not a Covered Expense, and that includes mouth guards. The Fund will cover surgery to the jaw if it is determined to be medically necessary by the Fund's Medical Consultants.

23. Charges for birth control pills, contraceptive devices, drugs, or implants, are covered at 100% if obtained and approval is gained from Sav-Rx through their prior authorization process. Medical charges connected with placement or removal of IUD devices will be covered at 100% if performed

by a PPO Provider. Medical charges connected with placement or removal of an IUD devise are not covered if performed by a non-PPO provider.

24. Charges for surgical sterilization (i.e., vasectomy or tubal ligation).

25. Routine patient costs for items and services furnished in connection with participation in an approved clinical trial, but only to the extent that those same items and services would be covered under this Plan to patients not participating in a trial.

26. Breast pumps, up to a maximum of $300, but only if referred by a Physician.

27. Gene Therapy, using human DNA to treat or prevent genetic disease in humans, such as by replacing a gene that causes a medical problem with one that does not; adding genes to help the body fight or treat disease; or inactivating genes that cause medical problems. The new DNA usually contains a functioning gene to correct the effects of a disease-causing mutation. The technique allows doctors to treat a disorder by inserting a gene into an individual's cells instead of using drugs or surgery. All gene therapy must be pre-certified. The therapy must have received approval from the U.S. Food and Drug Administration, and must not be considered experimental or investigative. Non-human gene therapy is not covered.

COMPREHENSIVE MEDICAL BENEFITS LIMITATIONS AND EXCLUSIONS

Benefits will not be payable under the Plan for:

1. Services, supplies and treatment unless prescribed as necessary by a Physician.

2. Except as may be provided by a separate arrangement for dental benefits from time to time, services, supplies or appliances provided in connection with treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat:

   a. The jaw, and jaw implant or the joint of the jaw (the temporomandibular joint);

   b. The teeth;

   c. The gums and tissues around the teeth;

   d. The parts of the upper or lower jaw which contain the teeth (the alveolar process and ridges);

   e. The meeting of upper and lower teeth; or

   f. The chewing muscles.

   These services, supplies or appliances are not covered even if they are:

   (i) needed because of symptoms, sicknesses or injuries which affect some other part or parts of the body; or

   (ii) provided in connection with any examination or treatment of the teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

However, the following will be covered if they are otherwise Covered Expenses:

A. Services, supplies or appliances needed to correct damage caused by an accident, provided the treatment is begun within six (6) months of the accident;

B. Hospital room and board and other Hospital services while the Eligible Individual is confined;

C. Treatment of tumors; and

D. Treatment of cysts which do not result from infection of the teeth or gums.

E. Medically necessary surgery to the jaw that is not related to the temporomandibular joint.

3. Expenses in connection with cosmetic surgery, except to the extent necessary to repair disfigurement due to an accidental injury. However, in the case of a participant or beneficiary who is receiving, benefits under the Plan in connection with a mastectomy and who elects breast reconstruction coverage will be provided in a manner determined in consultation with the attending Physician and the patient for the following:

   a. Reconstruction of the breast on which the mastectomy was performed;

   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

   c. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

   Coverage of breast reconstruction benefits is subject to the Deductible Amount and coinsurance limitations consistent with those established for other benefits under the Plan.

4. Except as otherwise provided in the Plan, expenses incurred in connection with routine physical examinations and normal eye and ear examinations, including services for eye refraction, the fitting of glasses, and contact lenses, or other charges associated therewith, except to the extent covered under "Vision Benefits," and except for the first pair of contact lens prescribed after cataract surgery.

5. Expenses in connection with sickness for which benefits are provided under any workers' compensation act or similar law, or in connection with any occupational injury or sickness.

6. Charges for services or supplies for which no charge is made or for which the Eligible Individual is not legally required to pay or is not billed (or wouldn't have been billed but for coverage hereunder), or for which any part of the cost sharing is reduced, waived or not collected. For example, if a provider waives or otherwise fails or refuses to bill or collect all or any part of the deductible or coinsurance for a medical service, then charges associated with that service are not covered hereunder. The Plan Administration has the right to require proof that you've paid your out-of-pocket costs, before any related charges will be paid hereunder. In addition, benefits are also not payable for charges for services or supplies received from or in facilities owned or operated by the United States government, or rendered in any facility for care, treatment or services for which you are not normally required to pay, or furnished by/or payable under any plan or law of any government, unless the Eligible Individual is legally required to pay for such charges in the absence

of the benefits provided by this Plan. However, benefits will be payable for Reasonable and Customary Charges covered under this Plan which were incurred by:

a. An Eligible Individual at a Veteran's Administration facility; or

b. An employee, as an armed service retiree, or his Dependent, for services or supplies which are not related to military service.

7. Treatment of injury or sickness which is occasioned by war, declared or undeclared.

8. Nursing, speech therapy, or physiotherapy rendered by an Active Employee (or former Active Employee), his spouse, or a child, brother, sister or parent of the Active Employee (or former Active Employee) or his spouse.

9. Charges which have been paid under the Supplemental Accident Expense Benefit.

10. Charges that are covered under a prior plan's extension of coverage provisions.

11. Expenses in connection with obesity unless the condition is diagnosed as exogenous and:

(i) The claimant is fifty percent (50%) or more over his medically desired weight, and

(ii) The obesity is a threat to the claimant's life due to other complicating health factors, and

(iii) The claimant has a medical history of unsuccessful attempts to reduce weight by more conservative measures; or

(iv) The expense qualifies as a Preventive Care Service.

12. Expense in excess of fifty-two (52) chiropractic and/or acupuncture treatments or visits in a calendar year.

13. Any surgical procedure for the correction of visual refractive problems, including radial keratotomy, PRK, LASIK and similar procedures.

14. Charges for the treatment of non-accidental, self-inflicted injury or illness or attempted suicide, unless such injuries result from an act of domestic violence or a medical condition (e.g., depression).

15. Charges relating to transgender or transsexual procedures or treatments, gender identity disorder, hormone replacement treatment, or treatment to alter physical characteristics to those of the opposite sex.

16. Charges for achieving or inducing pregnancy by any method or for otherwise treating infertility, including, without limitation, in vitro fertilization, fertility drugs, GIFT procedures, artificial insemination, or treatment to reverse a sterilization procedure.

17. Charges for pregnancy, childbirth, or related medical conditions for any Dependent other than the employee's spouse (other than what may be covered under Maternity Services).

18. Charges for abortion, except as expressly provided for in the Plan.

19. Charges relating to surrogate pregnancy and childbirth, including the entire process of obtaining, carrying and delivering a child for another person. This includes, without limitation, a woman who, through in vitro fertilization or any other means, becomes pregnant with and/or gives birth to a child which she may or may not have a genetic relationship to, or an individual who provides a uterus for the gestation of a fertilized ovum obtained from a donor, in each case where the child will be parented by someone other than the birth mother.

20. Charges for injury or illness resulting from participation in, or in consequence of having participated in, the commission of an assault or a felony.

21. Charges which are reported to the Fund or its agent more than twelve (12) months after the date the charges were incurred, or charges relating to subrogation where the Covered Individual has not signed the Fund's Reimbursement Agreement within twelve (12) months after it is sent to him / her.

22. Except to extent covered under Preventive Care Services or the prescription drug card program, if at all, charges for vitamins and nutritional supplements.

23. Charges for (a) medications that can be purchased without a prescription, other than insulin or what may be covered under Preventive Services, or (b) for drugs prescribed for purposes not consistent with generally accepted medical practices.

24. Charges for a site where care is provided where the site is not Medically Necessary.

25. Charges for services, supplies, treatments, or procedures that are not Medically Necessary or appropriate (including any service, supply, treatment, or procedure not approved for reimbursement by the Center for Medicare and Medicaid Services), or which are not in accordance with generally accepted principles of medical practice in the United States at the time furnished, as determined by the Board or its agent in its sole and absolute discretion and authority. The Board or its agent will have complete fiduciary discretion and authority to establish and apply its own standards and criteria to make determinations under this paragraph and to enforce the same in deciding benefits hereunder.

26. Charges for services, supplies, treatments, or procedures that are experimental or unproven (including any practice which is not approved by Medicare), investigative, educational, or furnished in connection with medical or other research, as determined by the Board or its agent in its sole and absolute discretion and authority. The Board or its agent will have complete fiduciary discretion and authority to establish and apply its own standards and criteria to make determinations under this paragraph and to enforce the same in deciding benefits hereunder.

27. Charges for behavioral modification, marriage, job, education, religious or sex counseling.

28. Charges for services ordered by a court which are not otherwise covered.

29. Charges for custodial care, regardless of who prescribes or renders such care.

30. Expenses paid for as a part of a legal settlement or judgment.

31. Expenses that exceed Reasonable and Customary Charges for the services or supplies provided.

32. Expenses for any injury arising out of and in the course of employment.

33. Expenses incurred if treatment commences more than ninety (90) days after the date of the accidental bodily injury.

34. Any charges incurred to treat an illness or an injury where an Eligible Individual has received a settlement or a recovery from any third party related to such illness or injury regardless of whether or not the settlement or recovery is designated as for the payment of medical expenses.

35. Except as provided under “Specialty Drugs,” below, or under “other Covered Expenses - Self Injectables,” above, prescription drugs that are not covered under the prescription drug card program.

36. Specialty drugs included in the Plan’s Prescription Benefits Manager’s (“PBM’s”) M2P Program (however these M2P specialty drugs may be covered under the prescription drug card program). “Specialty Drugs” means injectable, infusion, and high-cost drugs used to treat complex or rare conditions, including but not limited to, anemia, immune deficiency, neutropenia, cancer, growth deficiency, multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Specialty Drugs also include high- cost pharmaceuticals with special administration requirements (such as complex dosing regimens, special handling (including temperature sensitive delivery), special clinical support, and /or special requirements for access to product. However, notwithstanding the above, M2P Specialty Drugs administered in a physician’s office, out-patient infusion center or via home health care will be covered, subject to all of the Plan’s normal terms and conditions (including, without limitation, reasonable and customary limits), under PRESCRIPTION DRUG BENEFITS, unless specifically authorized by the Plan’s PBM. All other Specialty Drugs not part of the M2P Program, plus those M2P Specialty Drugs so authorized by the Plan’s PBM, will be covered under the Medical Plan, subject to all the Medical Plan’s normal terms and conditions (including, without limitation, reasonable and customary limits).

37. Charges for genetic testing (unless medically necessary).

38. Charges for treatment of impotency.

39. Charges for non-emergency care provided outside the United States or Canada.

40. Treatment that is not expected to materially improve the patient’s condition or symptoms.

PRESCRIPTION DRUG BENEFITS

(At a network pharmacy or through the mail order program)

The Fund has a contract with a national pharmacy network to provide prescription drugs either at a network pharmacy or through the mail order program. The prescription drug program covers only those drugs that require a Physician’s written prescription. Prescriptions filled at a network pharmacy are limited to a 34-day supply. However, participating pharmacies in the Sav-Rx Walk-In Mail Order Pharmacy Network permit up to a 90-day supply. The mail order program is to be used for “maintenance drugs.” Maintenance drugs are those drugs that are regularly taken on a long-term basis and are limited to a 102-day supply. Specialty drugs are limited to a 30-day supply.

When you have a prescription filled or refilled at a network pharmacy, just present your prescription drug card to the pharmacist. Your copayments for prescriptions filled or refilled at a network pharmacy are as follows:

Generic	$10 copayment per prescription or refill.
Brand Name-Formulary*	30% cost share with a minimum $30 co-pay.
Brand Name - Non-Formulary*	30% cost share with a minimum $45 co-pay.
Specialty Drugs (including biotech drugs and high-cost injectables)	30% cost share with a minimum $45 co-pay and a maximum $100 co-pay for a 30-day supply. However, for selected drug classes where a drug manufacturer's copay assistance is available, the copay is 20% and the $100 maximum shall not apply. Prior Authorization and use of the Sav-Rx Specialty Pharmacy is mandatory for all high cost, or specialty drugs where such manufacturer's coupons or other patient assistance program is available. In addition, in all cases, the $100 maximum also won't apply where the Board or Sav-Rx specifies that the Specialty Drug must be purchased through a Sav-Rx Pharmacy but you nonetheless choose to purchase them elsewhere. Your final cost though will not exceed the $100 maximum for a 30-day supply if purchased through the Sav-Rx Pharmacy. Specialty drugs are limited to a 30-day supply unless they are included in the Sav-Rx 90-day program and the patient qualifies clinically, in which case the above costs will be adjusted accordingly.

The mail order copayments are as follows:

Generic	$10 co-pay per prescription or refill.
Brand Name-Formulary*	$40 co-pay per prescription or refill.
Brand Name - Non-Formulary*	$55 co-pay per prescription or refill.
Specialty Drugs (including biotech drugs and high-cost injectables)	30% cost share up to a maximum of $100 for a 30-day supply. However, for selected drug classes where a drug manufacturer's co-pay assistance is available, the co-pay is 20% and the $100 maximum shall not apply. Prior Authorization and use of the Sav-Rx Specialty Pharmacy is mandatory for all high cost or specialty drugs where such manufacturer's coupons or other patient assistance program is available. In addition, in all cases, the $100 maximum also won't apply where the Board or Sav-Rx specifies that the Specialty Drug must be purchased through a Sav-Rx Pharmacy but you nonetheless choose to purchase them elsewhere. Your final cost though will not exceed the $100

	maximum for a 30-day supply if purchased through the Save-Rx Pharmacy. Specialty drugs are limited to a 30-day supply unless they are included in the Sav-Rx 90-day program and the patient qualifies clinically, in which case the above costs will be adjusted accordingly.

The Walk-In Mail Order copayments are as follows (Participating Pharmacies in the Sav-Rx Walk-In Mail Order Network only) (up to 90 day supply):

Generic	$30 co-pay per prescription or refill.
Brand Name-Formulary*..	30% cost share with a minimum $90 co-pay per prescription or refill for a 90 day supply.
Brand Name - Non-Formulary*	30% cost share with a minimum $135 co-pay per prescription for a 90 day supply.

***If you choose a brand name drug for which an alternative, generic equivalent is available, then you must pay the difference in cost. Accordingly, you will pay both the copayment and the difference in cost between the brand name drug and its generic equivalent.**

If you are not certain whether the prescription is for generic or a brand name drug, ask your Physician.

Formulary drugs are drugs chosen by the Fund that have been demonstrated to be safe, effective and affordable. For a listing of drugs on the formulary, please contact the Fund's pharmacy network provider, whose phone number is listed on page 83, or visit its web site at the address noted on page 41.

When you use the mail order program, complete the mail order form (which may be obtained from the Fund Office) and mail it along with your copayment to Sav-Rx Prescription Services, P.O. Box 8, Fremont, NE 68026-0008; 1-866-233-(IBEW) 4239. Sav-Rx requires the co-payment on all mail order medication. You may pay by check, money order, or by putting a credit card on file. Sav-Rx accepts MasterCard, Discover and Visa.

If you decide not to or if you cannot use the prescription drug card program, you must submit your claim to the Fund's pharmacy network provider. If you have any questions or need a claim form, please contact the Fund Office or the Fund's pharmacy network provider.

DRUGS AND MEDICINES THAT CAN BE PURCHASED ON AN OVER-THE-COUNTER BASIS ARE NOT COVERED.

This benefit is only available for prescription drugs approved by the Food and Drug Administration ("**FDA**") and obtained from a retail network pharmacy while the Fund's network pharmacy program contract is in force.

PRESCRIPTION DRUG MAIL ORDER BENEFITS

This benefit is only available from the Fund's designated mail order pharmacy company, for FDA approved prescription maintenance drugs, for as long as the Fund's network pharmacy program contract remains in force. Schedule II medications are not available through mail service. Only one copayment will be charged

for items that are connected with insulin prescription including syringes, blood-glucose test stripes, lancets, swabs and control solution. These items will be provided as requested in lieu of diabetic kits.

ADDITIONAL COVERED PRESCRIPTION DRUGS AND SUPPLIES

All prescription non-sedating antihistamines require prior authorization by the prescription drug manager, Sav-Rx. This includes Zyrtec-D, Allegra, Allegra-D and Clarinex. Although these medications are covered, we encourage you to consider the use of the over-the-counter Claritin, Zyrtec, or Allegra. These medications and their generic equivalents are much less expensive than the prescription alternatives in the class.

The Fund's pharmacy program covers insulin, diabetic supplies (as requested), certain self-injectable medications that are prescribed by a Physician and pre-approved by the pharmacy network provider (or other review agent utilized by the Fund from time to time) before they are dispensed, pre-natal vitamins, and Retin-A (for acne only), subject to the copayments described above.

Self-injectable medications will be covered after a prior authorization through Sav-Rx. The prior authorization process is important to insure the proper usage of these medications. Proper usage of medications makes sure that the people who need these medications receive them while preserving the benefit for us all. Simply take your prescription to your pharmacy and present it to the pharmacist. The pharmacist will receive on-line instructions to call Sav-Rx to start the prior authorization process. Sav-Rx will then contact your physician. After Sav-Rx receives the authorization, they will contact your pharmacy to process the claim.

There is good news for participants with diabetes. Your diabetic supplies and syringes will now be available at no cost to you through the Sav-Rx Mail Order. You will need to have a prescription that specifies the quantity of each supply and directions for use. Diabetics can also contact Sav-Rx for information about our Free Diabetes Testing Meter.

If you have to pay out of pocket for a prescription claim, you can now submit the receipt to Sav-Rx for review and potential reimbursement. Please keep in mind that the prescription must be covered by your plan and also not exceed a 34-day supply. If your prescription is covered, you will be reimbursed at the IBEW contracted rate. If you choose to use a non-network pharmacy, it may significantly increase your out of pocket cost.

Insulin, Glucagon, Ana-Kit, bee sting kits and anticoagulants injectable medications will be covered subject to copayment and standard plan parameters.

Contraceptives for which you have a prescription are covered for women of childbearing age. This applies to all female cardholders, spouses and dependents. Covered items are paid by the Plan at 100% for generic products and 100% for brand products for which there is no generic available. Brand products that have a generic equivalent will charge the patient the difference in cost. Over the counter items are not covered, even if you have a prescription, unless required to be covered under Preventive Services. Contraceptives will not be covered by the medical plan and must be acquired at a retail network pharmacy or through mail order through Sav-Rx.

The prescription drug plan will cover smoking cessation prescription drugs that are supplied for oral administration, including over-the-counter products with a prescription. You and your dependents are entitled to a maximum of two ninety (90) day regimens per year. The Plan's Preventive Care provisions will apply to this benefit.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

1. Medications not covered hereunder include smoking cessation products (except as stated above); appetite suppressants; infertility drugs; durable or disposable medical supplies; legend vitamins; medications for cosmetic purposes; medications or prescription drugs that are applicable for the opposite sex; medications for impotency; medication requiring prior authorization where such authorization is not received; medications used for experimental indications and/or dosage regimens determined to be experimental; over-the-counter ("OTC") medications that do not require a Physician's authorization by state or federal law and any prescription medicine that is available as an OTC medication; and prescription refills dispensed after one year from the original date of dispensing. Prescriptions administered in a hospital also are not covered.

2. Prescription drug costs not expressly covered by the Plan will not be covered.

3. If you have a prescription filled at a non-network retail pharmacy, you may submit a claim for reimbursement to Sav-Rx. Sav-Rx will reimburse you for such expenses at the pharmacy non-network's rates for claims incurred at non-network retail pharmacies, subject to all of the limitation and exclusions that apply to network pharmacy claims provided above. However, expenses incurred at non-network pharmacies on the banned list of pharmacies, including Wal-Mart pharmacies, as determined by the Board in its sole discretion from time to time, will not be reimbursed or covered under this Plan.

4. M2P Specialty Drugs administered in a physician's office, out-patient infusion center, or via home health care will be covered, subject to all of the Plan's normal terms and conditions (including, without limitation, reasonable and customary limits), under PRESCRIPTION DRUG BENEFITS, unless specifically authorized by the Plan's PBM. All other Specialty Drugs not part of the M2P Program, plus those M2P Specialty Drugs so authorized by the Plan's PBM, will be covered under the Medical Plan, subject to all of the Medical Plan's normal terms and conditions (including, without limitation, reasonable and customary limits).

5. All Specialty Drugs costing over $5,000 per year or its equivalent on an annualized basis, whether covered under the Prescription Drug Program or the Main Medical Plan, require clinical review and prior authorization by the prescription drug manager (currently Sav-Rx), and will not be covered without such prior review and authorization.

MEDICARE PART D PRESCRIPTION DRUG COVERAGE

Medicare prescription drug coverage (Medicare Part D) became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare for a monthly premium. Some plans offer more coverage for a higher monthly premium. Your existing prescription drug coverage has been determined by the Trustees to be at least as good as coverage under the standard Medicare Part D prescription drug plan.

Your plan has automatically enrolled you in a Medicare Part D program with UnitedHealthcare. You will have the option to opt out of this prescription drug program but that is not advisable for most people. The IBEW-NECA Southwestern Health and Benefit Fund will also provide a secondary prescription benefit through Sav-Rx that will "wrap around" the Medicare Part D drug program provided by UnitedHealthcare, known as a Medicare Part D Employer Group Waiver Plan ("EGWP")

Coverage Options

Effective as of January 1, 2023, a Retired Employee who is eligible for Medicare can choose coverage either under the Prescription Drug Wrap Around Program for Self-Paying Medicare Eligible Retirees (known as the Medicare Supplement Plan or EGWP), or the Medicare Advantage Plan (MAP). These two plans offer different levels of coverage and different self-pay rate structures. Self-paying Medicare eligible Retired Employees can elect once per year, at annual enrollment, whether to participate in the Medicare Supplement Plan or the Medicare Advantage Plan.

Because both the Medicare Supplement Plan and the Medicare Advantage Plan offered by the Fund provides prescription drug coverage that is at least as good as the standard Medicare prescription drug coverage, depending upon your individual situation, you may want to keep your current coverage under the Fund, and not enroll in a Medicare Part D prescription drug plan when you become eligible for it.

For Retirees:

- As long as you do not enroll for Medicare Part D and you maintain your retiree status as provided by the rules of the Fund, your prescription drug and other coverage will continue, provided you make the required self-payments to the Fund.
- **Please note that if you sign up for any other coverage, including <u>an individual</u> Medicare Part D prescription drug plan, you will lose prescription drug coverage under this Fund. If your prescription drug coverage under this Fund terminates in favor of coverage under a Medicare prescription drug plan, you will not be able to get the Fund's prescription drug coverage back later. However, you can continue your other (non-prescription drug) medical coverage under the Fund, provided you meet the requirements set forth herein, regardless of whether you keep or drop prescription drug coverage under the Fund.**

For Active Employees:

- You are not required to drop your coverage under the Fund in order to enroll in Medicare prescription drug coverage. As long as you maintain your eligibility status as provided by the rules of the Fund, your prescription drug and other coverage will continue. If you keep your coverage under the Fund and enroll in a Medicare prescription drug plan, the Fund will usually pay primary and Medicare will pay secondary (exceptions below).
- If you qualify for Medicare coverage because of end-stage renal disease, then the Fund will only act as the primary payer for the first 30 months. After 30 months, the Medicare Part D plan will act as the primary payer and the Fund will pay secondary.
- If you are not actively employed but are covered under the Fund through COBRA or other self-pay, and you are eligible for Medicare coverage because of age or disability, then the Fund will pay secondary and the Medicare prescription drug plan will pay primary.

Because your existing Fund Coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep you Fund coverage and not pay extra Medicare Part D premiums if you later decide to timely enroll in Medicare coverage.

The prescription drug coverage under this Fund qualifies as "creditable coverage." This means, as stated above, that the drug coverage the plan expects to pay on average for prescription drugs for individuals covered by the Fund is at least as good as or better than what standard Medicare prescription drug coverage would be expected to pay on average.

You should also know that if you drop or lose your coverage with the Fund and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. In particular, if you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, then if you later enroll in Medicare Part D, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, and then enroll in Medicare Part D, your Medicare Part D premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

Please note that in addition to this SPD, you are entitled to receive an additional notice of creditable coverage from the Fund on at least three occasions: (i) annually, prior to November 15; (ii) if the Fund makes changes to your prescription drug coverage that changes whether it is as good as Medicare prescription drug coverage; and (iii) at your request.

More detailed information about "creditable coverage," the Medicare prescription drug plan enrollment period, and your prescription drug benefits and self-pay rates under the Fund are available from the Fund Office.

STEP THERAPY PROGRAM

Certain classes of drugs may be designated by the Fund as subject to the Fund's generic drug step therapy program. If a class of drug is included in this program, the Fund will only cover the generic version of the drug, unless use of the generic version has been proven ineffective for you, after you have tried it. Please contact Sav-Rx at (800) 228-2181 for additional information on whether any of your medications are included in this program.

THERAPEUTIC QUANTITY LIMITATION PROGRAM

The Sav-Rx Therapeutic Maximum Quantity Program identifies several medications that often experience over utilization in the number of doses taken per day. These classes include drugs used to treat migraines, arthritis, severe pain and inhalers used for asthma and allergies. Recommendations on approved dosages will be utilized. If your treatment requires dosages over the recommended level, it will require prior authorization. If you are taking the recommended dose of one or more of these medications, you will not be affected. The below chart lists the correct maximum quantities, as of the date of this SPD.

Antiemetics		
Brand	**Generic**	**Limit**
Aloxi		5mL per 15 days
Anzemet 50mg and 100mg tablets		3 tablets per 15 days
Anzemet Injection		5mL per 15 days
Emend Tri-pack		1 pack (3 tablets) per 15 days
Emend Inj		10mL per 15 days

Emend 40mg capsule		3 capsules per 6 months
Emend 80mg capsule		2 capsules per 15 days
Emend 125mg capsule		1 capsule per 15 days
Kytril 1mg tablet	granisetron	6 tablets per 15 days
Kytril 2mg/10mL Oral Soln (30mL)		30mL per 15 days
Granisol Oral Soln (30 mL)		30mL per 15 days
Kytril Inj	granisetron	1mL per 15 days
Sancuso		2 patches per 15 days
Zofran Injection 2mg/1mL	ondansetron HCl injection	10mL per 15 days
Zofran IV Injection 32 mg/50 mL	ondansetron HCl injection	50mL for 15 days
Zofran/Zofran ODT tablets	ondansetron ODT	30 tablets per 30 days
Zofran Oral Soln 4mg/5mL	ondansetron 4mg/5mL	100mL per 15 days
Zofran 24mg Tablet	ondansetron	1 tablet per 15 days
Marinol, Cesamet	dronabinol	2 capsules per day

Antimigraine Drugs			
Drug	**30-Day Limit**	**90-Day Limit**	
Oral - Amerge, Cambia, Frova, Imitrex, Maxalt, Maxalt MLT, Relpax, Treximet, Zomig, Zomig ZMT and all generics	9 tablets	27 tablets	
Injectable - Imitrex Statdose, Alsuma Auto-Injector, Sumavel DosePro	4mL	12mL	
Injectable - Imitrex injection	3mL	9mL	
Nasal Spray - Imitrex, Zomig	1 box (6 doses)	3 boxes (18 doses)	
Nasal Spray - Migranal	1 box (8 vials)	3 boxes (24 vials)	

Nasal Inhalers			
Drug	**Generic**	**90-Day Limit**	**30-Day Limit**
Astelin. Astepro, Beconase AQ, Dymista, Flonase, Nasacort, Flunisolide, Nasonex, Omnaris, Patanase, Qnasl, Rhinocort, Veramyst, Zetonna	azelastine, fluticasone, triamcinolone, flunisolide	3 inhalers	1 inhaler
Oral Inhalers and Inhalant Solutions			
Drug	**Generic**	**90-Day Limit**	**30-Day Limit**
Advair Diskus, Advair HFA		3 inhalers	1 inhaler
ProAir HFA		6 inhalers	2 inhalers
Proventil HFA		6 inhalers	2 inhalers
Ventolin HFA		6 inhalers	2 inhalers
Albuterol inhalation solution 0.63mg-3mL		15 boxes	5 boxes
Albuterol inhalation solution 1.25mg/3mL		15 boxes	5 boxes
Albuterol inhalation solution 0.5% (5mg/mL)		6 boxes	2 boxes
Albuterol inhalation solution 0.083%(2.5mg/3mL)		15 boxes	5 boxes
Alvesco		6 inhalers	2 inhalers
Anoro Ellipta 62.5/25 mcg Inhalation		3 inhalers	1 inhaler
Asmanex		3 inhalers	1 inhaler
Atrovent HFA MDI		3 inhalers	1 inhaler
Atrovent Nebulizer Solution	Ipratropium	360 vials	120 vials

Breo Ellipta 100/25 mcg Inhalation		3 boxes	1 box
Brovana inhalation soln (30 vials per box)		6 boxes	2 boxes
Brovana inhalation soln (60 vials per box)		3 boxes	1 box
Combivent Respimat		3 inhalers	1 inhaler
Dulera 100mcg/5mcg		3 inhalers	1 inhaler
DuoNeb Nebulizer Solution	Ipratropium-Albuterol	1620mL	540mL
Flovent Diskus		720 inhalations	240 inhalations
Flovent HFA		6 inhalers	2 inhalers
Foradil Powder for Inhalation 12mcg (60 caps)		3 inhalers	1 inhaler
Intal Nebulizer Solution	cromolyn	360mL	120mL
Maxair Oral Autohaler 200mcg		3 inhalers	1 inhaler
Perforomist inhalation solution		180 vials	60 vials
Pulmicort Flexhaler 90mcg		12 inhalers	4 inhalers
Pulmicort Flexhaler 180mcg		6 inhalers	2 inhalers
Pulmicort Nebulizer Solution 0.25mg vial	budesonide	180 vials	60 vials
Pulmicort Nebulizer Solution 0.5mg vial	budesonide	180 vials	60 vials
Pulmicort Nebulizer Solution 1mg vial	budesonide	90 vials	30 vials
Qvar		78.3GM	26.1GM
Serevent Diskus		3 inhalers	1 inhaler
Spiriva HandiHaler Inhalation Powder (30 capsules)		90 capsules	30 capsules
Spiriva Respimat Inhaler 2.5 mcg/actuation (60		3 units	1 unit

dose)			
Symbicort MDI		3 inhalers	1 inhaler
Symbicort MDI 160/4.5mcg (120 dose)		30.6GM	1 inhaler
Xopenex HFA inhaler		6 inhalers	2 inhalers
Xopenex inhalation solution	levalbuterol	12 boxes	4 boxes
Controlled Substances			
Drug	**Generic**	**90-Day Limit**	**30-Day Limit**
APAP/Codeine Tablets		10 tablets per day	
Avinza		1 tablet per day	
Stadol NS 10mg/mL 2.5mL	butorphanol	6 bottles per 90 days	2 bottles per 30 days
Codeine tablet		135 tablets	45 tablets
Duragesic Patch	fentanyl	30 patches	10 patches
Exalgo	hydromorphone er	1 tablet per day	1 tablet per day
Fioricet w/ codeine	acetaminophen/butalbital/caffein e/codeine	6 capsules per day	
Fiorinal w/ codeine	aspirin/butalbital/caffeine/codein e	6 capsules per day	
Hydrocodone/APAP Tablet		4,000gm of APAP daily	
Vicoprofen 7.5/200mg	hydrocodone/ibuprofen	5 tablets per day	
Kadian		2 tablets per day	
Meperidine liquid		180mL per 90 days	60mL per 30 days
Meperidine tablet		90 tablets per 90 days	30 tablets per 30 days
Methadone 5mg tablet		8 tablets per day	
Methadone 10mg tablet		8 tablets per day	
Methadone 40mg		2 tablets per day	

tablet			
Morphine liquid		2700mL per 90 days	900mL per 30 days
MS Contin	Morphine Sulfate ER	2 tablets per day	
Nucynta 50mg Tablet		12 tablets per day	
Nucynta 75mg Tablet		8 tablets per day	
Nucynta 100mg Tablet		6 tablets per day	
Nucynta ER		2 tablets per day	
Opana	oxymorphone	4 tablets per day	
Opana ER		2 tablets per day	
Oramorph SR	Morphine Sulfate ER	2 tablets per day	
Oxycodone		6 tablets per day	
Oxycontin		2 tablets per day	
Oxycodone/APAP		4,000gm of APAP daily	
Oxycodone/ASA 4.8/325		12 tablets per day	
Oxycodone/Ibu 5/400		84 tablets for 90 days	28 tablets for 30 days
Reprexain	hydrocodone/ibuprofen	5 tablets per day	
Soma 250 mg & 350 mg	carisoprodol	360 tablets	120 tablets
Soma Compound 200/325mg	carisoprodol/aspirin	720 tablets	240 tablets
Soma Compound/Codeine 200/325/16 mg	carisoprodol/aspirin/codeine	720 tablets	240 tablets
Talwin NX 50/0.5mg	pentazocine-naloxone	1080 tablets	360 tablets
Ultram 50mg tablet	tramadol	8 tablets per day	
Ultracet Tablet 37.5/325mg	tramadol/APAP	8 tablets per day	
Ultram ER	tramadol ER	1 tablet per day	
Xodol	hydrocodone/APAP	10 tablets per day	
Zohydro ER	hydrocodone	2 tablets per day	
Antiviral Agents			
Drug	**Generic**	**180-Day Limit**	
Tamiflu 30mg		20 capsules per 180 days	

Capsule			
Tamiflu 45mg Capsule		10 capsules per 180 days	
Tamiflu 75mg Capsule		10 capsules per 180 days	
Tamiflu O/S 12mg/mL (25mL)		75mL per 180 days	
Relenza Diskhaler		20 capsules per 180 days	
Valtrex	valacyclovir	21 tablets/30 days	63 tablets/90 days
Sleep Aids			
Drug	**Generic**	**Limit**	
Ambien CR, Ambien, Dalmane, Doral, Edluar, Halcion, Intermezzo, Lunesta, ProSom, Restoril, Rozerem, Sonata	zolpidem ER, zolpidem, flurazepam, triazolam, estazolam, temazepam, zaleplon	1 tablet per day	
Zolpimist		1 bottle (7.7 mL) per 30 days	
Non-Controlled Pain Medications			
Drug	**Generic**	**90-Day Limit**	**30-Day Limit**
Amrix 15 mg	cyclobenzaprine ER	2 capsules per day	
Amrix 30 mg	cyclobenzaprine ER	1 capsule per day	
Celebrex		2 capsules per day	
Conzip capsule		1 capsule per day	
Fioricet	butalbital/APAP/caffeine	180 tablets	60 tablets
Fiorinal	butalbital/aspirin/caffeine	180 tablets	60 tablets
Flector Patch		180 patches	60 patches
Lidoderm		270 patches	90 patches
Pennsaid 1.5% Topical Solution	diclofenac solution	1350 mL (9 bottles)	450 mL (3 bottles)
Pennsaid 2% Topical Solution		1,008 gm (9 bottles)	336 gm (9 bottles)
Ryzolt Tablet		1 tablet per day	
Rybix ODT		8 tablets per day	
Toradol Tablet	ketorolac	60 tablets	20 tablets (5 day

			supply)
Voltaren Gel		900GM	300GM
Zipsor		4 capsules per day	
Zorvolex		3 capsules per day	
Oral Acne Medications			
Drug	**Generic**	**Limit**	
Doryx	doxycycline delayed-release	12 weeks/year	
Solodyn	minocycline ER	12 weeks/year	
Other Topicals			
Drug	**Generic**	**90-Day Limit**	**30-Day Limit**
Elidel		100 GM	30 GM
Solaraze Gel		300 GM	100 GM
Topical Acne Medications			
Drug	**Generic**	**30-Day Limit**	**90-Day Limit**
Differin Cream	adapalene	45 GM	135 GM
Differin Gel	adapalene	45 GM	135 GM
Differin 0.1% Lotion		59 mL	177 mL
Epiduo		45 GM	135 GM
Acanya		50 GM	150 GM
Duac	clindamycin/benzoyl peroxide	45 GM	135 GM
Ziana		30 GM	90 GM
Veltin		30 GM	90 GM
Tazorac Cream		30 GM	90 GM
Tazorac Gel		30 GM	100 GM
Atralin		45 GM	135 GM
Retin-A Cream	tretinoin	20 GM	60 GM
Retin-A Gel	tretinoin	15 GM	45 GM
Retin-A Micro Gel		20 GM	60 GM

GERD Medications			
Drug		**30-Day Limit**	**90-Day Limit**
Proton Pump Inhibitors		1 tablet or capsule per day	
Hematological Agents			
Drug		**30-Day Limit**	**90-Day Limit**
Lysteda		30 tablets	90 tablets
Diabetic Testing Supplies			
Drug		**30-Day Limit**	**90-Day Limit**
Glucose Test Strips		200 strips	600 strips

VISION BENEFITS

Your vision benefits are self-insured by the Fund through an administrative arrangement with VSP Vision Care. This Summary Plan Description is not meant to interpret, extend, or change the provisions of the VSP contract in any way. The provisions of the VSP contract may only be accurately determined by reading the actual contract document. A copy of the vision contract is on file at the Fund Office and you or your legal representative may read it at any reasonable time or request a copy. In the event of any discrepancy between this Summary Plan Description and the actual provisions of the vision contract, the vision contract provisions will govern.

Vision care services MUST be provided by a licensed optometrist or ophthalmologist. Examinations and prescribed lenses are considered Covered Expenses once a calendar year between January 1st and December 31st (the "vision plan year"). Frames are considered a Covered Expense once every two consecutive calendar years. For Active Employees only, prescription safety glasses (frames and lenses), after a $25 copay, are considered a Covered Expense once every two consecutive calendar years.

The Plan provides vision care benefits from a VSP-approved doctor as follows:

Your Coverage from a VSP-approved doctor:

Vision Examination every vision plan year. .... $25 copay

Prescription Glasses .... $25 copay

Lenses every vision plan year:

- Single vision, lined bifocal, lined trifocal and lenticular lenses
- Polycarbonate lenses for dependent children

Lens Enhancements:

- Standard progressive lenses -- $55 copay
- Premium progressive lenses -- $95 - $105 copay
- Custom progressive lenses -- $150 - $175 copay
- Average savings of 20% - 25 % on other lens enhancements

Frames every other vision plan year

- $130 allowance for frame of your choice ($150 for featured frame brands; $70 Costco frame allowance)
- 20% off of the amount over your allowance, subject to restrictions by various retail providers.

Prescription Safety Glasses every other vision plan year

- For Active Employees only
- $25 copay

Necessary Contact lenses every vision plan year (in lieu of lens and frame benefit)..... No copay

Elective Contact lenses -- $130 allowance for contacts and the contact lens examination may be used in lieu of the Prescription glasses coverage

Low Vision Benefit

- Supplementary Training - covered in full
- Supplemental Care Aids - 75% of Cost, after 25% copay
- Maximum Benefit - $1,000 every two years (excluding copay)

The Plan also provides the following extra discounts and savings:

Glasses and Sunglasses

- Average 20-25% savings on all non-covered lens options
- 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last vision examination
- Extra $20 spend on featured frame brands. See VSP.com / special offers.

Contact Lens Exam

- 15% off the cost of contact lens exam (fitting and evaluation)

Diabetic Eyecare Plus Program

Services related to diabetic eyecare disease, glaucoma and age-related macular degeneration; retinal screening for eligible members with diabetes. Limitations and coordination with main Medical coverage may apply -- $20 copay.

Retinal Screening - no more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.

Laser Vision Correction

- Average of 15% off of the regular price or 5% off of the promotional price. Discounts are only available from contracted facilities.

If you see a non-VSP provider, you'll receive a lesser benefit. Before you see a non-VSP provider, call VSP at (800) 877-7195 for more details.

OUT-OF-NETWORK REIMBURSEMENT AMOUNTS (AFTER APPLICABLE COPAY):

Exam.. Up to $45

Single vision lenses .... Up to $30

Lined bifocal lenses.. Up to $50

Lined trifocal lenses .... Up to $65

Progressive lenses.. Up to $50

Lenticular lenses.. Up to $100

Frames .... Up to $70

Necessary Contacts.. Up to $210

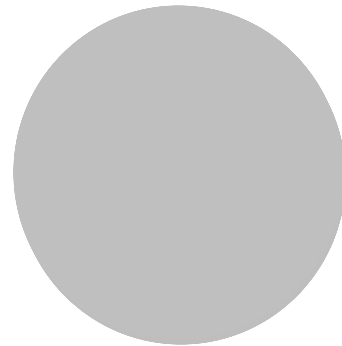
Elective Contacts... Up to $105

Low vision Out of Network Benefit

- Supplementary Training - up to $125
- Supplemental Care Aids - 75% of Cost, after 25% copay
- Maximum Benefit - $1000 every two years (excluding copay)

Sample Vision Claim

Exam/Eyewear	Without VSP	With VSP
Frame	$130	$0
Single Vision Lenses	$ 86	$25 Copay
Anti-reflective Coating	$110	$69
Photochromic Adaptive Lenses	$103	$70
Total	**$583**	**$189**



Comparison based on national averages for eye exams and most commonly purchased brands.

Exclusions and Limitations of Benefits

Patient Options

The Vision Plan is designed to cover medically necessary visual needs, not cosmetic materials. Therefore, if you select any of the following extras, the Fund will only pay the basic cost of the allowed lense or frame, and you will be responsible for any additional costs relating to the following:

- optional cosmetic processes

- anti-reflecting coating
- color coating
- mirror coating
- scratch coating
- blended lenses
- cosmetic lenses
- laminated lenses
- oversize lenses
- polycarbonate lenses
- photochromatic lenses, tinted, except Pink #1 and Pink #2
- progressive multifocal lenses
- UV (ultraviolet) protected lenses
- certain limitations on low vision care
- a frame that costs more than the Plan allowance
- contact lenses (subject to the above limitations)

Not Covered

Benefits are not covered under this Vision Plan for the following:

- Orthoptics or vision training and any associated supplemental testing
- plane lenses (less than a .50 diopter power)
- two pairs of glasses in lieu of bifocals
- replacement of lenses and frames furnished under this Plan which are lost, stolen or broken
- medical or surgical treatment of the eyes
- corrective vision treatment of an experimental nature
- cost for services or materials above the vision Plan allowances
- services or materials not expressly covered on the above schedule of benefits

Opt-out

The Plan's Vision Benefits are "excepted benefits" that are not subject to HIPAA or the Affordable Care Act. Accordingly, you have the right to opt-out of this coverage if you wish. To do so, please contact the Fund Office for the appropriate form. However, please note that there is no charge for the Fund's Vision coverage, and opting-out will not decrease your (or your Employer's) premium costs.

DENTAL BENEFITS

Dental benefits are self-insured by the Fund, but are provided through an administrative services contractual arrangement with Delta Dental Insurance Company ("DDIC" or "Delta Dental"). This Summary Plan Description is not meant to interpret, extend, or change the provisions of the Delta Dental contract in any way. The provisions of the Delta Dental contract may only be accurately determined by reading the actual contract document, which is on file at the Fund Office and you or your legal representative may read it at any reasonable time or request a copy. In the event of any discrepancy between this Summary Plan Description and the actual provisions of the dental contract, the dental contract provisions will govern.

Delta Dental contracts with a group of dental care providers who furnish dental services at lower than usual fees - the Delta Dental PPO. Please use the Plan's PPO networks when and where they are available to you. Use of non-PPO dentists will result in higher costs to you. There is also a middle tier of providers, Delta Dental Premier Dentists, that is typically lower cost for you than non-contracted dentists. The maximum annual benefit under the Plan is $1,250 per individual for Delta Dental PPO Providers or $1,000 per individual for Premier Network or Non-Network Providers.

Retirees will be eligible for the dental benefits described herein.

After you have satisfied a $50 per individual annual deductible or $100 per family annual deductible (which is separate from the Fund's deductibles for medical coverage), the Fund will pay for qualifying dental expenses not covered by the Medical Plan as follows.

	In-network*	Out-of-Network
Diagnostic and Preventative Services**	100%	100%
Basic Services	80%	60%
Major Services	50%	40%

* Reimbursement is based on contracted fees for in-network dentists (Delta Dental PPO Dentists and Delta Dental Premier Dentists) and on the program allowance for out-of-network dentists.

** The $50 annual individual and $100 annual family deductibles do not apply to diagnostic and preventative services.

DIAGNOSTIC AND PREVENTATIVE SERVICES

- Oral exams: 2 exams per Calendar Year
- Cleanings: 2 cleanings per Calendar Year (including periodontal cleanings)
- Emergency Exams
- Fluoride treatments: limited to eligible persons under age 19
- Space maintainers: limited to persons under age 14 and the initial appliance only
- X-rays:

- Bitewing twice in any Calendar Year for your Dependent Child Enrollees; once every Calendar Year for you and your spouse.

- Full mouth or panoramic - once every 5 years.

BASIC SERVICES

- Oral surgery: Extractions and certain other surgical procedures, including pre- and post-operative care

- Restorative: Amalgam, synthetic porcelain, posterior composite resin, and plastic fillings and prefabricated stainless steel restorations for treatments of tooth decay or dental cavities (but does not include any replacements within 24 months of treatment if service is provided by the same dentist)

- Palliative: Treatment to relieve pain

- Denture Repair of both complete and partial dentures

- Endodontic Services: Treatment that deals with the tooth pulp and tissues surrounding the root of the tooth

- Periodontic services: Treatment of the gums and bones supporting the teeth (periodontal scaling and root planning in the same quadrant are generally limited to once in every 24-month period)

- Sealants: Protective coating for posterior molar teeth (limited to permanent first molars through age 8 and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface and does not include repair or replacement of a sealant on any tooth within 2 years of its application)

- General anesthesia

MAJOR SERVICES

- Crowns, jackets and cast restorations (but does not include any replacements for any crowns, inlays, jackets or cast restorations received within the previous 5 years)

- Prosthodontic services (prosthodontics appliances will generally only be replaced once every 5 years).

Only standard partial or complete dentures are covered under the Plan. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means. Implants (artificial teeth implanted into or onto the bones or gums), their removal or other associated procedures are not covered under the Plan. However, the Plan will credit the cost of a crown or standard or complete partial denture that would have been allowed hereunder toward the cost of an implant and related services, but only when the crown is actually installed.

LIMITATIONS AND EXCLUSIONS

- Optional Services: Optional Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services.” Optional Services also include the use of specialized techniques instead of standard procedures.

For example, a crown where a filling would restore the tooth; a precision denture/partial where a standard dental/partial could be used; or an inlay/onlay instead of an amalgam restoration. Benefits for Optional Services will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service.

- Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, except for services covered by the Medical Assistance Act of 1967, as amended (Article 695j-1, Vernon's Texas Civil Statutes) as provided in the Delta Dental administrative services contract.

- Cosmetic surgery or dentistry for purely cosmetic reasons.

- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), unless the service is provided to a newborn or adopted Dependent child for treatment of a medically diagnosed congenital defect.

- Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth (including but not limited to equilibration, periodontal splinting, and occlusal adjustment).

- Any single procedure that is assigned a separate current dental terminology ("CDT") number started prior to the date the Eligible Individual became covered for such services under the Plan.

- Prescribed drugs, pain killers or experimental procedures.

- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility. Notwithstanding the above, the Medical Plan will cover claims for disabled children and children who cannot sit still for a procedure who need to be sedated, including the facility charges and anesthesia fees, subject to all of the normal terms and conditions, maximums, and limitations of the Medical Plan's coverage.

- Charges for anesthesia, other than by a licensed dentist for administering general anesthesia in connection with covered oral surgery services.

- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

- Treatment performed by someone other than a dentist or a person who by law may work under a dentist's direct supervision.

- Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplicators, cancer screening or broken appointments.

- Services or supplies covered under the Plan's comprehensive medical benefits.

- Service for orthodontic treatment (treatment of malocclusion of teeth and/or jaws).

- Services for any disturbances of the temporomandibular jaw joints.

Sample Dental Claim

Delta Dental Benefit Comparison by Provider Type
Claim Payment Example

Example**	Delta Dental PPO Dentists	Delta Dental Premier Dentists	Non-contracted Dentists (MPA)
Dentists Charge for a crown	$1,000	$1,000	$1,000
Sample Plan Allowance	$640	$800	$800
Coinsurance Amount	50%	50%	40%
Plan Payment	$320	$400	$320
Balance Billing	No	No	Yes: $200***
Enrollee Payment	[$640 x .5] = $320	[$800 x .5] =$400	[$800 x .6] + $200 = $680

** Note: This is for illustrative purposes only. Assume no maximum or deductibles are applicable.
***Non-contracted dentists may charge members the difference between their usual fees and the carrier reimbursement (dental payment)

Opt-out

Dental Benefits are "excepted benefits" that are not subject to HIPAA or the Affordable Care Act. Accordingly, you have the right to opt-out of this coverage if you wish. To do so, please contact the Fund office for the appropriate form. However, please note that there is no charge for the Fund's Dental Benefit coverage, and opting-out will not decrease your (or your Employer's) premium costs.

PREFERRED PROVIDERS

You can obtain an up-to-date list of the providers in the PPO Networks on their web sites at the following addresses:

	Provider	Web site	Phone
●	Sav-RX	www.savrx.com	866 233-4239
●	Blue Cross Blue Shield	www.bcbs.com	800 810-2583
●	Blue Cross Blue Shield of Illinois (Mental Health)	www.bcbsil.com	800 851-7498
●	Delta Dental	www.deltadentalins.com	800 521-2651
●	VSP Vision Care	www.vsp.com	800 877-7195

AUTHORIZATION PROGRAMS

PRE ADMISSION AUTHORIZATION

"**Pre-Admission Authorization**" is a Hospital certification program that requires you and your Dependents to have a proposed non-emergency Hospital admission reviewed for medical necessity to determine whether or not an alternate type of care and/or treatment can be made effectively in another setting, or through a facility other than a Hospital. Post-admission certification is also required for emergency Hospital admissions if further hospitalization is required after the completion of the emergency services.

WHEN MUST THE PRE-ADMISSION OR POST-ADMISSION AUTHORIZATION PROGRAM BE USED?

You are required to obtain Pre-Admission Authorization prior to a non-emergency Hospital admission or any non-emergency hospitalization. Pre-Admission Authorization should be obtained as soon as your Physician recommends hospitalization. Before any expenses are incurred for a non-emergency hospitalization, you, a family member or your Physician should call Blue Cross Blue Shield at (800) 433-3232 (or for mental health or substance abuse issues, contact Blue Cross Blue Shield of Illinois at (800) 851-7498) at least 10 days prior to the admission. If the admission to the Hospital is due to an emergency and you need further hospitalization after the completion of the emergency services (including Stabilization and post-Stabilization emergency services as defined in the No Surprises Act), you, a family member, your Physician or the Hospital must call Blue Cross Blue Shield at (800) 433-3232 (or (800) 851-7498 for Mental Health / Substance Abuse) by the close of the business day following the completion of the emergency services.

WHAT WILL HAPPEN IF YOU DO NOT USE THE PRE-ADMISSION PROGRAM FOR A HOSPITAL CONFINEMENT?

Failure to comply with these provisions will result in a 50% reduction in benefits, up to a maximum penalty of $250 (or per BCBS provider sanction).

MATERNITY PRE-ADMISSION AUTHORIZATION

In the event of pregnancy, Blue Cross Blue Shield should be notified twice. The first notification should be as soon as the pregnancy is confirmed. This will provide Blue Cross Blue Shield with the opportunity to identify any high-risk pregnancy for early intervention. The second notification is at the actual time of delivery.

Pursuant to federal law, the Plan will not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, the mother's or newborn's doctor, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Although Blue Cross Blue Shield must be notified at the time of delivery, Plan benefits will not be reduced for Hospital stays not in excess of 48 hours (or 96 hours if applicable) if you fail to timely notify Blue Cross Blue Shield.

MENTAL HEALTH AND SUBSTANCE ABUSE PRE-CERTIFICATION

The Fund has a contract with Blue Cross Blue Shield to provide referrals and treatment for inpatient and/or outpatient mental health and substance abuse. Referrals and benefits are also provided for stress-related and smoking cessation problems.

To the fullest extent permitted by the Mental Health Parity Act, a Blue Cross Blue Shield representative must also pre-certify any non-emergency inpatient services, partial hospitalization, intensive outpatient, or

residential treatment center admissions. Whenever you or one of your Dependents is in need of such care and/or treatment as a result of one of the situations mentioned above, you should contact Blue Cross Blue Shield at (800) 851-7498 to pre-certify those services. A Blue Cross Blue Shield representative will refer you to one of its providers. Failure to do so will result in a 50% penalty, up to $250 (or per BCBS provider sanction).

REMEMBER!

YOU MUST USE THESE CERTIFICATION PROGRAMS ANY TIME YOUR OR YOUR DEPENDENT'S PHYSICIAN RECOMMENDS HOSPITAL CONFINEMENT. YOU AND YOUR DEPENDENTS MUST ALSO USE THESE PROGRAMS IN THE EVENT OF A PREGNANCY OR SPECIFIED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

IN THE CASE OF AN EMERGENCY ADMISSION, IF FURTHER HOSPITALIZATION IS RFEQUIRED AFTER THE COMPLETION OF EMERGENCY SERVICES, CERTIFICATION IS REQUIRED BY THE CLOSE OF THE BUSINESS DAY FOLLOWING THE COMPLETION OF EMERGENCY SERVICES.

ELIGIBILITY RULES FOR COLLECTIVELY BARGAINED EMPLOYEES

INITIAL ELIGIBILITY

If you are an employee of an employer that is required through a collective bargaining agreement to contribute to the Fund on your behalf (a "Contributing Employer"), you may become eligible for benefits under this Plan as described below. All individuals who meet this Plan's initial eligibility requirements, including non-bargaining employees who meet the special non-bargaining eligibility rules are referred to as "Active Employees" while they maintain their eligibility during their active employment. An individual who is making self-payments for coverage is NOT considered an Active Employee.

Initial eligibility can be established in two ways:

1. If you work for a Contributing Employer and that employer makes contributions for at least 375 hours on your behalf during a period of 3 consecutive months, you will become eligible for benefits on the first day of the second calendar month following that 3-month period.

EXAMPLE

Work Month	Hours Worked	Reserve Account	Withdrawal	Reserve Account Max*	Benefit Month
April	150	150			
May	180	330			
June	175	505	375	130	August (initial)
July	180	310	140	170	September
August	185	355	140	215	October
September	190	405	140	265	November
October	190	455	140	315	December
November	180	495	140	355	January
December	185	540	140	400	February
January	180	580	140	440	March
February	185	625	140	485	April
March	185	670	140	530	May

*** Your Reserve Account will be limited to a maximum of 700 hours after the deduction for the current month's coverage (e.g., 840-140 = 700).**

or

2. If you work for a Contributing Employer and that employer makes contributions for at least 500 hours on your behalf during a period of 6 consecutive months, you will become eligible for benefits on the first day of the second calendar month following that 6-month period.

EXAMPLE

Work Month	Hours| Worked	Reserve Account	Withdrawal	Reserve Account Max*	Benefit Month
April	140	140			
May	0	140			
June	100	240			
July	120	360			
August	120	480			
September	160	640	500	140	November (initial)
October	170	310	140	170	December
November	170	340	140	200	January
December	185	385	140	245	February
January	180	425	140	285	March
February	185	470	140	330	April
March	185	515	140	375	May

*** Your Reserve Account will be limited to a maximum of 700 hours after the deduction for the current month's coverage (e.g., 840-140 = 700).**

Maintenance Of Eligibility

Reserve Account (Hour Bank)

A Reserve Account or Hour Bank has been established by the Fund for each Active Employee who works for a Contributing Employer that makes contributions to the Fund on his or her behalf. All hours required to establish initial eligibility and all hours worked thereafter for one or more Contributing Employers will be credited to your Reserve Account when the Fund receives the required contributions from your employer. You will be allowed to accumulate a maximum of 700 hours in your Reserve Account, after deduction for the current month's coverage (e.g., 840-140= 700).

Monthly Deductions from the Reserve Account

Currently, as illustrated in the above examples, 375 hours are deducted from your Account for your initial eligibility and 140 hours are deducted from your Account for each month of coverage thereafter. A lag month will be used in determining continuing eligibility. Thus, hours worked in a given month may not be used for eligibility until the second month following the month in which the hours were worked. Generally, once eligible, you will continue to be eligible as long as your Reserve Account contains at least 140 hours. Your Reserve Account cannot be used to supplement contractually required contributions that are less than the amount required by the Trustees.

If you have less than 140 hours in your Reserve Account and would therefore lose coverage, the following month, you may make a one-time direct cash payment (on an after tax basis), based on the current contribution rate, to make up for such shortfalls. This direct cash payment can only be used to make up a shortfall for the 1st month of lost coverage; you must have current Active Coverage at the time; and this direct pay option cannot be used more than one time per year.

Withdrawals for coverage from the Reserve Account will be made based on the Plan's current contribution rate. Whenever the Plan's contribution rate increases, the number of hours in your Reserve Account will automatically be proportionately reduced by the percentage difference between the old and new contribution rates.

The Reserve Account is merely a bookkeeping entry and neither you nor your Dependents have any right to any particular Fund assets or any vested or accrued right to your Reserve Account or to any Fund eligibility or participation by virtue thereof. The Trustees can modify, reduce, forfeit or terminate the Reserve Accounts at any time.

Termination Of Eligibility For Active Employees

As an Active Employee, your eligibility will terminate on the earliest of the following:

1. The last day of the month in which you have less than 140 hours in your Reserve Account, after deduction for the current month's eligibility (see the example below);

2. Except as otherwise required by applicable law, the last day of the month in which you enter full-time active duty in the Armed Forces of the United States or any other country;

3. The 31st day following the day that (or, if sooner, the last day of the month following the month in which) the IBEW Local Union that represents you for the purpose of collective bargaining withdraws from participation in the Fund;

4. The 31st day following the date on which (or, if sooner, the last day of the month following the month in which) the collective bargaining agreement under which you are working no longer provides for the continued remittance of employer contributions as established by the Trustees for participation in this Fund. If a new labor agreement provides for employer contributions at a rate less than those required by the Fund, your coverage will also terminate. Under no circumstances will hours be deducted from your Reserve Account to supplement contributions under the situation described above.

5. The date this Plan terminates, either in full or as to you or the group to which you belong.

EXAMPLE OF TERMINATION DUE TO INSUFFICIENT HOURS

Work Month	Hours Worked	Reserve Account	Withdrawal	Reserve Account Max*	Benefit Month
April	105	105			
May	0	105			
June	100	205			
July	110	315			
August	115	430			
September	120	550	375	175	November (initial)
October	110	285	140	145	December
November	105	250	140	110	January
December	105	215	140	75	February
January	105	180	140	40	March
February	105	145	140	5	April
March	130	135	0	135	May-COBRA

Reinstatement Of Eligibility

Except as provided below, if your eligibility is terminated because of a lack of necessary hours in your Reserve Account, your eligibility can be reinstated if your Reserve Account shows a total of at least 140 hours within the 12-month period immediately following such termination. Your coverage will be reinstated on the first day of the month following the month in which this requirement is met.

If your Account does not show at least 140 hours within such 12-month period, all hours in your Reserve Account will be forfeited unless you continue coverage hereunder by making self-payments in accordance with the Plan's self-payment provisions, described under "COBRA Self-Payment Provisions for Active Employees and the Dependents."

Once your Reserve Account bas been forfeited for this reason, you will be required to meet the Initial Eligibility requirements mentioned above to regain eligibility.

Special Rules For Military Service

If you are absent from employment, whether voluntarily or involuntarily, by reason of service in the uniformed services of the United States (including the Armed Forces, National Guard and the Commissioned Corps of the Public Health Services) under such conditions as you qualify for re-employment rights under federal law (including the Uniformed Services Employment and Re- employment Rights Act of 1994), you will be eligible to continue coverage hereunder through self-payment to the extent required by applicable law. The maximum period of coverage under such an election will be the lesser of: (i) the 24 month period beginning on the date on which the your absence begins; or (ii) the day after the date on which you were required to apply for or return to a position or employment and failed to do so.

If the entire length of the leave is 12 weeks or less, you will not be required to pay any more than the amount you paid before the leave. If the entire length of the leave is longer than 12 weeks, you may be required to pay up to 102% of the full premium charged to participants who are not on military leave.

If you subsequently return to work or apply for reemployment with a Contributing Employer within the time period required by law for the maintenance of re-employment rights, you will, upon return to work for a Contributing Employer, be credited with the hours held in your Reserve Account at the time of entrance into active duty.

During the 90-day period following your return to work for a Contributing Employer, if the hours in your Reserve Account are insufficient to maintain coverage under the Plan, you may continue coverage hereunder by making self-payments. If the re-employment requirement is not met, all hours credited to your Reserve Account will be forfeited.

The Fund's current design takes into account the presence of TRICARE; the health insurance program for military personnel and their families. TRICARE is available to all military personnel and their families immediately upon entrance into active duty at no cost to the employee (depending on the option he selects). TRICARE is comparable to or better than the coverage provided under the Fund. Given the presence of quality health insurance while serving in the military, you are best served by preserving your hour bank for your return to civilian employment under the Fund. However, if you wish to continue coverage under the Plan in lieu of, or in addition to TRICARE, then you may do so by paying the applicable premium.

For more information on the Plan's self-payment rules, please see "COBRA Self-Payment Provisions for Active Employees and Their Dependents."

Continuation During Total Disability

If you are an Active Employee and you become "Totally Disabled," as defined below, while covered by the Plan and you remain so disabled for 30 days or more, you will not have any hours deducted from your Reserve Account from the first day of the month in which your Total Disability commences. (However, if hours in the hour bank are reduced for employees in active service, then the hours in your hour bank will be similarly changed by the same increment it is changed for such Active Employees. The hour bank may also be reduced due to (i) contribution rate increases; or (ii) if your Local Union withdraws.) Subject to the applicable coverage termination rules discussed above, your coverage will automatically be continued during such Total Disability for up to 6 consecutive months. After that time, the hours in your Reserve Account will be used to continue your coverage until you no longer have sufficient hours in your Reserve Account. At that point, you will then be allowed to continue your coverage by self-paying the required amount in accordance with the self-pay provisions of this Plan, which are discussed under "COBRA Self-Payment Provisions for Active Employees and the Dependents."

If you lose your eligibility and you are making self-payments under this Plan's self-pay rules when you become Totally Disabled and remain so disabled for 30 days or more, your coverage will automatically be continued during the period of disability for up to 6 months, without payment of your self-payment monthly premium. After the 6-month period ends, or if you recover from your disability, you may resume self-payments in accordance with this Plan's self-pay rules.

For purposes of this provision, you will be considered to be "Totally Disabled" when you are completely unable, due to a sickness or injury or both, to engage in a gainful occupation within your trade, provided you are working within the jurisdiction of the IBEW when you become disabled.

Family And/Or Medical Leave

If you have completed 1,250 hours of employment with an employer that employs 50 or more employees in the preceding 12-month period, you are generally entitled pursuant to the Family and Medical Leave Act of 1993, as amended (the "FMLA") to up to 12 weeks each year of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child; to provide care for a spouse, child or parent who is seriously ill, or for your own serious illness; or for "qualifying exigencies" (such as arranging childcare, making financial arrangements, attending military functions, etc.) if you, your spouse, son, daughter, or parent is called to active military duty. In addition, you are entitled to 26 weeks of unpaid military caregiver leave each year to care for a spouse, son, daughter, parent or next of kin who is a covered military service member with a serious injury or illness.

While you are on FMLA leave, your employer may be required to continue making contributions on your behalf, which the Fund will credit to your Reserve Account. If your employer is not required to continue such contributions (for example, because your employer employs fewer than 50 people and is not subject to the FMLA), you will be eligible to continue coverage for yourself and your Dependents under the Plan by making self-payments to the Plan or your employer. You will be eligible to continue coverage for yourself and your Dependents under the Plan as long as you have sufficient hours in your Reserve Account. Please note, however, that your Reserve Account will not be credited while you are on FMLA Leave, unless your employer continues to make contributions to the Fund on your behalf, or you make self-payments.

Whether or not you keep your coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, your medical coverage will be reinstated without any additional limits or restrictions imposed on account of your leave, so long as you have sufficient hours in your Reserve

Account for continued coverage. This is also true for any of your Dependents who were covered by the Plan at the time you took your leave.

Any changes in the Plan's terms, rules or practices that go into effect while you are on leave will apply to you and your Dependents in the same way they apply to all other Active Employees and their Dependents. To find out more about your entitlement to family or medical leave as required by the FMLA and/or state law, and the terms on which you may be entitled to it, contact the Fund Office.

Special Rules For Employees Of Newly Organized Employers

If you are a Union employee of a newly organized employer, special rules may apply with respect to your initial eligibility for Plan benefits. You will be eligible for coverage on the first day of the month agreed to by the Union and your employer. If you fail to work the required hours to continue your coverage after your first month of eligibility, you will be permitted to continue your coverage under the Plan's self-payment provisions. You will be notified if these special eligibility rules apply to you.

Special Rule For Withdrawing Local Unions And Neca Chapters

If your IBEW Local Union and/or corresponding NECA chapter chooses to leave the Fund, all hours in your Reserve Account will be forfeited immediately. If you are eligible for benefits under the Fund at the time of the withdrawal, whether as an Active Employee, by making self-payments under the Fund's COBRA or extended self-payment provisions for former Active Employees, or under the Fund's self-payment provisions for Totally Disabled or Retired Employees, your coverage will end on the 31st day following the withdrawal (or, if sooner, will end the last day of the month following the month of such withdrawal).

Moreover, if your IBEW Local Union and/or corresponding NECA chapter chooses to leave the Fund, then you, or your Dependents can only purchase up to a 30-day supply of maintenance prescription mail order drugs, subject to the co-payment structure outlined above under "Prescription Drug Benefits." Additionally, you have only 6 months to submit any claims for reimbursement for expenses incurred prior to your IBEW Local Union and/or corresponding NECA chapter's withdrawal.

Important Note About The Eligibility Rules

The Trustees reserve the right to change the rules with respect to the Reserve Accounts and the Fund's eligibility rules at any time.

Eligibility For Sub-Plans – – APPRENTICES AND INTERMEDIATE JOURNEYMAN

Apprentices and Intermediate Journeyman may be eligible to participate in one of two available sub-plans (tier B-1 or tier B-2) where local collective bargaining agreements are modified to specifically participate in such sub-plans. Benefit levels will be determined based on the contribution rate that is made on behalf of an Apprentice or Intermediate Journeyman. The collective bargaining parties will determine which of the two sub-plan contribution rates apply, based together on the tenure of Apprentices and the experience of Intermediate Journeymen. Apprentices or Intermediate Journeymen for whom contributions are made at the higher of the two rates (currently $2.60) will be eligible for Sub-Plan B-2. Apprentices and Intermediate Journeymen for whom contributions are made at the lower of the two rates (currently $1.60) will be eligible for Sub-Plan B-1.

Such Apprentices or Intermediate Journeymen will initially be eligible for participation in the applicable sub-plan on the first day of the second calendar month following the earlier of (i) a period of three (3) consecutive calendar months during which such Apprentice or Intermediate Journeyman has been credited with three hundred and seventy-five (375) hours, or (ii) a period of up to six (6) consecutive calendar months during which such Apprentice or Intermediate Journeyman has been credited with at least five hundred (500) hours.

Effective November 1, 2012, a Reserve Account will be established and maintained by the Fund for each apprentice and intermediate journeyman who works for a Contributing Employer that makes contributions to the Fund on his or her behalf. All hours worked during the initial eligibility period in excess of those

required to establish initial eligibility and all hours worked thereafter for one or more Contributing Employers will be credited to this Reserve Account when the Fund receives the required contributions from the apprentice or intermediate journeyman's employer. If an Apprentice or Intermediate Journeyman covered under the sub-plans becomes disabled, then he or she will be credited with 140 hours for each month he or she is disabled up to a maximum of six months. Effective as of January 1, 2016, an apprentice or intermediate journeyman will be allowed to accumulate a maximum of 280 hours in his or her Reserve Account, after deduction for the current month's coverage (e.g., 420-140 = 280).

Currently, 140 hours will be deducted from each Reserve Account for each month of coverage. A lag month will be used in determining continuing eligibility. Thus, hours worked in a given month may not be used for eligibility until the second month following the month in which the hours were worked. Generally, apprentices and intermediate journeymen will continue to be eligible as long as their Reserve Account contains at least 140 hours. Reserve Accounts cannot be used to supplement contractually required contributions that are less than the amount required by the Trustees.

Withdrawals for coverage from the Reserve Account will be made based on the Sub-Plan's current contribution rate. Whenever the Sub-Plan's contribution rate increases, the number of hours in the Reserve Account will automatically be proportionately reduced by the percentage difference between the old and new contribution rates.

The Reserve Account is merely a bookkeeping entry and neither you nor your Dependents have any right to any particular Fund assets or any vested or accrued right to your Reserve Account or to any Fund eligibility or participation by virtue thereof. The Trustees can modify, reduce, forfeit, or terminate the Reserve Accounts at any time.

Contact the Fund Office if you have questions regarding your eligibility to participate in a sub-plan. Please see the Summary Plan Description for the Sub-Plans for Apprentices & Intermediate Journeyman for participation rules and specific details about the sub-plans.

ELIGIBILITY RULES FOR DEPENDENTS

Establishment And Maintenance Of Eligibility

Your eligible Dependents, as defined below, will be eligible for Plan benefits provided to Dependents during any period you are so eligible.

Termination Of Eligibility

The eligibility of a Dependent will terminate on the earlier of the following dates:

1. On the date your eligibility terminates.

2. On the last day of the month concurrent with or next following the date he or she no longer qualifies as a Dependent, as defined below.

   Exception to the Termination Provisions

   In the event of your death at a time when your Dependents are covered under this Plan, coverage for your Dependents will remain in effect until the normal termination date of your coverage disregarding your death (i.e., when your hour bank runs out). Thereafter, your Dependents may continue their coverage by self-paying the required contribution amount under the Plan's self-payment rules. However, other than as may be required by COBRA, coverage may not be continued beyond the remarriage of your surviving spouse or extended to a dependent child once the child no longer meets the definition of an eligible Dependent.

Definition Of A Dependent

A Dependent is defined as follows:

l. Your lawful spouse.

2. Your child, through the end of the month in which they attain 26 years of age, including stepchildren, adopted children and children placed for adoption (but not foster children). A child is considered to be "placed for adoption" if you have assumed and retain a legal obligation for total or partial support of the child in anticipation of adoption. However, children of a child or the spouse of a child are not considered Dependents. If a child is eligible for health coverage through their employer or their spouse's employer, such other coverage will be primary to coverage under the Plan.

   Dependent children who lose eligibility because of reaching the maximum age are eligible to continue their medical benefits under the COBRA continuation provisions or the special self-pay provisions provided under "COBRA Self-Payment Provisions for Active Employees and the Dependents." They many also obtain coverage under the Affordable Care Act Marketplace / Healthcare Exchange.

3. Your qualifying child or children as described in Code Section 152(c), excluding any child defined in Code Section 152(d)(l), including grandchildren, brothers, sisters, nieces and nephews, who reside in your household for more than half of the Plan Year; are less than 19 years of age or less than 24 years of age and attending an accredited school, college or university as a full-time student (for a minimum of 12 credit hours per a semester or are an indentured apprentice in an IBEW program) (or are on a medically necessary leave of absence from school, to the extent covered by ERISA Section 714); and

for whom you provide primary financial support and maintenance (at least one-half), and whom you claim as a dependent for federal income tax purposes.

4. A child for whom coverage must be provided pursuant to a Qualified Medical Child Support Order (as such term is defined in section 609 of ERISA)

5. An unmarried child of any age who is unable to earn a living because of a mental or physical handicap is also considered an eligible Dependent, provided the child was both handicapped and eligible under the Plan prior to age 26, is solely dependent upon you for support, and provided the employee furnished proof of the dependent child's handicap not later than 31 days after the child's attainment of age 26. You may be requested by the Fund to furnish proof of the continued existence of such handicap from time to time.

Qualified Medical Child Support Orders

If an order is issued by a court or through an administrative process under state law with respect to the provision of health care coverage for your child(ren), the Fund Office or its designee will determine if the court order is a Qualified Medical Child Support Order ("QMCSO") as defined by federal law, and that determination will be binding upon you.

To be qualified, an order must contain specific information, must be submitted to the Fund Office and it must be approved. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws.

If an order is determined to be a QMCSO, and if you are eligible for Plan benefits, the Fund Office or its designee will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the dependent child(ren).

Upon request, you may obtain from the Fund Office, free of charge, a copy of the Plan's procedures governing QMCSOs.

The Board of Trustees has the right to require proof of Dependent status from time to time.

SPECIAL ELIGIBILITY PROVISION FOR NON-BARGAINING EMPLOYEES

If you are a full-time or regular part-time employee who is not subject to the collective bargaining agreement of a Contributing Employer (a "Non-Bargaining Unit Employee"), you may be eligible for benefits provided by the Plan in accordance with all of the following provisions:

1. Your employer must sign a non-bargaining participation agreement with the Fund that covers your employment.

2. Your employer must agree to offer coverage to all of its regular full-time or part-time non-bargaining employees who are not covered by another multiemployer plan.

3. A Non-Bargaining Unit Employee may opt out of coverage only by filing notice with the Fund Office. Once you opt-out, you cannot get back in unless and until you or your spouse have a Qualifying Change in Family Status (as defined under Section 125 of the Internal Revenue Code Regulations).

4. One hundred and seventy-three (173) hours per month must be contributed by your employer on your behalf at the rate established by the Trustees.

5. Unless you are an employee of a Local Union, your employer **must** also cover some or all of its bargaining unit employees hereunder pursuant to a collective bargaining agreement, letter of assent, or participation agreement.

   If your employer meets these conditions, your benefits under the Fund will be the same as those for an employee who is subject to the collective bargaining agreement.

   Your coverage under the Plan will terminate as provided in this SPD, or if your employer (i) is delinquent in its required contributions or fails to pay at the required rate, (ii) discontinues its contributions, (iii) otherwise ceases to cover its non-bargaining employees or bargaining unit employees under the Plan, or (iv) breaches its participation agreement with the Fund.

6. You will automatically participate in the Main Plan unless your Contributing Employer elects for you to participate in the Sub-Plans. Once you are participating in the Main Plan, you cannot transfer to the Sub-Plans. Participation in the Sub-Plans is limited to newly hired employees only. If your Employer elects for you participate in the Sub-Plans, participation in Sub-Plan One shall be limited to the first 12 months of coverage, and participation in Sub-Plan Two shall be limited to the second 12 months of coverage. After 24 months of Sub-Plan coverage, you will automatically be transferred to the Main Plan.

COBRA SELF-PAYMENT PROVISIONS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

LOSS OF ELIGIBILITY

If you are participating in the Plan as an Active Employee and you lose your eligibility for benefits because of insufficient hours in your reserve account, or in the case of a non-bargaining unit employee because your employment terminated (other than for reasons of gross misconduct), you and/or your eligible Dependents may continue coverage by making self-payments directly to the Fund Office. This right to continue you and/or your Dependents' coverage under the Plan was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

This Section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your rights to get it.

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation 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.

The following is an explanation of your COBRA rights.

If your loss of coverage is due to your retirement, you may be eligible to elect between coverage under these provisions or under the Plan's Retiree Self-Payment provisions. Once you decide the basis upon which you wish to continue coverage, you generally will not be permitted to change your decision. Please see the Retiree Self-Payment provision for more details on this rule. You may also be entitled to Medicare, which is discussed below.

Your Dependent or Dependents may continue coverage by making self-payments directly to the Fund Office if coverage is lost because of one of the following reasons:

1. You lose coverage as described above;
2. Your death or divorce;
3. Your eligibility for Medicare (under Part A, Part B, or both) if you are continuing coverage in accordance with these provisions; or
4. In the case of your dependent child, the failure of such child to meet the definition of Dependent.

Notice

The Fund Office will notify you and your eligible dependents of your and their ability to elect continued coverage under these special self-payment provisions when you have lost coverage because of insufficient hours (or for non-bargaining employees, because your employment terminated).

If your Dependent loses coverage under the Plan as a result of (1) your death or divorce, (2) your eligibility for Medicare if you are continuing coverage in accordance with these provisions, or (3) the failure of a dependent child to meet the definition of Dependent, then you or your Dependent is responsible for

notifying the Fund Office of those facts within sixty (60) days of the date you or your Dependent would lose coverage on account of the event.* If neither you nor your Dependent notifies the Fund Office of the events listed in items (1) and (3) within sixty (60) days of the date you or your Dependent would lose coverage on account of the event, then your Dependent will not be eligible to continue his or her coverage under the Fund's self-payment provisions. Once the Fund Office is timely notified of these events, it will then notify your Dependents of their rights under these provisions, if any, within fourteen (14) days.

You and/or your Dependent(s) will have until the later of sixty (60) days from the date of the notice from the Fund Office, or sixty (60) days from the date eligibility is lost, to notify the Fund Office of the election to continue eligibility by making self-payments.

Self-Payment Amounts and Benefits Available

You will be notified by the Fund Office when you receive notice of your right to elect continued coverage of the then-current premium rates for your coverage. The amount of the monthly self-payment(s) will be established by the Board of Trustees and is subject to change at their discretion.

If you and/or your Dependents choose to continue your coverage, you will generally be provided the same benefits as those provided to Active Employees, excluding the weekly accident and sickness benefit. In addition, you will be given the option, for an additional premium, of continuing your life insurance benefits while you are on COBRA coverage.

Acquiring New Dependents while Covered by COBRA

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while you are continuing your coverage under these special self-payment provisions, you may add that Dependent to your coverage for the balance of your available coverage period. In order to do so, you must notify the Fund Office and enroll the Dependent within 30 days of his or her birth, adoption, placement for adoption or your marriage.

Spouse or Dependent's Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while you are enrolled in the self-pay continuation coverage under this section, your spouse or dependent (who was not previously covered under the Fund) loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA continuation coverage. The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage. To take advantage of this special right, you must enroll your spouse or dependent within 31 days after the termination of the other coverage.

The loss of coverage under the other health plan must be due to exhaustion of COBRA continuation coverage under the other plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does

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* Please note that if your Dependent loses coverage by virtue of your death, he or she will remain covered under the Plan until your reserve account is exhausted. In this case, your Dependents have 60 days from the date the reserve account is exhausted to notify the Fund Office.

not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

Maximum Number of Self-Payments

Your and/or your eligible Dependents' right to continue coverage under this section will be continued until the end of the month in which the earliest of the following events occurs:

1. The Fund ceases providing any benefits to any participants.

2. The failure to make the timely self-payments required by the Trustees.

3. After you elect coverage hereunder, you and/or your eligible Dependents become covered under any other group health care plan, or becomes eligible for Medicare.

4. Except as provided in 5 and 6 below, in the case of loss of active coverage because of insufficient credited hours, eighteen (18) months have passed since the loss of coverage.

5. If the loss of coverage is due to your active duty service, twenty-four (24) months have passed since the loss of coverage.

6. If you or one of your Dependents is disabled for purposes of Social Security when you lose coverage (or is found to be disabled within 60 days thereafter) as a result of insufficient hours, the earlier of (a) 11 months from the date the 18-month period described in 4 above or the 24-month period described in Item 5 above ends, or (b) 30 days after the date you or your Dependent is found to no longer be disabled. Please note that this COBRA coverage extension applies to your entire family, not just to the disabled person. In order to take advantage of this 11-month extension, you or your Dependent must notify the Fund Office of the disability within 60 days of the Social Security Administration's determination of your disability, and before the expiration of the 18-month period described in 4 above or the 24-month period described in Item 5 above.

7. In the case of your death or divorce, your eligibility for Medicare (Part A, Part B, or both) while continuing coverage in accordance with these provisions, or a Dependent child's ceasing to meet the definition of Dependent, thirty-six (36) months have passed since the loss of regular coverage under the provisions of this Plan. If you become eligible for Medicare within 18 months before your loss of coverage, the 36 months begin to run from your Medicare eligibility date. If you become eligible for Medicare more than 18 months prior to your loss of coverage, your COBRA rights are limited to 18 months from your loss of coverage.

8. In the case of multiple qualifying events, COBRA coverage will be extended in no event for more than 36 months from the date of initial loss of coverage.

9. Except as otherwise required by COBRA, your local Union ceases participation or withdraws from the Fund, or your last employer is no longer required by a collective bargaining agreement to contribute to the Fund.

Termination of Self-Payments

If you or your Dependents fail to make a required self-payment within the specified time or make the maximum number of self-payments, then you and/or your Dependents will not be permitted to make any more self-payments for COBRA coverage unless and until you first requalify for active coverage under this

Plan in accordance with the Initial Eligibility rules. If you were working under a collective bargaining agreement prior to losing your coverage, you may be eligible for the specified extended self-pay provisions described below under "Extended Self-Payment Provisions".

Payment of Self-Payment Premium for Employee and Dependents

Your initial self-payment must be paid no later than the forty-fifth (45th) day after the date you submit your election to make self-payments. Your initial payment must cover both the required self-payment premium for the month you submit the payment, plus the premiums for any prior months back to the date you lost coverage. Each subsequent self-payment is due on the first (1st) day of the month for which coverage is intended. Self-payments received at the Fund Office later than thirty (30) days after the due date will not be accepted, and rights to self-payment will terminate. Once terminated, self-payment cannot be reinstated. There will be no waivers granted.

Trustee Rights Concerning Self-Pay Eligibility

Please note that if you and/or your Dependents are continuing your coverage under these provisions, the Board of Trustees may request from time to time any pertinent information bearing on your eligibility for the benefits provided under these self-payment provisions. If you fail to promptly respond to the Trustees' request for such information, the Trustees may suspend or terminate your self-payment rights.

Self-Pay Eligibility Affected by Multiple Events

An additional 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months from the first day COBRA coverage begins. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify the Fund Office within 60 days after a second qualifying event occurs. If you fail to notify the Fund Office within 60 days of the second qualifying event, you will not be eligible for the 12- or 18-month extension. Please note that this COBRA extension is generally available only if the second qualifying event would have caused the spouse or dependent child to lose coverage had the first qualifying event not occurred.

Notwithstanding anything to the contrary herein, no person may enjoy any one continuous self-pay coverage extension under the Plan beyond thirty-six (36) months from the end of the month in which the first event giving rise to self-payment rights with respect to that person occurred. Please note that the retiree self-payment program is not considered an event giving rise to self-payment rights.

Condition for Self-Payment Rights

Please note that the self-payment provisions under this section are provided pursuant to a federal law known as COBRA. Thus, eligibility for self-payment is expressly conditioned on your and/or your Dependents' entitlement to COBRA health care continuation coverage under applicable law. For example, you or your Dependents will not be entitled to self-payment rights if you lose eligibility under the Plan due to (i) an employer withdrawing from the Fund, (ii) the employer going non-union, (iii) a Local Union withdrawing from the Fund, (iv) an employer failing or refusing to make its required contributions, or (v) any other act or omission which does not qualify as a "qualifying event" under COBRA.

COBRA Alternatives

Please note that you and your family may have other options available to you when you lose coverage under the Plan, such as through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

For example, you may be eligible to enroll in and buy coverage through the Health Insurance Marketplace. The monthly premiums through the Marketplace may be lower than the COBRA rates under the Plan. By enrolling in coverage through the Marketplace, you may also qualify for lower costs (such as through a premium tax credit or cost-sharing reductions) and/or lower out-of-pocket costs. You will generally qualify for a 60-day special enrollment period in the Marketplace when you become eligible for COBRA under the Plan. However, if you elect the Plan's COBRA coverage (such as due to the currently subsidized COBRA rates for the first 9 months of coverage), and then drop the Plan's COBRA coverage (such as due to the increased costs after the first 9 months), you will not be eligible for a special mid-year enrollment right in the Marketplace, and will have to wait until the first day of the following calendar year for Marketplace coverage.

Other coverage options may include other group coverage (such as through your spouse's employer), Medicaid or the Children's Health Insurance Program (CHIP). If you or your children are eligible for Medicaid or CHIP and you're also eligible for health coverage under the Plan, your State (including Kansas, Oklahoma, and Texas) may have a premium assistance program that can help pay for coverage. Contact your State Medicaid or CHIP office or call 1-877-KIDS NOW or www.insurekidsnow.gov for more information.

You may also be eligible to enroll in Medicare. In general, if you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, your COBRA coverage under the Plan will end. However, if Medicare Part A or B is effective on or before the date of your COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of your COBRA election.

If you are enrolled in both COBRA and Medicare, Medicare will generally pay first (primary payor) and COBRA will pay second. Moreover, please note that the Plan will pay as if it is secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit https://www.medicare.gov/medicare-and-you.

For more information about your rights under ERISA, COBRA or the Affordable Care Act, contact the nearest Regional or District Office of the US Dept. of Labor's Employee Benefits Security Administration (EBSA) or see www.dol.gov/ebsa, or call 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, see www.HealthCare.gov.

EXTENDED SELF-PAYMENT PROVISIONS

At the end of the eighteen (18) month or thirty-six (36) month COBRA period your coverage may be continued in accordance with the provisions described below. However, in no event may coverage for surviving Dependents be continued beyond the remarriage of your surviving spouse or the dependent child no longer qualifying as a Dependent.

Keep the Fund Informed of Address Change

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Extended Self-Payment Provisions For Active Employees

If your eligibility terminates due to a shortage of required hours in your Reserve Account or if you are otherwise eligible for COBRA continuation coverage, and you are not engaged in Competitive Employment (as defined below), then, after you have first completely exhausted your COBRA self-pay rights discussed above, you may continue your Plan coverage (other than weekly accident and sickness, life insurance, and AD&D benefits) by making the required payment to the Fund, provided that you meet both (1) and (2) below:

1. You are either:

    a. actively seeking employment in the organized electrical industry and are registered on your Local's "out-of-work" list; or

    b. If employed outside the jurisdiction of this Fund, your employer is not making health care contributions on your behalf but is contributing on your behalf to the National Electrical Benefit Fund; and

2. The Business Manager of the IBEW Local in whose jurisdiction you reside certifies in writing to the Fund that you are eligible under the Plan's rules to continue to make self-payments.

The term "Competitive Employment" means performing any work within the building construction industry under the jurisdiction of the IBEW which is normally performed by an electrician apprentice, journeyman, foreman or superintendent.

These special extended self-payment provisions are available only if you established and continued your eligibility through contributions made on your behalf under a collective bargaining agreement and then completely exhausted your COBRA rights.

Self-Payment Provision For Totally Disabled And Retired Employees

If you are Totally Disabled (as defined above) or a Retired Employee (as defined below) you may continue Plan coverage (other than life insurance, accidental death and dismemberment, and weekly accident and sickness benefits) for yourself and your eligible Dependents, provided you were eligible for Plan coverage on the date your Total Disability or retirement commenced. A Totally Disabled employee or Retired Employee who elects coverage under this provision will not be allowed to change to any other self-pay provision hereunder. In addition, this provision does not apply if your disability arose while you were on COBRA coverage. Additionally, if you are a Retired Employee, you may resume Plan coverage (other than life insurance, accidental death and dismemberment, and weekly accident and sickness benefits) for yourself and your eligible Dependents in the event you experience a change in family status that results in a loss of health coverage.

The benefits provided for under these special rules will be the same as provided for an Active Employee, except that life insurance, accidental death and dismemberment, and weekly accident and sickness benefits will not be provided. However, on the date you or your eligible Dependent first becomes eligible for

Medicare, the benefits provided under these self-payment provisions for that individual will be coordinated with Medicare and Medicare will be the primary payer to the full extent permitted by applicable law.

Retired Employees

An individual may qualify to be a "Retired Employee"·if he:

1. was eligible for benefits under the Fund, or under the Fund and a prior fund before it merged with this Fund, for 48 of the 60 months immediately prior to retirement;

2. was eligible under the Fund at the time of retirement; and

3. meets the conditions described in either (a) or (b) below:

   a. Retires on or after age 62 and is receiving benefits under the National Electrical Benefit Fund, IBEW Pension Fund, Social Security Old Age Survivors and Disability Insurance Coverage, OPEIU pension fund or other equivalent electrical industry associated annuity, retirement or pension; or

   b. Is age 55 but less than age 62 when he/she retires; and is not engaged in or seeking any gainful employment in the electrical industry or any other employment with wages in excess of the annual amount allowable by the Social Security Old Age Survivors and Disability Insurance Coverage for full benefits thereunder.

If you meet the definition of Retired Employee and are receiving benefits from the International Brotherhood of Electrical Workers Pension Fund, then you will be considered retired even if you are not receiving pension benefits from any other retirement benefit fund or from Social Security. To the extent that you are not considered retired under the Plan, if you are still working under a collective bargaining agreement or in the industry, then you may self-pay through COBRA without having to refund the difference between the COBRA and Retired Employees self-pay premiums when you become eligible to self-pay as a Retired Employee. If you meet the definition of Retired Employee and are receiving benefits from the International Brotherhood of Electrical Workers Pension Fund, then you will be able to self-pay as a Retired Employee even if you work outside of a collective bargaining agreement (provided, however, that you continue to meet the requirements for receiving your IBEW pension).

Coverage Options

Effective as of January 1, 2023, a Retired Employee who is eligible for Medicare can choose coverage either under the Prescription Drug Wrap Around Program for Self-Paying Medicare Eligible Retirees (known as the Medicare Supplement Plan or EGWP), or the Medicare Advantage Plan (MAP). These two plans offer different levels of coverage and different self-pay rate structures. Self-paying Medicare eligible Retired Employees can elect once per year, at annual enrollment, whether to participate in the Medicare Supplement Plan or the Medicare Advantage Plan.

Payment Rules

The amount of the monthly self-payment premium will be established by the Board of Trustees and you will be notified of the current rates if applicable. Payment must be made to the Fund Office no later than the fifteenth (15th) day of the month following the month in which your eligibility terminates. Each subsequent payment must be received by the Fund Office no later than the fifteenth (15th) day of the month for which coverage is intended. If you fail to make the required self-payment on time, you will no

longer be eligible to continue your coverage under these special self-payment rules. Extensions for missed or late payment are available within three (3) months of the due date, or with the Trustees' approval, within twelve (12) months, but in either case, subject to the rules listed below.

Retirees will be permitted to use any remaining reserve account hours when they first become eligible for Retiree coverage, such that their first month's payment is only the additional amount needed (based on the current contribution rate and number of hours needed for one month's coverage) less credit for their remaining reserve account hours, on a one-time basis, for the first month of retiree coverage only.

Reinstatement of Self-Payment Provisions

Except as explained below for changes in status, if you miss a required premium payment and your right to continue your coverage terminates, you may apply for reinstatement of the self-payment privilege within twelve (12) months after your coverage terminates. Except as explained below for changes in status, the opportunity to reinstate the self-payment privilege is limited to once in your lifetime. If your application for reinstatement is made three (3) or more months following termination of your coverage, you must submit, at your expense, a health statement approved by the Board of Trustees and completed by a Physician selected by the Board of Trustees that establishes evidence of your good health. The statement must cover all of your Dependents for which you are seeking to reinstate coverage.

Changes in Status

If you did not elect Retiree Coverage or terminated Retiree Coverage because you were covered by another plan and subsequently lose your alternative coverage because:

1. your marital status changes (including because of marriage, death of spouse, divorce, legal separation or annulment); or

2. your spouse's employment status changes (including changes due to a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; or a change in worksite),

then you may reinstate your Retiree Coverage when you must submit, at your expense, a health statement that showing your good health. The Board of Trustees must approve the health statement and of the Physician who completes it.

Important Note for Retirees about COBRA Coverage

If you elect Retiree Coverage, your choice will impact your ability to elect continuation coverage under COBRA, and vice versa. Your Retiree Coverage will run concurrent with the COBRA continuation coverage offered under the Fund. This means that you will generally not be entitled to COBRA coverage after your Retiree Coverage ceases. For example, if your Retiree Coverage ends before your death because you did not pay your premium on time, you will NOT be eligible to then elect COBRA coverage. In addition, if you elect COBRA continuation coverage instead of Retiree Coverage, except as described below, you will not be able to later elect Retiree Coverage when your COBRA coverage expires.

In certain limited situations, you will be permitted to change from COBRA coverage to Retiree status on the condition that the change occurs immediately after you begin receiving Social Security or a NEBF, IBEW Pension Fund, Local IBEW Union or other equivalent electrical industry-associated pension. In order to make the switch, you must provide proof of the Social Security or pension start date by submitting a letter to the Fund from Social Security or the NEBF, IBEW Pension Fund, Local IBEW Union or other

equivalent electrical industry associated pension fund. If you remain on COBRA coverage after being notified of when your Social Security or pension will begin, you will be required to make an additional "make-up" payment equal to the aggregate difference between the COBRA premiums and the appropriate Retiree coverage premiums retroactive to such Social Security or pension start date if you later wish to switch from COBRA coverage to Retiree status. In effect, you can switch as long as it is an immediate switch once Social Security or pension pay status starts (or you pay the difference, retroactive to such date, for each month you were on COBRA but could have elected Retiree status).

Special Rule for Withdrawing Unions

If the Local Union and/or NECA chapter you were associated with as an Active Employee leaves the Fund, you will no longer be eligible to continue your coverage under this Plan's self-payment provisions for retirees. Your coverage will end on the 31st day after the Local Union and/or NECA Chapter withdraws from the Fund (or if sooner, on the last day of the month following the month of such withdrawal).

Special Rule for Spouse of Deceased Active Employees

Upon completion of thirty-six (36) months of Self-Payment coverage, as provided above, a deceased Employee's lawful spouse may continue his or her coverage under the Self-Payment Provision for Retired Employees, if (i) such Employee had at least twenty (20) years of service, as verified by NEBF, and (ii) such Employee's age and years of service equal or exceed seventy (70).

EMPLOYEE LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

LIFE INSURANCE

The life insurance benefit shown in the Summary of Benefits will be paid to your designated beneficiary after he or she provides the Fund with proof of your death (i.e., a certified copy of your death certificate) provided you are an Eligible Individual, and provided that no exclusions apply. For example, you cannot be considered both a covered individual and a dependent at the same time for purposes of the life insurance benefit.

BENEFICIARY

Subject to any applicable community property laws, which may give your spouse an automatic right to 50% of your life insurance, you may name any individual you wish as your beneficiary. Your beneficiary must, however, be a natural person taking in his own right as an individual and not in a fiduciary capacity. You may change your beneficiary designation at any time by completing the proper form. The change will be effective when the completed form is received by the Fund Office. If you name more than one beneficiary, and their respective interests are not specified, they will share alike.

If you have not named a beneficiary, or if your designated beneficiary dies before the life insurance benefit is paid, the life insurance benefit will be paid to your lawful spouse, if then living. If there is no lawful spouse alive at the time of payment, payment will be made to one or more of your surviving relatives as determined by the Fund in its sole discretion as follows: child or children, mother, father, brothers or sisters, or to your estate.

PAYMENTS

Life insurance benefits will be paid to your beneficiary in a single lump sum.

TOTAL AND PERMANENT DISABILITY

If you are an Active Employee who becomes Totally and Permanently Disabled (as defined below) while insured and before age 60, your life insurance coverage may be continued and benefits payable to your designated beneficiary upon your death if either of the following conditions are met:

1. If you die within one (1) year following the date when you cease to qualify as an Active Employee, your beneficiaries must submit evidence of your uninterrupted Total and Permanent Disability to the Fund Office no later than 12 months after the date of your death; or

2. Otherwise, you must submit proof to the Fund Office of your Total and Permanent Disability within nine (9) months to one year after the date you cease to qualify as an Active Employee. Thereafter, you must provide proof to the Fund Office of your continuing Total and Permanent Disability each year by the anniversary date on which you initially sent proof to the Fund Office of your Total and Permanent Disability.

The amount of life insurance that will be continued while you are Totally and Permanently Disabled will be the amount provided at the time you would have lost coverage as a result of your disability but for this disability extension.

The term "Total and Permanent Disability" means that you are unable to engage in any gainful occupation and completely unable, due solely to illness or injury or both, to engage in any and every gainful occupation for which you are reasonably fitted by education, training or experience.

Life insurance benefits will continue under this disability extension until the earliest of:

1. 31 days after the date you are no longer Totally and Permanently Disabled;

2. The date you fail to furnish the Fund Office with proof of your continued Total and Permanent Disability (the proof must be furnished each year by the anniversary of the date that you initially sent proof of your Total and Permanent Disability to the Fund Office); or

3. The date you fail to be examined by a Physician designated by the Fund Office provided the Fund Office has made such a request. Such an examination will not be required more than once a year after your life insurance has been continued under this disability extension for 2 full years.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR EMPLOYEES

If, while covered under this Plan as an Active Employee, you sustain any of the losses listed below as a direct result of an accidental injury independent of all other causes, you or your designated beneficiary will receive a benefit up to $10,000 (the "Principal Sum"). There must be a visible wound on your body, except in the case of drowning or internal injuries revealed by autopsy. For benefits to be payable, the loss must take place within 90 days from the date of the injury. This benefit is in addition to any other benefits under the Plan.

Who Will Receive the Benefits

For loss of life, benefits will be paid to the beneficiary you name. For any other loss, the benefits will be paid to you.

Benefits

For the Loss of	The Benefit Is
Life	The Principal Sum
Two Hands	$10,000
Two Feet	$10,000
Sight to Two Eyes	$10,000
One Hand and One Foot	$10,000
One Hand and One Eye	$10,000
One Foot and One Eye	$10,000
One Hand or One Foot	$5,000
Sight of One Eye	$5,000

If you suffer more than one loss in any one accident, payment will be made only for the loss for which the largest amount is payable.

Definitions

1. An accidental injury means physical pain or impairment that is unforeseen, unexpected, involuntary and due to violent and external means. It must be independent of illness, disease, bodily infirmity or other causes.

2. The loss of a hand or foot means that the limb is severed at or above the wrist or ankle joint, respectively.

3. The loss of sight means the total and irrecoverable loss of sight.

Beneficiary

Subject to any applicable community property laws, which may give your spouse an automatic right to 50% of your accidental death benefit, you may name any individual you wish as your beneficiary. You may change your beneficiary designation at any time by completing the proper form. The change will be effective when the completed form is received by the Fund Office. If you name more than one beneficiary, and their respective interests are not specified, they will share alike.

If you have not named a beneficiary, or if your designated beneficiary dies before the accidental death benefit is paid, the benefit will be paid to your lawful spouse, if then living. If there is no lawful spouse alive at the time of payment, payment will be made to one or more of your surviving relatives as determined by the Fund in its sole discretion as follows: child or children, mother, father, brothers or sisters, or to your estate.

Losses That Are Not Covered

No benefit is payable under the Plan if your death or any loss is caused by or contributed to, directly or indirectly, wholly or partly by:

I. Bodily or mental illness or disease of any kind, or any medical or surgical treatment or diagnosis thereof;

2. Ptomaine or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);

3. Suicide, attempted suicide, intentional self-destruction or self-inflicted injury, while sane or insane;

4. Participation in the commission of a felony or act of aggression;

5. War or an act of war, including resistance to an armed aggression, whether declared or undeclared;

6. Insurrection, rebellion or participation in a riot;

7. Boarding, traveling on or alighting from an airplane while being used for testing or experimental purposes or while you are operating, learning to operate or serving as a crew member thereof;

8. Asphyxiation from inhaling gas, whether voluntarily or involuntarily, and not as a result of your job;

9. Voluntarily taking any drug or narcotic unless prescribed by a Physician;

10. Driving while under the influence of alcohol; or

11. An accident occurring while serving in the armed forces of any country or international authority.

LIFE INSURANCE FOR ELIGIBLE DEPENDENTS

Upon the death of one of your eligible Dependents, the Fund will pay the amount of life insurance shown in the Summary of Benefits to you, provided that your Dependent was over fourteen (14) days old and no exclusions apply, and provided further that you are alive at the time of the death of the Dependent. If you are not living, payment will be made to the first surviving of the following classes of beneficiaries:

1. Your spouse;

2. Your children born to or legally adopted by you will share and share alike; or

3. Your estate.

If your Dependent's life insurance is payable to your children as outlined in Item 2 above, an affidavit signed by all of your children will be sufficient proof that the person or persons named in the affidavit are the sole surviving members of that group. Payment made on that basis discharges the Fund's liability.

Any benefits payable to a minor will be paid to the minor's legally appointed conservator or guardian.

WEEKLY ACCIDENT AND SICKNESS BENEFITS FOR ACTIVE EMPLOYEES

Benefits

If you are an Active Employee who is actively working for a Contributing Employer and you become disabled as a result of a non-occupational sickness or injury and are thereby prevented from performing any and all of the usual duties of your occupation, a weekly benefit of up to three hundred fifty dollars ($350) will be payable.

Weekly benefits will begin with the eighth day of disability, and will continue as long as you remain disabled and qualify as an Active Employee, up to a maximum of twenty-six (26) weeks for any one Period of Disability.

Period of Disability

In determining a "Period of Disability," successive periods of disability separated by less than two (2) weeks of continuous active employment with a Contributing Employer will be considered as one continuous Period of Disability unless they arise from different and unrelated causes and are separated by a return to active employment with a Contributing Employer for a least one full day.

Limitations and Exclusions

No benefits are payable for:

1. Any Period of Disability during which you are not under the direct care of a Physician.

2. Disability due to abortion, except as follows:

    a. The mother's life would be endangered if the fetus were carried to term.

    b. Medical complications that arise from an abortion.

    c. The mother's mental and emotional health would be seriously threatened as a result of delivering and caring for a severely physically handicapped or retarded infant, provided tests confirm the condition of the fetus.

3. Disability, in whole or in part, that either:

    a. Is covered by any workers' compensation or occupational disease law, or

    b. Arises from or is sustained in the course of any occupation or employment for compensation, profit and gain while working for another person.

GENERAL EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations

The Plan will not provide weekly accident and sickness income benefits, comprehensive medical benefits, prescription drug benefits, mental health and substance abuse benefits, dental benefits, vision benefits or any other benefits for:

1. Any bodily injury or sickness for which the Eligible Individual is not under the care of a Physician.

2. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication of settlement, under any workers' compensation or occupational disease law, even though the Eligible Individual fails to claim his or her rights to such benefits. (Expenses will be covered for claims that have been denied by a workers' compensation court or an administrative judge, provided that the individual signs a subrogation/reimbursement agreement with terms acceptable to the Fund whereby he or she agrees to reimburse the Fund from any settlement or recovery he or she may obtain in connection with such claims.)

3. Expenses incurred in connection with any occupational accident or sickness.

4. Conditions caused by or arising out of an act of war, armed invasion or aggression.

5. Charges for services or supplies for which no charge is made or for which you're not legally required to pay or aren't billed (or wouldn't have been billed but for coverage hereunder), including any charge for which any part of the deductible or coinsurance is waived, reduced or not collected.

6. Charges for services or supplies received from or in facilities owned or operated by the United States government, unless the Eligible Individual is legally required to pay for such charges in the absence of the benefits provided by this Plan. However, benefits will be payable for Reasonable and Customary Charges covered under this Plan which were incurred by:

    a. An Eligible Individual at a Veteran's Administration facility,

    b. An employee, as an armed service retiree, or his Dependent, for services or supplies which are not related to military service.

Reasonably Necessary Services and Reasonable and Customary Charges

The Plan will not be liable to provide weekly accident and sickness income benefits, comprehensive medical benefits, prescription drug benefits, mental health and substance abuse benefits, dental benefits, vision benefits or any other benefits for medical services or supplies not reasonably necessary for the care or treatment of bodily injuries or sickness, as determined in its (or its delegate's) sole discretion. Furthermore, the Plan will not provide benefits for services, treatments or supplies for the care and treatment of bodily injuries or sickness that are either:

7. Not prescribed by a Physician, or

8. Are in excess of the Reasonable and Customary Charges ordinarily associated with such care and treatment or in excess of such charges as would have been for such care and treatment in the absence of the benefits provided by the Fund.

A “**Reasonable and Customary Charge**” will mean the lesser of (a) the billed charges; (b) the usual charge made by a Hospital, Physician or other professional person, or other person or entity having rendered or furnished the services, treatments or supplies which do not exceed the general level of charges made by others rendering or furnishing such services, treatments, or supplies within the county in which the charge is incurred, for bodily injuries or sickness comparable in severity and nature to the bodily injuries or sickness treated or being treated, as determined in the Fund’s (or its delegate’s) sole discretion; (c) the charges listed on a national Relative Value Scale; or (d) the amount the Trustees or its delegate determines, in its sole discretion, is appropriate, given the services rendered, the geographic location, the value of the services relative to other services, market considerations, and provider charges patterns. However for non PPO facilities, “Reasonable and Customary” will be the lesser of the billed charges or 200% of the Medicare allowable.

If a medically appropriate alternative treatment is available, the Covered Expense will be limited to the amount of the less expensive treatment. In addition, Reasonable and Customary Charges will be based on the overall cost of the medical procedure, not the individual cost for the component steps involved in such procedure. Accordingly, “unbundling” or “fragmented billing” will not be permitted.

COORDINATION OF BENEFITS

Quite frequently, members of a family are covered under more than one group health plan. Thus, there are many instances of duplication of coverage - two plans paying benefits for the same dollar of hospital and medical expenses. For that reason, a Coordination of Benefits provision has been adopted that will coordinate the benefits payable herein (with the exception of life insurance) with similar benefits payable under other plans. The Fund will fully coordinate benefits with other plans, such that the combined benefits from both Plans can never exceed 100% of the Allowable Expenses. Deductible limits will still apply under both plans.

"**Plan**" includes any group health plan and any arrangement providing the following types of medical and dental care benefits:

1. Coverage (including Medicare regardless of whether or not one has enrolled in or registered for coverage) under a governmental program or program provided or required by statute, including no fault coverage to the extent required in policies or contracts by motor vehicle insurance statute or similar legislation;

2. Group, blanket or franchise insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution above the high school level; and

3. Any coverage under labor-management trusteed plans, union welfare plans, employer-sponsored plans, employer organization plans or employee benefit organizations.

4. Motor vehicle insurance.

5. Any employer-sponsored coverage provided to a Dependent child, other than the group health plan of the active employee.

"**Allowable Expenses**" are any necessary, Reasonable and Customary Charges for medical services, treatment or supplies covered by one of the plans under which the individual is covered.

Who Pays First?

When an individual is covered under more than one plan, one plan is considered the "primary plan," and the other plan is "secondary."

When a claim is made, the primary plan pays its benefits without regard to any other plan. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordination provision.

If another plan covering an eligible individual contains a similar non-duplication of benefits provision that coordinates its benefits with those of this Plan and would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and the rules set forth below require this Plan to determine its benefits before such other plan, then the benefits of such other plan will not be considered for the purposes of determining the benefits due under this Plan. In all other cases, when more than one plan covers the person for whom allowable expenses are incurred, the order of benefit determination is:

6. Motor vehicle insurance is always primary to this Plan. Likewise, government plans and any court-awarded judgment or out-of-court settlement are always primary to the Plan, except where otherwise required by law.

7. The Plan that does not contain any coordination of benefit provisions pays benefits first. Plans purporting to always be secondary or to not cover expenses in a coordination of benefits situation will automatically be primary to this Plan.

8. The benefits of a plan that covers the person on whose expense a claim is based as an active employee will be determined before the benefits of a plan that covers such person as a laid-off or retired employee or as a dependent or spouse.

9. The benefits of a plan that covers the person on whose expense a claim is based as a dependent of an active employee will be determined before the benefits of a plan that covers such person as a dependent of a laid-off or retired employee.

10. The benefits of a plan that covers the person on whose expense a claim is based as a spouse of an active employee shall be determined before the benefits of a plan that covers such person as a dependent of an active employee

11. When both plans cover the person on whose expense a claim is based as a dependent child, the benefits of the plan which covers the parent whose birthday (month and day only) occurs first during a calendar year will be determined before the benefits of the plan that covers the parent whose birthday (month and day only) occurs later in the year.

However, in the event the parents are legally separated or divorced, the following rules will apply:

a. When the parent with primary custody of the child has not remarried, the benefits of a plan that covers the child as a dependent of that parent will be determined first. The benefits of a plan that covers the child as a dependent of the parent without custody or without primary custody will be determined second.

b. When the parent with custody or primary custody of the child has remarried, the order of benefit determination is as follows:

(i) the plan of the parent with custody or primary custody;

(ii) the plan of the step-parent;

(iii) the plan of the parent without custody or without primary custody.

c. If there is a court decree as to which parent's plan will pay first, that order will supersede any order given in (a) or (b) above.

Notwithstanding the foregoing, where a Dependent is covered under this Plan as well as by a health maintenance organization ("HMO"), the benefits of the HMO will always be determined before the benefits of this Plan.

12. When this Plan and another plan cover the person on whose expense a claim is based as a dependent child, and such other plan does not contain the birthday rule as set forth in item (6) above, but uses the benefit determination provision which is based on the parent's sex, then, to the extent such provision is legally valid, this Plan will also use this benefit determination provision when applicable.

13. When rules (1) through (7) above do not establish an order of benefit determination, the benefits of a plan that has covered the person on whose expense a claim is based for the longer period of time will be determined before the benefits of a plan that has covered such person the lesser period of time.

14. Notwithstanding anything to the contrary herein, when the other plan that covers the person on whose expense a claim is based is Medicare, then the benefits of this plan will be determined after the benefits of Medicare unless the applicable provisions of federal law specifically provide otherwise. Similarly, any other plan that is required or provided by law will be the primary plan unless the law forbids such plan to be the primary plan.

15. Notwithstanding anything to the contrary herein, the Fund will also coordinate benefits within itself, such that whenever two or more covered individuals who are members of the same immediate family and household and are employees of one or more contributing employers during any year (and one of whom is a non-dependent participant and all other such covered individuals are dependents of such participant, or would qualify as such but for being participants themselves) then these Coordination of Benefits provisions will be applied as if the eligible participant who is (or would be) primary in coverage hereunder will be entitled to whatever additional benefits, if any, that would otherwise be available under this Plan in such case (in addition to the benefits received hereunder by the eligible participant who was primary in coverage).

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of this Plan.

Benefits payable under another plan include the benefits that would have been payable had claims been duly made for them, and in the case of benefits payable under Parts A and B of Medicare (or Medicare Advantage), the benefits that would have been payable had the Eligible Individual enrolled for coverage under the plan.

Benefit Determination

When this Plan is the primary plan, there is no change in the Plan's payment schedule. When this Plan is the secondary plan, the Plan calculates what it would have paid as the primary plan and then pays, up to this amount, any excess after first subtracting the benefits paid by the primary plan. In no case will a participant receive more than the original claim amount.

EXAMPLE

Claim	$1,000
Primary plan	
Deductible	$ 250
Coinsurance	80%
Amount paid by plan [($1,000- $250) x .80]	$ 600
Deductible	$ 400
Coinsurance	80%
Amount paid had this been the primary plan (($1,000-400) x .80)	$ 480
Amount unpaid by primary plan ($1,000- $600)	$ 400
Amount paid by this Plan (lesser of $480 and $400)	$ 400
Amount paid by participant	$0

SUBROGATION AND REIMBURSEMENT

In the event of any payment under this Fund, you automatically agree to assign your rights of recovery to the Fund, and the Fund will be subrogated to all the rights of recovery of either you or your Dependent against any person or entity, and you or your Dependent will be required to execute and deliver instruments and papers and whatsoever else is necessary to secure such rights including, but not limited to, a written Subrogation Agreement. Neither you nor your Dependent may do anything after a loss to prejudice such rights. Prejudicing the Fund's subrogation rights may result in the denial of benefits or termination of your participation in the Fund.

If requested in writing by the Trustees, their Administrative Manager or Legal Counsel, you or your Dependent will take, through any representative designated by the Trustees, such action as may be necessary or appropriate to recover such payment as damages from any person or entity with said action to be taken in the name of you or your Dependent. In their sole discretion, the Trustees reserve the right to prosecute an action in the name of you or your Dependent against any third parties and/or entities potentially liable to you or your Dependent in an effort to recover monies paid by the Fund; or to intervene in the name of the Trustees into any legal proceeding initiated by you or your Dependent against any third parties and/or entities. In connection therewith, the Fund may disclose your relevant claims information to its outside counsel in order to pursue a legal recovery.

By virtue of any payment under this Fund, an equitable lien by agreement will automatically be deemed to be established against both (i) any person or entity legally responsible for the Injury or Illness for which such payment was made or their insurer; and (ii) you and your Dependents and anyone else who receives or who has a right to a recovery. By receiving Fund benefits, you and your Dependents automatically agree to (i) segregate and hold any settlement funds, recoveries or damages you receive or have control over in trust, either in a separate bank account in your name or your attorney's trust account, and that you or your attorney will serve as trustee over such funds to the extent of the benefits the Plan has paid or that are payable, and (ii) if the Fund deems necessary, for an injunction and/or temporary restraining order to be issued against you and your Dependents, in order for the Fund to enforce its lien.

In any action or actions by you or your Dependent against a third party (or multiple third parties), the Fund will be subrogated to the right or rights of you or your Dependent to the extent necessary to reimburse it for 100% of all sums paid or assumed by the Fund under the Amended and Restated Rules and Regulations of the Fund, together with reasonable costs and expenses including attorneys' fees, if any, incurred by the Fund in enforcing the liability of a third party or you or your Dependent under this Agreement.

In addition, the Fund has a first priority right of reimbursement from any recovery you receive or are entitled to receive, up to the amount paid by the Fund, without regard to whether or not you are made whole. Any sums recovered from the third party by you or your Dependent or by the Fund on behalf of you or your Dependent either by judgment or compromise will be applied first to reimburse the Fund for benefits paid or to be paid and to pay its costs and expenses including attorneys' fees, if any, without regard to any setoff or contribution for the payment of your or your Dependent's attorneys' fee and costs in pursuing and enforcing the liability of the third party or parties. The Fund will not be responsible for the payment of your or your Dependent's attorneys' fees without its written consent, nor will the Fund share any responsibility, pro-rata or otherwise, for your or your Dependent's attorneys' fees or expenses. However, this amount is limited to the amounts that you or your Dependent has, may or could have reasonably recovered from any third party or parties that are related to the same condition or to the events giving rise to the condition for which benefits are paid. In this connection, the Fund will not be bound by the characterization of any recoveries given by any other person(s). The Fund Administrator will determine, in its sole discretion, what actual or potential recoveries from the third party or parties are related to the condition or to the events giving rise to the condition. This amount will not be limited or reduced pro-rata

or otherwise because you or your Dependent is liable only in part, because your or your Dependent's resources or insurance are limited, or for any other reason.

These obligations and rights supersede any laws or legal theories that purport to limit, reduce or eliminate the contractual Subrogation or reimbursement rights of the Fund including, but not limited to, the "make whole doctrine," the "common fund doctrine" or other federal, state or local "common law" theories. Amounts recovered in excess of the Fund's reimbursement and costs and expenses including attorneys' fees may be paid to you or your Dependent, but such excess will apply as a credit against liability of the Fund for further payments to or on behalf of you or your Dependent under the Rules and Regulations of the Fund, which has arisen or may arise from the condition sustained by you or your Dependent as referred to under these provisions.

With respect to claims involving subrogation or reimbursement, payment of benefits may be delayed pending receipt of any and all of the requested documentation, including a completed and executed Subrogation Agreement and any other necessary paperwork from the Employee, Dependent, their legal or medical representative, medical providers and the like. The Trustees have the absolute discretion to settle Subrogation claims on any basis they deem warranted and appropriate under the circumstances.

The fund has the right to pend benefit payments until the Subrogation / Reimbursement Form is completed in full, signed and returned to the Fund Office. Moreover, you have a one year maximum time limit to complete, sign and return the Fund's Subrogation / Reimbursement Form after it has been sent to you or your guardian or attorney. If the form is not returned by the deadline, the Fund will have no further obligations to pay any benefits for any claims relating to such illness or injury.

In addition if you or your Dependents violate the Fund's subrogation or reimbursement rights, fail to cooperate, or fail or refuse to reimburse the Fund, the Fund has the right to offset any and all future benefits due to you or your Dependents, whether or not related to the illness or injury in question. This right of offset also applies with respect to any third party claiming reimbursement or similar rights against the Fund.

What is Subrogation?

If you or your covered dependents incur an illness or injury where any other party may have a legal obligation to pay for the same (such as a third party tortfeasor, his insurance company, or even your own insurance company, including any uninsured or under-insured motorist coverage), then you will be required to sign a Subrogation/Reimbursement Agreement before the Fund will pay any benefits. In addition, if the Fund pays claims relating to the illness or injury, you and your Dependents are required to reimburse the Fund up to the amount of benefits paid from the recovery of any settlement, judgment, award, or other payment from any other person, corporation, insurance carrier (including your own insurance carrier) or governmental agency, regardless of how or for what losses the settlement, award, judgment, or other payment is denominated, and regardless of whether it is large enough to make you or your dependents whole for the loss. The Fund's right of subrogation and reimbursement from such proceeds will be a "First Dollar" priority right and lien, and will come before all other payments, including payments to your attorney. In no event will the Fund be obligated or required to reduce its lien or otherwise share in any costs or attorneys' fees you incur in connection with obtaining recovery.

The Fund's rights will apply with respect to all "injured persons," which will mean an eligible employee participant, eligible spouse, or eligible dependent child or the heir, guardians, personal representatives, trustee, estate, guardian or other representative of such employee, spouse or child.

These provisions also apply to the parents, guardians or other representative of a dependent child who incurs an injury or illness for which a third party may be liable. The Fund's right to subrogation and reimbursement apply regardless of whether you are disabled or incapacitated, and shall apply to (i) any funds held by a third party in any form; (ii) any funds held by a trustee (including any type of special needs trust or any other type of trust arrangement); and (iii) any funds converted to an annuity or any other type or form of payment. These rights to subrogation and reimbursement apply regardless of whether you have possession or control of the funds. The Fund shall have a constructive trust and equitable lien over all such funds described in this Subrogation and Reimbursement Section.

The Fund will also have the right to offset future benefits, from any family member, whether or not they were the injured party, whether or not related to the injury or illness in question, in order to satisfy its reimbursement and subrogation rights.

Example A

While walking across the street, John Jones is struck by an automobile driven by Mr. White. Mr. Jones submits claims to the Fund for payment and the Fund pays $1,000 in benefits for medical and hospital expenses resulting from the accident. Mr. White or his automobile insurance company is liable for Mr. Jones' damages, including his medical and hospital bills. Mr. Jones will be contacted by the Fund and required to complete a Subrogation/Reimbursement Agreement and questionnaire. The Fund will request a payment of $1,000 from Mr. White or his automobile insurance carrier. If Mr. Jones files a claim or action against Mr. White or his insurance company, the Fund may intervene or join in the action. If Mr. Jones does not file such a claim or action, the Fund may file a claim or action in its own name for the amount of benefits paid. If Mr. Jones settles his claim or suit against Mr. White, or Mr. White's insurance carrier pays Mr. Jones, the Fund will require repayment of the $1,000 from the recovery. Should Mr. Jones refuse to reimburse the Fund for the amount of benefits paid by the Fund, the Fund may sue Mr. Jones for $1,000 in benefits paid. The Fund may also deduct $1,000 from any future claims Mr. Jones or his dependents submit.

Example B

While at work, John Jones is struck by a forklift driven by a co-employee. Mr. Jones submits his claim to the Fund for payment, but does not inform the Fund that the claim is the result of an on-the-job accident, and the Fund pays $1,000 in benefits for medical and hospital expenses. Mr. Jones' employer and workers' compensation insurance carrier are responsible for his medical and hospital bills. Mr. Jones will be contacted by the Fund and required to complete a questionnaire. Mr. Jones will also be required to sign a Subrogation/Reimbursement Agreement. The Fund will request the payment of $1,000 from the employer or the employer's workers' compensation insurance carrier. If Mr. Jones does not file a workers' compensation claim, the Fund may file a claim in Mr. Jones' name for the amount of benefits paid. If Mr. Jones settles his claim against his employer and workers' compensation insurance carrier, Mr. Jones will be required to reimburse the Fund for the $1,000 from the recovery. Should Mr. Jones refuse to reimburse the Fund for the amount of benefits paid by the Fund, the Fund may sue Mr. Jones for the $1,000 in benefits paid. The Fund may also deduct $1,000 from any future claims Mr. Jones or his dependents submit.

How Will You Know if a Claim You Submit to the Fund is Affected by a Reimbursement Obligation?

All claims the Fund pays for an illness or injury caused by another person are subject to the reimbursement obligation. The Fund will contact you and request the completion of a questionnaire if it appears that you or your dependents' claim may involve liability of another person, corporation, insurance carrier or governmental agency. You will be required to complete the questionnaire and return it to the Fund Office before any benefits will be paid by the Fund. Both the Fund member and the injured person or legal guardian (if different) will be required to sign a Subrogation/Reimbursement Agreement.

What Happens Next?

The Fund will contact the party responsible for the illness or injury or his insurance company and a determination will be made concerning that party's liability. If you have an attorney, the Fund may also contact your attorney for such information. You must keep the Fund Office informed concerning the status of your claim and its final settlement.

What Are Your Obligations?

You are required to complete, sign and deliver any documents and papers (including but not limited to, a Subrogation/Reimbursement Agreement) requested by the Fund. You are also required to do whatever else is necessary to secure the rights of the Fund, including allowing the joinder of the Fund or the intervention of the Fund in any claim or action against the responsible party or parties.

In the event you fail or refuse to execute or deliver any document requested by the Fund, or to take any other action requested by the Fund to protect its interests, the Fund may withhold benefits payments or deduct the amount of any payments from future claims otherwise payable to you or your dependents. You and your agents will take no action which will or may prejudice the rights of the Fund.

If you or any person acting upon your behalf, does not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated to pay, the Fund is entitled to institute legal action against the responsible party or parties in its name or the Trustees name in order to recover all amounts paid to or on your behalf.

In the event you recover any amount by settlement or judgment from or against the responsible person, corporation, insurance carrier or governmental agency, you are required to repay the full amount of benefits paid by the Fund from that recovery. If you refuse or fail to repay such amount, then the Fund will be entitled to recover such amounts from you and/or your dependents by instituting legal action against you and/or deducting such amount from your future claims. After you have received a recovery from the responsible person, corporation, insurance carrier or governmental agency, no further benefits for treatment or services related to that injury will be paid by the Fund, up to the amount of your recovery that is not reimbursed to the Fund.

Altered Or Forged Claims And Fraud

If you or one of your Dependents knowingly misrepresents or falsifies any information or matter in connection with a claim or otherwise engages in any act of fraud, or knowingly allows such information or matter to be misrepresented or falsified, or knowingly allows any act of fraud, the Trustees will deny all or any part of the benefits otherwise due. In addition, legal action may be taken against you or your Dependents.

Right Of Recovery

If the Plan makes inadvertent, mistaken or excessive payment of benefits, premiums, or other amounts, (i) the Trustees or their representatives will have the right to recover such payments and/or deduct such payments from future claims or amounts owed; (ii) such payment will automatically give rise to an equitable lien and a contractive trust in favor of the Fund (equal to the amount of such inadvertent, mistaken or excessive payment); and (iii) the Fund will have an automatic security interest in such payment amount.

Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund shall have the right to recover such payments, to the extent of such excess, including, without limitation, from one or more of the following, as the Board determines:

1. Any person to or for or with respect to whom such payments were made; or

2. Insurance companies, service plans or any other organizations.

Full Plan Document Governs

This SPD briefly explains your rights and responsibilities as a covered individual by the Fund. The Fund and this summary is governed by the Fund's plan document. For a complete description of your rights, please see the plan document. In the event of a conflict between this summary and the plan document, the plan document controls.

Assignment Of Benefits

You may not assign (or otherwise anticipate, alienate, sell, transfer, pledge, encumber or charge) your benefits under the Plan to any person or entity, and any attempted assignment (or related action) will be null and void. However, the Board may agree to pay benefits directly to a Hospital or other Provider for services rendered to you. Nonetheless, any such payment is not an assignment of rights; does not give the Provider any right to bring an action against the Plan; your right to sue the Plan may not be assigned or transferred to any medical Provider or other person; no attempt at assignment of benefits will be

recognized by the Plan; and in no event will the Plan be responsible to any third party to whom you may be liable for healthcare treatment, supplies or services.

CLAIMS AND APPEALS PROCEDURES

No individual or other person will have any right or claim to benefits under the Fund other than as specified in the Fund's Rules and Regulations. If any person will have a dispute as to eligibility, type, amount, or duration of such benefits, the dispute will be resolved by the Board of Trustees, which has complete fiduciary discretion and authority to interpret the Plan, decide all questions of benefits, and adjudicate all claims and appeals, and its decision of the dispute will be final and binding upon all parties thereto. Please note, however, that any disputes over the benefits that are provided under the Plan through an insurance contract will be decided by the insurance company.

Definitions

1. An "**Adverse Benefit Determination**" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part), denial of eligibility to participate in a plan, or rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time) under the Plan. Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the participant pays the entire cost, is not considered an Adverse Benefit Determination.

2. A "**Claim**" is a request for a benefit made by a claimant in accordance with the Fund's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of Plan are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a claimant files a request for specific benefits and the request is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim. If a pharmacy refuses to fill a prescription unless the participant pays the entire cost, the participant should submit a Post-Service Claim for the prescription to the Fund as described under Claim Procedures, below.

A request for prior approval of a benefit that does not require prior approval by the Plan is not considered a Claim. However, requests for prior approval of a benefit where the Plan does require prior approval are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures, below.

3. A "**Disability Claim**" is a Claim that requires a finding of total disability as a condition of eligibility (e.g., weekly accident and sickness benefit claims). Furthermore, waivers of life insurance premiums during Total and Permanent Disability would be considered Disability Claims unless the determination of disability is made by a party other than the Plan for purposes other than a benefit determination under the Plan (e.g., a Social Security determination).

4. A "**Post-Service Claim**" is a Claim for medical, dental, prescription drug or vision benefits that is not a Pre-Service or Urgent Claim.

5. A "**Pre-Service Claim**" is a Claim for a medical, dental, prescription drug or vision benefit for which the Plan requires approval before medical care is obtained. For example, a request to have a non-emergency Hospital stay pre-authorized as required by the Plan qualifies as a Pre-Service Claim.

6. “**Relevant Documents**” include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the applicable DOL Regulations, or constitute the Plan’s policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan’s rules were appropriately applied to a Claim.

7. An “**Urgent Claim**” is a Claim for medical care or treatment that, as determined by the attending provider, and the Plan shall defer to such determination of the attending provider, if normal Pre-Service standards were applied, would seriously jeopardize the life or health of the participant or the ability of the participant to regain maximum function or, in the opinion of a Physician with knowledge of the participant’s medical condition, subject the participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

Claims Procedures

Pre-Service Claims

A Pre-Service Claim is a Claim for a benefit for which the Plan requires approval before medical care is obtained. The Plan requires precertification of all non-emergency Hospital admissions, as discussed in detail above.

Thus, a request to have a Hospital admission precertified is treated as a Pre-Service Claim. Each of these Pre-Service Claims must be submitted by calling Blue Cross Blue Shield at [800 433-3232].

The Plan also requires precertification of in-patient hospitalization, partial hospitalization, residential treatment centers and intensive outpatient treatment by Blue Cross Blue Shield with respect to mental and nervous disorders, alcoholism, drug addiction and substance abuse. Each of these is treated as a Pre-Service Claim and must be submitted by calling Blue Cross Blue Shield at (800) 851-7498 or www.bcbsil.com .

The Plan also requires precertification of a wide range of outpatient medical benefits, including home health care, certain specialty drugs, intensive outpatient procedures, neurological procedures, ear, nose & throat services, any many more, as specified above under “Outpatient Medical Benefits Requiring Precertification.”

In some cases, the Plan may require prior approval of certain prescription drugs before the prescription drug is obtained from the pharmacy. In such cases, a Pre-Service Claim for the prior authorization of the prescription drug must be submitted by calling Sav-RX at (800) 233-4239.

For properly filed Pre-Service Claims, you will generally be notified of a decision within 15 days from receipt of your Claim. The time for response may be extended for an additional 15 days (for a total of 30 days) if necessary due to matters beyond the control of the Plan or its agent. In such case, you will be notified in writing of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered within the 15-day period after the claim is filed.

If an extension is needed because the Plan or its agent needs additional information from you, you will be notified of the information needed. You will then have at least 45 days to supply the additional information. If the information is not provided within that time, then your Claim will decided based on the information available and may be denied. During the period in which you are allowed to supply

additional information, the normal deadline for making a decision on your Claim will be suspended until either the date you respond to the request or the deadline for responding, whichever is earlier.

If you improperly file a Pre-Service Claim, you will be notified as soon as possible but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a Claim. However, you will only receive notice of an improperly filed Pre-Service Claim if your claim includes (i) the patient's name, (ii) the patient's specific medical condition or symptom, (iii) the patient's specific treatment, service or product for which approval is requested, and (iv) it is received by someone who customarily handles claims. Unless the claim is refiled properly, it will not constitute a Claim for Plan benefits.

Urgent Claims

If a Claim for the precertification of a Hospital admission constitutes an Urgent Claim, Blue Cross Blue Shield will respond to the claimant with a determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim. The determination may be communicated orally, but will also be confirmed in writing within 3 days.

If your Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the appropriate Fund agent will notify you as soon as possible, but not later than 24 hours after receipt of your Claim, of the specific information necessary to complete the Claim. You must provide the specified information within 48 hours. If the information is not provided within that time, then the claim will decided based on the information available and may be denied. Notice of the decision will be provided as soon as possible, but no later than 48 hours after the Fund's agent receives the specified information or the end of the 48-hour period given for you to provide this information, whichever is earlier.

If you file an Urgent Claim improperly, you will be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a Claim. However, you will only receive notice of an improperly filed Urgent Claim if your claim includes (i) the patient's name, (ii) the patient's specific medical condition or symptom, (iii) the patient's specific treatment, service or product for which approval is requested, and (iv) it is received by someone who customarily handles claims. Unless the claim is refiled properly, it will not constitute a Claim for Plan benefits.

If you request to extend a pre-approved Urgent Claim, your request will be acted upon by Blue Cross Blue Shield and you will be notified of the decision as soon as possible, taking into account the medical exigencies, within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the pre-approved period. If the request is not received more than 24 hours prior to the expiration of the previously approved claim, it will be decided according to the normal guidelines for Urgent Claims.

Concurrent Claims

If the Fund's agent reconsiders and terminates or reduces a previously approved benefit (other than by Plan amendment or termination), you will be notified by in enough time to appeal that decision and to have the appeal decided before the benefit is reduced or terminated. Accordingly, the previously approved on going course of treatment will continue pending outcome of the appeal.

Post-Service Claims

Post-Service Claims must be submitted in writing, using the appropriate claim form, within 90 days from the date on which the expenses were first incurred. Failure to file a Post-Service Claim within the required

time frame will not invalidate the Claim if it is shown not to have been reasonably possible to file the Claim within such time. **However, in that case, the Claim must be submitted as soon as reasonably possible. In no event will benefits be provided if the Claim is submitted more than one (1) year from the date on which the expenses were first incurred.**

Post-Service Claims for all medical, mental health / substance abuse, prescription drug, dental and vision care must be submitted to the Fund Office. Claim forms may be obtained by contacting the Fund Office.

An itemized bill(s) should be attached to the claim form and should include the following information:

1. Patient's name;

2. Date of service;

3. Type of service or CPT-4 code (the code for Physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);

4. Diagnosis or ICD-9 code (the diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);

5. Billed charge;

6. Provider's federal taxpayer identification number (TIN); and

7. Provider's billing name and address.

   Post-Service Claims are considered to have been filed when the Fund Office receives them. Claims should be submitted to the Fund Office at the following address:

   IBEW - NECA Southwestern Health and Benefit Fund
   P.O. Box 819015
   Dallas, TX 75381-9015
   (800) 527-0320

Ordinarily, you will be notified of the decision on your Post-Service Claim within 30 days following the day your Claim is received. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the Fund's control. If an extension is necessary, you will be notified in writing, before the end of the initial 30- day period, of the circumstances requiring the extension and the date by which the Fund expects to render a decision, which will be no later than 45 days after the claim was initially received.

If an extension is required because the Fund Office needs additional information from you, the Fund Office may issue a request for additional information that specifies the information needed. You will then have at least 45 days to supply the additional information. If the information is not provided within that time, your Claim will be decided based on the information that is available. During the period in which you are allowed to supply the additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the request for additional information until either the date you respond to the request or the deadline for doing so, whichever is earlier.

Weekly Accident and Sickness Benefit Claims

Weekly accident and sickness benefit Claims must be submitted in writing to the Fund Office, using the appropriate claim form, within 90 days from the date on which the accident or sickness first occurred. Claim forms may be obtained from the Fund Office. Failure to file a weekly accident and sickness benefit Claim within the required time frame will not invalidate the Claim if it is shown not to have been reasonably possible to file the Claim within such time. However, in that case, the Claim must be submitted as soon as reasonably possible. In no event will benefits be provided if the Claim is submitted more than one (1) year from the date on which the accident or sickness first occurred.

The Fund Office will make a decision on your Claim and notify you of that decision within 45 days after it receives the Claim. If the Fund Office requires an extension of time due to matters beyond its control, it will notify you of the reason for the delay and indicate when the decision will be made. This notification will occur before the expiration of the initial 45-day period. A decision will be made and you will be notified of that decision typically within 75 days after the Fund Office first received your Claim. However, if due to matters beyond the Fund's control, a decision cannot be made during this time, the period for making a decision may be delayed an additional 30 days. In such case you will be notified prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Fund expects to render a decision. In such case, a decision will be made and you will be notified of that decision no later than 105 days after your Claim is received.

If an extension is needed because the Fund Office needs additional information from you, the extension notice will specify the information needed. In that case the claimant will have at least 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be decided based on the available information. During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until the date the claimant responds to the request or the deadline for doing so (whichever is earlier).

Life Insurance and AD&D Benefit Claims

Claims for life insurance benefits or accidental death and dismemberment benefits must be submitted in writing to the Fund Office as soon as possible after the individual's death or the accident. In most cases, a decision will be made on the claim and the claimant will be notified of that decision within 90 days after the claim is received. If, however, special circumstances require additional time to process the claim, the claimant will be notified in writing of the extension within the initial 90-day period after the claim is received. The extension notice will include the date by which a decision is expected to be made and the special circumstances necessitating the extension. In such case, a decision will be made and the claimant will be notified of that decision no later than 180 days after the claim is received.

Authorized Representatives

Your authorized representative may submit a Claim on your behalf and/or appeal the initial decision on the Claim, if applicable. An appointment of authorized representative form, which may be obtained from the Fund Office, may be used to designate an authorized representative. The Fund may request additional information to verify that the designated person is authorized to act on the participant's behalf.

A health care professional with knowledge of the participant's medical condition may act as an authorized representative in connection with an Urgent Claim without the participant having to complete the appointment of authorized representative form.

Notwithstanding the above, the Plan Administrator may reject the appointment of any individual or entity as your authorized representative if the Plan Administrator determines that such appointment is intended to circumvent or effectively circumvents the anti-assignment rules of the Plan.

In addition, no individual or entity, without the express written permission of the Board of Trustees, can be an authorized representative where the individual or entity would be a direct or indirect beneficiary of the benefits subject to the claim in question, such as a medical provider who is seeking payment for services rendered to you.

Moreover, the Plan Administrator may also reject as invalid the appointment of any individual or entity as an authorized representative if the Plan Administrator determines that such individual or entity has previously engaged in practices that violate the Plan's terms or that attempts to modify, without the Board of Trustee's express written approval, the Plan's requirements with respect to cost sharing (such as deductibles and coinsurance).

Further, the Plan Administrator may at any time reject an appointment of an authorized representative on any grounds noted herein, regardless of whether the Plan Administrator has previously communicated with the appointed individual or entity without challenging the propriety of the individual's or entity's appointment as authorized representative, including by approving any claims submitted by such individual or entity.

Notice of Initial Benefit Determination

You will be provided, in a culturally and linguistically appropriate manner, with written notice of the initial benefit determination if it is an Adverse Benefit Determination, which will include:

(1) Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning):

(2) The specific reason(s) for the determination;

(3) Reference to the specific Plan provision(s) on which the determination is based;

(4) A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;

(5) A description of the Fund's appeal procedures and applicable time limits; and

(6) A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse decision on appeal.

If the Adverse Benefit Determination was made in connection with a Pre-Service, Post-Service, Urgent or Weekly Accident and Sickness Benefit Claim, the notice will also include the following, if applicable:

(1) If an internal rule, guideline or protocol was relied upon in deciding the Claim, a description of such rule, guideline or protocol or a statement that a copy is available upon request at no charge;

(2) If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of or a statement that

an explanation of the scientific or clinical judgment for the determination is available upon request at no charge; and

(3) For Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).

Upon request, the Fund will provide you with the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination. Such a request, by itself, will not be considered to be an appeal or request for External Review under the Plan.

Appeal Procedures

Appealing an Adverse Benefit Determination

If your Claim is denied in whole or in part, you or your authorized representative may appeal the decision. The appeal of Adverse Benefit Determinations of Post-Service, Pre-Service, Urgent or weekly accident and sickness benefit Claims must be submitted in writing to the Fund Office within 180 days after you receive notice of the Adverse Benefit Determination. Appeals of all other Claims must be submitted in writing to the Fund or its Agent within 60 days after receipt of the notice of the initial Adverse Benefit Determination. Your appeal must include:

I. the patient's name and address;

2. the claimant's name and address, if different;

3. the date of the Adverse Benefit Determination; and

4. the basis of the appeal (i.e., the reason(s) why the Claim should not be denied).

Appeals of Pre-Service or Urgent Claim Adverse Benefit Determinations by Blue Cross Blue Shield may be made by contacting Blue Cross Blue Shield at (800) 433-3232. Appeals of Pre-Service or Urgent Claim Adverse Benefit Determinations by Blue Cross Blue Shield may be made orally by calling Blue Cross Blue Shield at (800) 851-7498 or www.bcbsil.com. Appeals of Pre-Service or Urgent Claim Adverse Benefits Determinations by Sav-RX may be made by contacting Sav-RX at (866) 233-4239. Appeals must be made within 180 days, or 60 days as applicable, after you receive notice of initial Adverse Benefit Determination. All other appeals of Adverse Benefit Determinations, including all Post-Service Claims, must be made by filing the appeal with the Fund Office.

The Appeal Process

If you or your authorized representative submits an appeal, you may review the claim file and present evidence and testimony as part of the internal appeals process. You will also be given the opportunity to submit written comments, documents, and other information for consideration during the appeal process, whether or not such information was submitted or considered as part of the initial benefit determination. Upon request and free of charge, you also will be given reasonable access to and copies of all Relevant Documents pertaining to your Claim. The decision on appeal will be made on the basis of the record, including such additional documents and comments that you or your authorized representative may submit in connection with the appeal.

The following additional procedures will apply to Pre-Service, Post-Service, Urgent and weekly accident and sickness Claims.

(i) You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the Claim prior to the time when a decision is to be made on the appeal, and you will be given the opportunity to respond to such information.

(ii) If the decision on the appeal is to be based on a new or additional rationale, you will be given this rationale and an opportunity to respond to the rationale prior to the time when a decision is to be made on the appeal.

(iii) The Plan will prohibit conflicts of interest, such as making hiring, compensation, termination, promotion, or other employment decisions about a claims adjudicator, medical expert, or other employee based on the likelihood that the individual will support a denial of benefits.

(iv) A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination and the reviewer will not be the subordinate of the person who made the initial decision.

(v) If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Such professional shall not be the same person who was consulted in connection with the initial decision on the Claim, if any, nor his or her subordinate.

(vi) Upon request, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice in connection with the decision on the initial Claim, without regard to whether the advice was relied upon in deciding the Claim.

(vii) In the case of an appeal of an Urgent Claim, the appeal request may be submitted orally or in writing and all necessary information, including the notice of the decision on review, may be submitted by telephone, facsimile or other similarly expeditious methods.

Timeframes for Notices of Appeal Determinations

- If your appeal involves a Pre-Service Claim, you will be notified of the final decision on appeal no later than 30 days after your appeal is received.

- If your appeal involves an Urgent Claim, you will be notified of the final decision on appeal as soon as possible, but in all circumstances no later than 72 hours after your appeal is received.

- If your appeal involves any other type of claim, ordinarily a decision on your appeal will be made at the next regularly scheduled meeting of the Board of Trustees following after your appeal is received by the Fund Office. However, if your appeal is received within 30 days of the next regularly scheduled meeting, it will be considered at the second regularly scheduled meeting following receipt of the appeal. In special circumstances, regardless of when your appeal is received, a delay until the third regularly scheduled meeting following receipt of the appeal may be necessary. If this is the case, you will be notified of the extension and why it is necessary. Once a decision on your appeal has been reached, you will be notified of that decision within 5 days after the Board meeting at which the decision was made.

Notices of Appeal Determinations

If your appeal is denied, you will be notified of the decision in writing in a culturally and linguistically appropriate manner that complies with applicable legal requirements. The denial notice will include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The specific reason(s) for the determination, including without limitation, the denial code and its corresponding meaning; the plan's standard, if any, that was used in denying the claim; and a discussion of the decision to deny;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that the claimant is entitled to receive reasonable access to and copies of all Relevant Documents pertaining to the Claim, upon written request and free of charge;
- A description of available external review processes, including information regarding how to initiate an appeal and a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

For appeals of Pre-Service, Post-Service, Urgent and weekly accident and sickness benefit Claims, the denial notice will also include the following, if applicable:

- If an internal rule, guideline or protocol was relied upon, a copy of such rule, guideline or protocol or a statement that a copy is available upon request at no charge; and
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of or a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

Important Note

No legal action, grievance, or arbitration proceeding against the Fund, the Board of Trustees, Blue Cross Blue Shield, Delta Dental, VSP Vision Care, Sav-RX, or any other person for the recovery of any benefits under the Fund may be commenced until the Plan's claim procedures set forth above have been exhausted. In addition, all legal actions for the recovery of benefits must be commenced within one year after the Plan's claim review procedures have been exhausted. Any legal action must be filed exclusively in the Federal District Court for the Northern District of Texas, Dallas Division.

External Review Program

An external review program is available only if your Adverse Benefit Determination (i) involves medical judgment (including, but not limited to, determinations based on the Plan's requirement for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or its determination that a treatment is experimental or investigational); (ii) involves a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time); (iii) effective as of

September 1, 2022, involves an adverse determination relating to surprise medical billing (to the extent provided under the federal No Surprises Act); or (iv) is otherwise required by applicable law. Adverse claim decisions that involve only contractual or legal interpretation without any use of medical judgment, including without limitation Adverse Benefit Decisions that are based on a determination that a participant or beneficiary is not eligible for coverage under the Plan's terms, are not eligible for the external review process.

Timeframes for External Review Process

You may file a request for an external review with the Plan if your request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination.

Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

(1) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(2) The adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

(3) You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the internal appeals process under applicable law; and

(4) You have provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue you a notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow you to perfect the request for external review within the original four (4) month period beginning with the date of receipt of notice of the Adverse Benefit Determination or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

External Review Process

The Plan will assign an independent review organization ("IRO") that has no material affiliation with the Fund to conduct the external review. The IRO will be accredited by the URAC or by a similar nationally recognized accrediting organization to conduct the external review. The Plan will contract with at least three (3) accredited IROs and rotate assignments among them. The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan;

(2) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO is not

required to, but may, accept and consider additional information submitted after ten (10) business days.

(3) Within five (5) business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination. Within one (1) business day after making the decision, the IRO will notify you and the Plan.

(4) Upon receipt of any information submitted by you, the assigned IRO will, within one (1) business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan.

(5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(i) your medical records;

(ii) the attending health care professional's recommendation;

(iii) reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating provider;

(iv) the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(vi) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(vii) the opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(v) with respect to any claims involving experimental or investigational treatments, adequate clinical and scientific experience and protocols will be taken into account as part of the external review process.

(6) The assigned IRO will provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO will deliver the notice of final external review decision to you and the Plan.

(7) The assigned IRO's decision notice will contain:

(i) a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(ii) the date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(v) a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(vi) a statement that judicial review may be available to you; and

(vii) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

(8) After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six (6) years. An IRO will make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(9) Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the Claim.

Expedited External Review Process

The Plan will allow you to make a request for an expedited external review with the Plan at the time you receive either: (i) an adverse benefit determination or final internal adverse benefit determination if the adverse benefit determination or final internal adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of an expedited internal appeal or standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function (and, in the case of an adverse benefit determination, the claimant has filed a request for an expedited internal appeal); or (ii) a final internal adverse benefit determination, if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following information concerning the Plan is being provided to you in accordance with government regulations:

1. **Name and Type of Administration of the Plan**. The IBEW-NECA Southwestern Health and Benefit Fund is a group health plan sponsored and administered by a joint Board of Trustees consisting equally of Union representatives and Employer representatives.

2. **Address and Telephone Number of the Plan Sponsor and Plan Administrator**

   Board of Trustees

   IBEW-NECA Southwestern Health and Benefit Fund
   P.O. Box 819015
   Dallas, TX 75381-9015
   (972) 980-1123

3. **Names and Business Addresses of the Trustees as of September 1, 2023**

Union Trustees

Price Warwick
IBEW Local 20
684 W. Tarrant Rd
Grand Prairie, TX 75050

Michael Henderson
IBEW Local 301
P.O. Box 490.
Nash, TX 75059

Alfonso Martinez
IBEW Local 611
4921 Alexander Blvd. NE
Albuquerque, NM 87107

Robert Bausch
IBEW Local 226
1620 N.W. Gage Blvd, Suite A
Topeka, KS 66614

Michael Leonard
IBEW Local 444
615 West Grand.
Ponca City, OK 74601

Josh DeSpain
IBEW Local 570
750 S. Tucson Blvd.
Tucson, AZ 85716

Employer Trustees

David Sanchez
Sanbros Corp
6020 Academy Rd. NE #205
Albuquerque, NM 87109

Mark Huston
Lone Star Electric
2008 West Fifth Street
Fort Worth, TX 76107

Cindy Flowers
Southern Arizona NECA, Inc.
2500 N. Tucson Blvd., Suite 132
Tucson, AZ 85716

Duwayne Herrmann Jr.
D&H Electrical Services, Inc.
3750 Milam Road
Beaumont, TX 77701

Brian McFarland
Shawver & Sons, Inc.
144 NE 44th Street
Oklahoma City, OK 73105

Dylan Woodard
Kansas Chapter NECA
810 W. Douglas, Suite E
Wichita, KS 67203

4. In addition to the Board of Trustees, the following person has been designated as agent for the service of legal process:

   David I. Schiller, Esq.
   Baker Botts L.L.P.
   2001 Ross Avenue, Suite 900
   Dallas, TX 75201

5. The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 23-7259768. The Plan Number assigned by the Board of Trustees is 501.

6. For purposes of maintaining the Plan's fiscal records, the year-end date is August 31.

7. **Funding Medium**. Benefits are provided from the Plan's assets which are accumulated pursuant to contributions made by contributing Employers and held by the Trustees in trust for the purpose of providing benefits to covered participants and defraying reasonable Fund expenses.

8. **Contribution Source**. All contributions to the Plan are primarily made by Contributing Employers in accordance with collective bargaining agreements between various Contributing Employers and Local Union of the International Brotherhood of Electrical Workers. The collective bargaining agreements require contributions to the Plan at a fixed rate per hour. There are special provisions where participants or their Dependents may contribute to the Fund to continue their benefits.

   You may write the Board of Trustees to determine whether a particular employer is contributing to this Plan on behalf of participants working under the collective bargaining agreements and, if the employer is contributing to this Plan, the employer's address.

9. **Organizations Accumulating Plan Assets**. The Plan's assets and reserves are held in custody by:

   UBS Financial Services
   1000 Harbor Blvd.
   Weehawken, NJ 07086

   See item 16 below if you wish to obtain additional information concerning the Plan's investment of assets and checking accounts.

10. **Selection of Physicians and Facilities**. The Plan pays benefits for certain health care expenses, but the Plan does not provide hospital or medical services. Accordingly, the Plan is not responsible for any acts of omission by Hospitals or other facilities, or by Physicians, other professionals, or any facility staff member.

11. **Plan Change or Termination**. The Trustees reserve the right to amend the Plan at any time, change or discontinue the types and amounts of benefits under the Plan, and eligibility rules for extended or accumulated eligibility even if extended eligibility has already been accumulated.

    Plan benefits and eligibility rules are not guaranteed; may be changed or discontinued by the Board of Trustees; are subject to the rules and regulations adopted by the Board of Trustees; are subject to the Trust Agreement which established and governs the Fund's operations; and are subject to the provisions of the group insurance policies purchased by the Trustees.

    The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

If the Plan is changed or discontinued, it will not affect your or your beneficiary's right to any insured benefit to which you have already become entitled.

12. **Collective Bargaining Agreements**. This Fund is maintained pursuant to various collective bargaining agreements. Fund participants and beneficiaries may examine these collective bargaining agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees at the address listed in 2 above.

13. **Insurance Companies**. None of the Plan's benefits are currently insured.

14. **Type of Plan**. This Fund is maintained for the purpose of providing life insurance, major medical, dental, vision, mental health, substance abuse, AD&D, and prescription drug benefits.

15. **Type of Plan Administration**. Zenith American Solutions has contracted with the Fund to handle the Plan's day-to-day operations. Sav-Rx administers the Fund's prescription drug benefits. Delta Dental administers the plan's dental benefits. Blue Cross Blue Shield administers the Fund's mental health and substance abuse benefits. VSP Vision Care administers the Fund's vision benefits.

16. **Procedure for Obtaining Additional Plan Documents**. If you wish to inspect or receive copies of additional documents relating to this Fund, contact the Board of Trustees at the Fund Office at the address or phone number in item 2 above. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.

17. **ERISA Rights**. As a Participant in the Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Fund participants are entitled to:

    a. Examine, without charge, at the Plan Administrator's office, all documents governing the Fund, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

    b. Obtain, upon written request to the Plan Administrator, copies of all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor. The Plan Administrator may charge a reasonable fee for the copies.

    c. Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

    d. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Fund as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Fund on the rules governing COBRA continuation coverage rights.

    In addition to creating rights for Fund 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," have a duty to do so prudently and in the best interest of you and other Fund participants and beneficiaries. No one, including your employer, your union, or any other person,

may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the 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 these rights. For instance, if you request a copy of Fund documents or the latest annual report from the Fund and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a domestic relations order or a medial child support order, you may file suit in federal court. If plan fiduciaries misuse the Fund's money, or if you are 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.

If you have any questions about the Fund, you should contact the Plan 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 Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications office of the Employee Benefits Security Administration. You may contact the nearest area office of EBSA in Dallas, Texas at (214) 767-6831.

18. **Amendment and Termination of the Plan**. The Board of Trustees reserves the right, in its sole and absolute discretion at any time and from time to time, but upon a non-discriminatory basis to:

a. Amend or terminate either the amount or condition with respect to the payment of any benefits, even if such termination or amendment affects claims which have already accrued;

b. Alter or postpone the method of payment of any benefit;

c. Increase or decrease the benefits and change the eligibility rules, including rules relating to the Hour Bank;

d. Amend or rescind any other provisions of the Fund;

e. Modify or terminate retiree coverage; or

f. Increase employee premium or other employee cost.

In the event of any change or amendment to the Fund that results in a material reduction in covered benefits to Eligible Individuals, all affected Eligible Individuals will receive notice of such change within 60 days after its adoption.

19. **Disclaimer**. There is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for such purpose.

NOTHING IN THIS BOOKLET IS MEANT TO INTERPRET OR CHANGE IN ANY WAY THE PROVISIONS EXPRESSED IN THE RULES AND REGULATIONS OF THE HEALTH AND BENEFIT FUND. THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN, WHENEVER IN THEIR SOLE DISCRETION, CONDITIONS SO WARRANT.

APPENDIX A

NOTICE OF PRIVACY PRACTICES

The provisions of this HIPAA Privacy Rule Exhibit C shall apply to the portion of the Plan that is a group health plan (within the meaning of 45 CFR §160.103).

a. For purposes of this Exhibit, the terms defined in the Plan and the following additional definitions (a) shall apply:

(i) "**Business Associate**" shall have the same meaning as the term "business associate" in 45 CFR § 164.103, and includes any person or entity which assists in the performance of a function or activity of the Group Health Plan involving the use or disclosure of Protected Health Information (for example, claims processing and administration) or provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services for the Plan where the provision of such services involves the disclosure of Protected Health Information from the Group Health Plan to the service provider.

(ii) "**Covered Entity**" means a health plan, a health care provider and a health care clearinghouse, as such terms are defined in 45 CFR § 160.103.

(iii) "**Group Health Plan**" means the portion of the Plan or the portion of a Plan Benefit Program that is a group health plan (within the meaning of 45 CFR § 160.1 03).

(iv) "**Health Care Operations**" shall have the same meaning as the term "health care operations" in 45 CFR § 164.501, and shall include the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and coordination, disease management, and contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning- related analyses related to managing and operating the Group Health Plan, including formulary development and administration,

and development or improvement of payment methods or coverage policies; and

- business management and general administrative activities of the Group Health Plan, including management activities related to the implementation of and compliance with the Privacy Rule, customer service, resolution of internal grievances and due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a Covered Entity, or following the completion of the sale or transfer, will become a Covered Entity.

(v) “**HIPAA**” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and all rules and regulations promulgated under HIPAA.

(vi) “**Individual**” shall have the same meaning as the term “individual” in 45 CFR § 164.501, and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

(vii) “**Payment**” shall have the same meaning as the term “payment” in 45 CFR § 164.501, and shall include any activity undertaken by the Group Health Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits, including:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an Individual’s claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on employee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to employee inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-Joss and excess loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;

- utilization review, including precertification, preauthorization, concurrent review and retrospective review;

- disclosure to consumer reporting agencies relating to the collection of premiums or reimbursements, but such disclosures are limited to the Individual's name, address, date of birth, Social Security number, payment history, account number and name and address of provider and the Group Health Plan; and

- reimbursement to the Group Health Plan.

(viii) "**Privacy Rule**" shall mean the Standards for Privacy of Individually Identifiable Health Information codified at 45 CFR Part 160 and Part 164, Subparts A and E.

(ix) "**Protected Health Information**" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501 .

(x) "**Required By Law**" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

(xi) "**Secretary**" shall mean the Secretary of the Department of Health and Human Services or his designee.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your health information is important to the Fund. In addition, we have a legal obligation to provide you with a copy of this Notice and to follow its terms. Please review this Notice carefully, as it describes what health information is protected, how your medical information is maintained and how it may be used and disclosed by the group health plans sponsored by the Fund for your benefit (collectively, the "Plan") and certain designated staff who administer the Plan. It also describes your rights as to this information and how you can gain access to it.

Information is the cornerstone of the Fund's ability to provide you with superior service and health insurance plan choices. We want you to know that we will safeguard this information in a secure manner. Further, it is a top priority for us that we limit the collection and use of your Protected Health Information (defined below) to the minimum necessary, and provide access to it only to those authorized employees who have been trained in the proper handling of your information. Any trained employee who violates our rules regarding the proper procedures for handling Protected Health Information will be subject to discipline.

THE FUND'S PRIVACY OFFICIAL is Lisa Szatkowski. If you have any questions regarding this Notice, you may contact the privacy official in writing, Zenith American Solutions, 4101 McEwen, Suite 600, Dallas, TX 75244; or you may contact the official at (972) 980-1123 or at lszatkowski@zenith-american.com. We are required to respond to your inquiry within 30 days. However, we will make every effort to contact you sooner, if possible.

This Notice applies to Protected Health Information generated with respect to the Plan. The law requires us to notify you of the availability of this Notice every three years. In this Notice, "we" refers to the group health plan portion of the Plan sponsored by the Fund.

YOUR PROTECTED HEALTH INFORMATION

This Notice describes how we may properly use and share "Protected Health Information," which is defined as information that identifies you personally, in any form, and which relates to your past, present, or future physical or mental health condition, provision of care, or payment for provision of care. Summary information that we may receive about you and other health plan participants, but which does not contain information which specifically identifies you, is not considered Protected Health Information and is not covered by this Notice. This Notice also describes your rights to access and control your Protected Health Information. In reviewing this Notice, it may appear that your medical information is used or shared in many ways. Because this is a comprehensive list, certain events cited in this Notice may never occur or might only happen once or twice.

In the course of the operation and administration of our Plan, certain designated staff at the Fund office, Plan administrators, insurers, HMOs and other business associates may create or handle your Protected Health Information. This information is needed in order to operate and administer the Plan and to comply with certain legal requirements. It is our goal to make sure that the medical information we receive or handle is kept confidential. It is necessary under certain circumstances, however, to use the information or to share it with others.

HOW WE USE OR SHARE PROTECTED HEALTH INFORMATION

Your Protected Health Information may be used or disclosed in the following typical situations, without your prior authorization, because under HIPAA, the Fund and/or the Plan is allowed by law to conduct these activities on your behalf:

Treatment: We may disclose your Protected Health Information to a physician, hospital or other provider who requests this information to treat you.

Payment: We may use and disclose your Protected Health Information to provide support for, approval or verification of, or to pay claims for medical services provided to you.

Plan Operations: We may use and disclose your Protected Health Information to determine eligibility or premiums due for the Plan, to conduct quality improvement activities, or to engage in care coordination, case management, and other similar activities.

Insurers, HMOs, Fund Affiliated Companies: We may disclose your Protected Health Information to the insurer, HMO or to certain designated staff at a Fund affiliated company in connection with your treatment or payment for services and for Plan administration purposes.

Underwriting: Except as provided below under "Prohibited Uses and Disclosures" regarding genetic information, we may collect your Protected Health Information for underwriting purposes, premium rating or other activities relating to the creation, renewal or replacement of a contract for health insurance or health benefits.

Health & Wellness Information: We may use your Protected Health Information to contact you with information about health-related services, appointment reminders or treatment alternatives. If you do not wish to receive this type of information, you may request to opt out of receiving this information by contacting the Fund's Privacy Official, in writing, as referenced above. Even if you do opt out, you may continue to receive non-personal information that is typically provided to all employees.

You, Family and Friends: We may disclose your Protected Health Information to you. We may also disclose information to a family member, friend or other person if you are unavailable to agree to such disclosure in the case of a medical emergency or disaster relief. We will disclose this information only to the extent necessary to help with your health care or with payment for your health care, and you can indicate to us in writing if you do not wish your information to be shared with any of these individuals.

Outside Service: We may also need to use and disclose your Protected Health Information to outside individuals or companies that perform services for us. For example, we may have contracts with other companies that may need access to your Protected Health Information for Plan payment or operation matters. However, we require that any such outside service safeguard the privacy of your Protected Health Information in their possession. We do not intend to share your information with any outside service that does not need the information in order to accomplish services for the Plan.

Authorized Use or Disclosure: If you specifically authorize us to do so in writing, we will share your Protected Health Information with persons not involved with your care. This might include an insurance company or a relative. Upon your request, we will provide the necessary form for this authorization. You may cancel this authorization as specified in the authorization form. Your revocation will not affect any use or disclosures you permitted while your authorization was in effect and prior to your cancellation.

UNUSUAL USES OR DISCLOSURES

Among the unusual uses or disclosures of your Protected Health Information that may occur without your prior authorization are the following:

Unintended Disclosures: We will try our best to prevent or minimize the disclosure of Protected Health Information to unauthorized persons, but it is possible (although unlikely) that someone may hear or see information that is not meant for them.

Required by Law or Order: We will use or disclose your Protected Health Information when we are required to do so by law, or by a court or administrative order, subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the Protected Health Information of a suspect, fugitive, material witness, crime victim or missing person.

Public Health and Safety: We may use and disclose your Protected Health Information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

Military and National Security: We may disclose to military authorities the Protected Health Information of Armed Forces personnel. We may disclose to authorized federal officials Protected Health Information required for lawful intelligence, counterintelligence and other national security activities.

USES AND DISCLOSURE THAT REQUIRE YOUR WRITTEN AUTHORIZATION

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes without authorization when needed by the Plan to defend against litigation filed by you.

We will generally obtain your authorization before the Plan, its business associates (or their agents or subcontractors) use or disclose your Protected Health Information for marketing. Your authorization is not required if the Plan, its business associates (or their agents or subcontractors) communicate with you face-to-face or give you a promotional gift of nominal value.

Your written authorization is generally required for the Plan, its business associates (or their agents or subcontractors) to directly or indirectly receive compensation in exchange for your Protected Health Information. This authorization must specify whether your Protected Health Information may be further exchanged for remuneration by the entity receiving the Protected Health Information. Your authorization will not be required if the purpose of the exchange is: (a) for public health activities, (b) for research, (c) for treatment of you, (d) for the sale, transfer, merger, or consolidation of all or part of the Plan with another plan or entity that will become a Plan, and any due diligence related thereto, (e) for remuneration that is provided by a plan to a business associate for activities involving the exchange of Protected Health Information that the business associate undertakes on behalf of and at the specific request of the Plan pursuant to a business associate agreement, (f) to provide you with a copy of your Protected Health Information, as provided below, or (g) determined by the Secretary of Health and Human Services in regulations to be necessary and appropriate.

PROHIBITED USES AND DISCLOSURES

The Plan, its business associates and their agents or subcontractors may not use or disclose Protected Health Information that is genetic information for underwriting purposes (even if such use or disclosure would otherwise be considered for payment or health care operation purposes).

> **Genetic information** includes information about genetic tests, the genetic tests of family members, family medical histories, the request or receipt of genetic services and the participation in any clinical research that includes genetic services.
>
> **Underwriting purposes** include the determination of enrollment or continued eligibility under the Plan, the determination of benefits payable under the Plan, the calculation of required premiums and premium contributions, the application of any pre-existing condition exclusions, and engagement in any other activity related to the creation, renewal, or replacement of your health insurance coverage or benefits.

INDIVIDUAL RIGHTS

You have rights with respect to your Protected Health Information. If you have any questions about these rights or want to exercise any of these rights, please contact Lisa Szatkowski, at (800) 527-0320, via e-mail at lszatkowski@zenith-american.com, or in writing, Zenith American Solutions, 4101 McEwen, Suite 600, Dallas, TX 75244. They will make every effort to assist you. You may be required to pay a fee, depending on your request.

Copy, Inspect Records: You may inspect and receive a copy of your Protected Health Information. Your request must be in writing to the Privacy Official named above, and a fee may be assessed to provide you with a copy.

We will respond to your request within 30 days. We may request up to an additional 30 days to gather the information. If we do not have the information, we will advise you where you can obtain the information if we know where the information is located.

Under certain limited circumstances your request to review and copy your Protected Health Information may be denied. For example, the law states that an individual does not have the right to review and copy psychotherapy notes and information compiled in anticipation of a lawsuit. If your request is denied, you will be notified, in writing, why the request was denied, how you can appeal the decision and provided with a copy of the Plan's complaint procedures.

If the Plan uses or maintains an electronic health record of your Protected Health Information, then you may obtain a copy of it in an electronic format, or request that the Plan directly transmit it to an entity or person that you designate. The designation of any person to receive such electronic health records must be clear, conspicuous, and specific. The Plan may impose a fee to cover the costs of responding to such a request but the fee will not be greater than the Plan's labor costs in responding to your request.

Accounting Log: We will maintain a log which lists disclosures of your Protected Health Information resulting from unusual circumstances. We are required by law to maintain known information regarding such events for six years from the date of disclosure. You have the right to request information concerning your Protected Health Information, which may be stored on this log. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee. The log will only list very unusual disclosures, specifically where the disclosure was not authorized by you and involves an extraordinary situation. For example, our disclosure to a police officer investigating a crime would be listed on the log. On the other hand, day-to-day use of this information, for administration purposes, such as determining your eligibility or case management review, would not be included. Except as provided below concerning an electronic health record of your Protected Health Information, the Plan is not required to provide you an accounting of disclosures that were made for purposes of treatment, payment or health care operations.

The Plan will respond to your request for Protected Health Information we have disclosed within 60 days unless the Plan requests an additional 30 days to respond to your request. If your request is denied, you will be notified, in writing, why the request was denied, how you can appeal the decision, and provided with a copy of the Plan's complaint procedures.

You may also request an accounting of disclosures by the Plan of an electronic health record with respect to your Protected Health Information made during the six years prior to the date on which the accounting is requested. However, if your request relates to treatment, payment, or health care operations, the Plan need only give you an accounting for the last three years.

If an electronic health record maintained with respect to your Protected Health Information has been disclosed to one or more of the Fund's business associate(s), the Plan will provide you with either (i) an accounting of the disclosures of your Protected Health Information made by the business associate(s) acting on behalf of the Plan, or (ii) a list of all business associates acting on behalf of the Plan, including contact information for such associates (such as mailing address,

phone, and e-mail address). You may request an accounting of all Protected Health Information disclosed by a business associate directly from the business associate.

Your right to an accounting of electronic health record disclosures only applies to disclosures of Protected Health Information made on or after (i) January I, 2011, for electronic health records acquired after January 1, 2009, and (ii) January 1, 2014, for electronic health records acquired on or before January 1, 2009.

Restriction Requests: You have the right to request restrictions on the use and disclosure of your Protected Health Information. You can request, in writing, to the Privacy Official named above, that we place restrictions on the use or disclosure of your Protected Health Information. We are not required to agree to these restrictions, but if we elect to do so, we will abide by your request (except in the case of an emergency).

Notwithstanding the above, you may request the Plan to restrict uses and disclosures of your Protected Health Information for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment), in the event that the Protected Health Information relates solely to a health care item or service for which the health care provider has been paid out-of-pocket in full. The Plan must comply with such requested restrictions.

Confidential Communication: You have the right to receive certain communications confidentially. You can request, in writing, that we communicate with you in confidence about your Protected Health Information by alternative means or to an alternative location. We will accommodate your request if it is reasonable, specifies the alternative means or location and continues to permit us to collect dues and pay claims under the Plan. For example, you may request that we send all correspondence for you to your work address, or provide all information via e-mail rather than regular mail. Otherwise, we will continue to send Protected Health Information to you in the same manner as we do for other employees, usually by mail to your home address.

Amendment: You have the right to amend your Protected Health Information if you feel the information is incomplete or incorrect. You must make a request in writing to obtain an amendment. Your written request must explain why the information should be amended. You can then submit a written statement of disagreement to be appended to the information you want amended. The Plan may deny your request to amend the information if you do not state why you want the information amended or if you refuse to supply the Plan with information it needs to determine if the amendment should be made. In addition, the Plan may refuse to amend the information if:

- the information is not part of the Plan's medical information;
- the information was not created by the Plan unless the person or entity that created the information is no longer available to make the amendment;
- the information is not part of the information which you are permitted to inspect and copy; or
- the Plan determines that the information is complete and accurate.

You have the right to request the Plan amend your Protected Health Information for as long as the Plan maintains that information. The Plan will respond to your request to amend your Protected

Health Information within 60 days unless the Plan requests an additional 30 days to respond to your request.

If your request is denied, you will be notified, in writing, why the request was denied, how you can appeal the decision, and will be provided with a copy of the Plan's complaint procedures.

Notice of Breach: You have the right to receive written or electronic notification, as you prefer, if the Plan, its business associates, or their agents or subcontractors breach your Unsecured Protected Health Information (defined below). The notice will describe the breach; the type of Unsecured Protected Health Information that was involved; the steps you should take to protect yourself; what we're doing to investigate the breach, mitigate losses, and protect against further breaches; and contact procedures for you to receive more information and ask questions.

The Plan will provide this notification to you without unreasonable delay, but at the latest, 60 days following the date it discovers the breach. If we have insufficient contact information for you, we will use alternative means to notify you, such as posting on our website or in a major print newspaper in your geographic area.

A Breach occurs when your Unsecured Protected Health Information is acquired, accessed, used, or disclosed, unless there is a low probability that the Unsecured Protected Health Information has been compromised.

Unsecured Protected Health Information is Protected Health Information that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through certain technologies or methodologies as set forth by applicable law.

Copy of Notice: You may request a paper copy of this Notice at any time.

RIGHT TO CHANGE NOTICE

We reserve the right to change the contents of this Notice. We may modify or change our privacy practices from

time to time, particularly as new laws and regulations become effective. Any changes will be effective for all the Protected Health Information that we maintain, even information in existence before the change. If we materially modify our privacy practices, we will provide you with a new Notice advising you of these changes.

COMPLAINTS

If you believe that your Protected Health Information was not handled properly, or feel that we have not allowed you to exercise your rights, you may file a written complaint with the Privacy Official at the address listed above.

You may also file a complaint by writing to the Region VI Office for Civil Rights of the Department of Health and Human Services. Its address is 1301 Young Street, Suite 1169, Dallas, TX 75202, and its phone number is (214) 767-4056.

All complaints should identify the Plan and list the acts or omissions that you believe violated your privacy rights. The complaint must be filed with the Office of Civil Rights at the above address within 180 days of

the date you knew or should have known of the alleged violation. The government may waive the 180-day filing deadline if you can show good cause why you failed to file the complaint in time.

We respect your rights and we will not and cannot by law retaliate against you if you feel it necessary to file a complaint.

APPENDIX B

HEALTH REIMBURSEMENT ARRANGEMENT SUMMARY PLAN DESCRIPTION

The Fund has adopted a Healthcare Reimbursement Arrangement ("HRA") component in connection with the Plan. The full text of the HRA is in the official Plan document. This HRA Summary Plan Description is not meant to interpret, extend, or change the provisions of your Plan in any way. The provisions of your Plan may only be accurately determined by reading the actual Plan document. In the event of any discrepancy between this HRA Summary Plan Description and the actual provisions of the Plan, the Plan provisions will govern.

The HRA puts you in charge of the money you spend for health care services. You have flexibility and control in choosing the health care services you and your family members receive and in determining how the costs of those services are paid.

Type of Plan

This is an Internal Revenue Code Section 105 HRA that permits participants to be reimbursed for certain medical expenses not otherwise payable under the Plan. The Trustees, in their sole discretion, may allocate a certain amount to your individual HRA Account from time to time. Individual Employers, pursuant to their Collective Bargaining Agreement, may also allocate amounts for all or any subclass of its Covered Employees to an Employee's HRA. For Employees not covered by a Collective Bargaining Agreement, the Employer (such as the Local Union, NECA Chapter, JATC, or Covered Employers with respect to their Non-Bargaining Employees) may also choose to allocate amounts to an Employee's HRA from time to time pursuant to the Employer's Participation Agreement.

Amounts not used in a plan year may be carried over to the following plan year(s). This Plan intends to comply with federal law under Section 105 of the Internal Revenue Code. The HRA is integrated with other coverage hereunder and therefore is exempt from any stand-alone compliance with the lifetime and annual limits under, Public Health Services Act Section 2711.

Simply put, an HRA is a reimbursement account that the Fund or Employers will contribute to and maintain on behalf of eligible, active employees. You can use this account to reimburse yourself for covered medical expenses you incur, such as deductibles and co-payments.

How the HRA Works

Each year, the Fund may allocate a specified dollar amount into a HRA Account for you and your Dependents. This amount is subject to change from year to year. The allocation amount of one year does not dictate or otherwise influence the allocation amount for future years. Future allocation amounts may be for any amount, including zero. Your local collective bargaining parties (or for non-covered employees, your employer) may also agree to contribute additional amounts to your HRA account. Finally, once a year, other HRA participants can elect to voluntarily transfer some of their HRA account to your account. However, you cannot add your own money to your HRA.

In addition, if you are an eligible member working outside of the Fund's jurisdiction, your HRA account may be credited with additional contributions from other health and welfare trust funds, if such contributions are required by such fund's collective bargaining agreement, plan or trust agreement, and/or reciprocity agreement, and are remitted to the Fund earmarked to a personal care or similar account.

Eligibility

Your eligibility for the HRA is based on your eligibility for the Health Plan. Your Dependents are eligible to request reimbursement under your HRA account if such Dependents satisfy the definition of "Dependent," as described in this SPD.

If the Fund decides to make an HRA allocation, your eligibility under the HRA will begin on the first day of a calendar year (or such later time as you're a Covered Employee), if you are covered under the Plan during the calendar year and otherwise satisfy the eligibility requirements for the HRA (i.e., if you were eligible on September I of the previous year, or were eligible for Plan benefits as an Active Employee or a COBRA participant paying both regular and HRA COBRA, for at least 6 out of 12 months in the previous plan year ending August 31).

If you are not covered under the Health Plan during the calendar year, then you will not receive an HRA allocation for that year, and will become eligible for an allocation under the HRA (if the Fund decides to make an allocation) on the first day of the next calendar year after you become covered under the Health Plan and satisfy the eligibility requirements for the HRA, as described above. You will continue to be eligible to draw on your HRA account as long as you have not ceased to qualify as an Active Employee for 12 consecutive months.

Retired Employees that are not eligible for Medicare coverage are eligible to receive an HRA allocation. Non-Medicare Retirees will be eligible to have an HRA account under the same conditions as provided above (i.e., eligible on the prior September 1, and/or six months coverage). If the Fund decides to make an allocation, non-Medicare Retirees will receive an allocation based on their prior year's participation in the Health Plan. For example, for an annual allocation of $600, $50/month, if you were eligible for all 12 months of the previous Plan Year (through either self-paid Retiree coverage, or as an Active Employee), then your HRA account would have a $600 credit ($50 x 12). If you were eligible for six months, your HRA account would have a $300 credit ($50 x 6). You will not receive your HRA allocation until you become eligible to participate in the Health Plan for the year in question (through either self-paid Retiree coverage, or as an Active Employee).

Extended Self-Pay Participants, Sub-Plan Participants, Retired Employees that are eligible for Medicare (and their Dependents), and surviving spouses and dependents are ineligible for the annual HRA allocation. However, eligible participants may use pre-existing funds from their HRA account to reimburse medical expenses they or their Dependents incur. Nevertheless, individuals will forfeit their HRA account balance if they have been inactive, with no reported hours for over 12 months.

If your Local Union and/or participating Employer leave the Fund for any reason, then you will forfeit all amounts in your HRA Account. In addition, except as provided below for COBRA or Retiree Coverage, if you are ineligible for participation in the Health Plan for more than 12 months, then you will forfeit your HRA account.

Benefits Provided Under the HRA

When you or your dependents have medical care expenses, you will continue to file them through the Health Plan as you do now. If your eligible expenses amount to less than your deductible, you can apply for reimbursement through your HRA or keep your HRA balance intact for future expenses.

In addition to submitting a reimbursement form, if you meet the required minimum balance of $300 in your HRA account, you will be issued a debit card that you can swipe at a point of service for eligible, reimbursable healthcare expenses. Once this card is issued, you will be charged a $4 monthly service fee directly from your HRA account for maintenance of the card.

Generally, non-reimbursed expenses covered under the Health Plan are eligible for reimbursement through your HRA.

A complete list of HRA eligible expenses is set forth in IRS Publication 502, available at www.irs.gov. The following are examples of the more common types of expenses that are reimbursable from your HRA account:

1. Amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body;

2. Payments to continue active coverage under the Main Plan or Sub-Plans by transferring allocations from your HRA account to your Hour Bank to purchase additional hours, based on the contribution rate then in effect.

3. Self-payment amounts for COBRA continuation coverage under the Plan, as described under "COBRA Self-Payment Provisions for Active Employees and the Dependents" of this SPD. Please note that COBRA premiums must be submitted for reimbursement- direct transfers from the HRA account to pay COBRA premiums are not permitted;

4. Self-payment amounts for extended Active Employee self-payment coverage under the Plan, as described in the Extended Self-Payment provisions of the SPD. Active Employee self-payment coverage premiums must be submitted for reimbursement - direct transfers from the HRA Account to pay Active Employee self-payment premiums are not permitted;

5. Self-payment amounts for Retired Employee coverage under the Plan, as described above. Please note that Retiree premiums must be submitted for reimbursement- direct transfers from the HRA Account to pay Retiree premiums are not permitted; ·

6. Premiums for long-term care insurance (but excluding long-term care services);

7. Premiums for Medicare Parts B and D;

8. Reconstructive surgery if the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease;

9. Home or automobile expenditures made primarily for the medical care of you or your Dependent (for example, ramps, hand controls on a vehicle, wheel chair lifts and racks, etc.). Such expenditures will only be reimbursable if they are related to alleviate sickness or disability and are not related to the permanent improvement or betterment of the property;

10. Amounts paid for custodial care services, to the extent that such amounts are attributable to the performance of services related to medical care;

11. Health club or fitness program dues, if treatment at such a health institute is specifically prescribed and substantiated by a physician as medically necessary to treat a recognized disease, including, but not limited to, obesity;

12. Massage therapy by a licensed massage therapist, if a physician specifically prescribes and substantiates it as medically necessary;

13. Over the counter drugs, as permitted by IRS Regulations for medical reimbursement, such as cold medicine, sunscreen, asthma medicine, allergy medicine, cough syrup, and prenatal vitamins;

14. Women's sanitary products;

15. Insulin treatment;

16. Vitamins, acne treatment, dietary supplements, probiotics, and weight loss programs, but only if prescribed by a doctor; and

17. Eyeglasses and contacts.

The HRA Plan can only reimburse medical expenses to the extent that the Health Plan, other insurance, or any other accident or health plan did not already reimburse you for it. If only a portion of a medical expense has been reimbursed from another source, then the remaining portion of such medical expense can be reimbursed under the HRA account if it is listed above.

You incur a medical expense at the time the medical care or service giving rise to the expense is furnished, and not when you are formally billed for it, charged for it, or pay for it. Medical expenses you incur before becoming eligible under the HRA are not reimbursable under the HRA Plan. Also, medical expenses incurred more than 12 months after you were an Eligible Employee under the Health Plan are not reimbursable.

Exclusions

The following expenses are not reimbursable under the HRA:

1. Amounts paid for any individual or group insurance coverage other than (i) Active Coverage under the Main Plan or Sub-Plans, or (ii) Self-Payment amounts described under "COBRA Self-Payment Provisions for Active Employees and the Dependents" of this SPD. For avoidance of doubt, the HRA cannot reimburse Eligible Individuals for premiums paid for health insurance in the individual market, the federal Marketplace or a state Exchange. However, notwithstanding the above, the HRA may reimburse Eligible Individuals for premiums for individual market coverage if that coverage consists only of "excepted benefits," such as insured dental, vision or specific illness coverage. Moreover, effective with the Plan Year beginning on or after January 1, 2017, if a spouse and/or Dependent are not enrolled in the Plan or in another group health plan, the HRA cannot reimburse their expenses.

2. Insurance premiums for life, accidental death and dismemberment, short-term disability, and long-term disability;

3. Long-term care services;

4. Cosmetic procedures or surgery, except as provided above;

5. Any item that is not deductible "medical care" as defined under §213(d) of the Internal Revenue Code of 1986, as amended;

6. Over-the-counter pregnancy testing kits;

7. Charges of a nurse to care for a healthy newborn at home;

8. Funeral and burial expenses;

9. Household and domestic help (even though recommended by a qualified physician due to your inability or your Dependent's inability to perform physical housework);

10. Social activities, such as dance lessons (even though recommended by a physician for general health improvement);

11. Cosmetics, toiletries, toothpaste, etc.;

12. Vitamins and food supplements, unless prescribed by a physician;

13. Transportation expenses of any sort, including transportation expenses to receive medical care;

14. Psychotherapy (including psychoanalysis);

15. Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician; and

16. HRA claims that you have not submitted within 12 months of the date they were incurred.

Carryover of HRA Account Balances

If any balance remains in your HRA account after all reimbursements have been made for a calendar year, then you will be able to carry over your remaining account balance to reimburse medical expenses incurred during subsequent years. Please note, however, that there are circumstances where your HRA account will be forfeited, such as where you are an inactive employee, with no reported hours, for 12 or more consecutive months.

Reimbursement Procedures

You may apply for Health Reimbursement benefits by submitting an HRA Reimbursement Form (available from the Fund Office), to the Fund Office by no later than 12 months after the expense was incurred. The following information must be included on .the Reimbursement Form:

I. The name of the person(s) who received the medical care;

1. The nature of the medical care and the date(s) on which it was received;

3. The amount of the requested reimbursement; and

4. A statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Any bills, invoices, or other statements showing that the medical care expenses have been incurred and the amounts of such medical care expenses, together with any additional documentation that the Plan may request, must accompany the application.

As noted above, in addition to the reimbursement form, if you have at least $300 in your HRA account, you will be issued a debit card that you can swipe at a point of service for eligible, reimbursable healthcare expenses.

Reimbursement by the Plan

The Plan Administrator will generally determine whether a medical expense is reimbursable under the HRA, following the above criteria, and notify you if it denies the claim within 30 days after the Plan receives the HRA Reimbursement Form. The Plan may extend this determination period for 15 additional days for matters beyond the control of the Plan, including in cases where a Reimbursement Form is incomplete.

The Plan will provide you written notice of any extension, including the reasons for the extension.

If approved, the Plan generally intends to reimburse the Eligible Individual for approved claims within 90 days of receipt or once each calendar quarter, although administrative delays may require additional time.

If the Plan Administrator completely or partially denies your claim for reimbursement under the HRA, then the appeal procedures and deadlines outlined above in this SPD will apply.

You must submit a complete claim within 12 months from the date of service or the claim will not be reimbursed.

COBRA Self-Payment Provisions

An individual whose coverage is terminated because of any COBRA qualifying event enumerated under "COBRA Self-Payment Provisions for Active Employees and the Dependents" has the right to continue coverage under the HRA if they were covered under the Health Plan as an Active Employee, Spouse or Dependent of an Active Employee on the day before the qualifying event. A child of the Active Employee who is born or placed for adoption during continuation of coverage also is eligible.

You may use your existing HRA Account balance to pay for such COBRA coverage. But you must make the COBRA self-payment premium and then submit an application to be reimbursed from your existing HRA Account balance. The Plan will not withdraw the COBRA self-payment premiums automatically from your HRA Account.

If your employment is terminated and you do not elect continuation coverage as outlined below, then your participation under the HRA will cease and you will forfeit any unused amount in your HRA account.

In addition to the regular COBRA premium, there will also be a separate HRA COBRA premium as well. If you only elect regular COBRA coverage, then you will be able to maintain your HRA Account balance as it existed immediately prior to the qualifying event. But you will not receive any additional annual Fund allocations to your HRA Account.

In order to receive additional annual allocations under the HRA, you must pay the HRA COBRA premium (in addition to the regular COBRA amounts for continuation coverage under the Health Plan). The Board of Trustees will set the monthly HRA COBRA coverage premiums at an amount equal to 102 percent of the current annual per person HRA contribution for the year multiplied by one-twelfth.

In the event of a new annual allocation, if you were not an Active Employee or HRA COBRA Employee for the entire prior plan year, then you will receive a new HRA allocation proportional to your period of

activity, provided that it was at least 6 months long. For example, if the new allocation is for $600 and you were active or paying HRA COBRA premiums for 6 months in the previous year, then you would be eligible for a $300 allocation- $50 for every month you were either an Active Employee or paying HRA COBRA premiums. So, if you were an Active Employee for 4 months and then paid for full COBRA coverage (both regular COBRA and HRA COBRA) for the remaining 8 months of the year, then, for purposes of the new annual allocation, you would be treated as if you were an Active Employee for the entire 12 months.

If you elect full HRA continuation coverage, then your HRA coverage will continue as though your loss of eligible status had not occurred. The maximum time period for which the COBRA (including HRA COBRA) continuation coverage is available is indicated above under "COBRA Self-Payment Provisions for Active Employees and the Dependents", in conjunction with the corresponding qualifying event.

Retired Employees

Retired Employees covered under the Plan are ineligible for continued HRA account allocations, but can use their existing HRA Account balances to pay the required premiums for retiree coverage. However, the Retired Employee must make the Retiree self-payment premium and then submit an application for reimbursement from his existing HRA Account balance. The Plan Administrator will not automatically withdraw Retiree self-payment premiums from the Retired Employee's HRA Account.

Reimbursement Upon Death

The remaining balance of an employee's HRA account may be used after the employee's death to pay for the medical care expenses incurred before the employee's death. Alternatively, the HRA account may be used to reimburse medical care expenses incurred by the employee's surviving spouse and other Dependents.

Amendment and Termination of the HRA

The Board of Trustees established the HRA with the intent that it continue for an indefinite period of time. However, the Board of Trustees reserves the right, in its sole and absolute discretion at any time and from time to time, to amend or terminate all or any part of the HRA at any time for any reason.

Taxation of HRA Benefits

The current IRS code provides that HRA benefits will not be subject to federal income taxes or to social security taxes. However, the Plan makes no commitment or guarantee that any amounts paid to you or for your benefit under the HRA will be excludable from your gross income for federal, state or local income tax purposes. It is your obligation to determine whether each payment under the HRA is excludable from your gross income for federal, state and local income tax purposes, and to notify the Plan if you have any reason to believe that such payment is not excludable.

Tax laws impose a variety of nondiscrimination requirements and benefits tests that must be met before benefits under the HRA will be nontaxable to all employees. These are generally intended to restrict the amount of nontaxable benefits available to certain employees who are "highly compensated." If the Plan Administrator believes that any of these requirements or limits may be violated, it may limit the amount of benefits available to certain participants, or treat such benefits as taxable compensation, so that the Plan and its benefits will not be discriminatory.

If You Need More Information

If you have any questions regarding the HRA or the subjects addressed above, please contact the Fund Office:

> IBEW - NECA Southwestern Health and Benefit Fund
> P.O. Box 819015
> Dallas, Texas 75244-9015
> Phone: (972) 980-1123
> National Toll-Free: (800) 527-0320
> Fax: (972) 341-8097
> https://inswhealth.zenith-american.com

Opt-Out.

Healthcare Reimbursement Arrangements are "excepted benefits" that are not subject to HIPAA or the Affordable Care Act. Accordingly, you have the right each year (and also upon loss of active Plan eligibility) to opt-out of this coverage and waive future reimbursements if you wish. To do so, please contact the Fund Office for the appropriate form. However, please note that there is no charge for the Fund's HRA coverage, and opting-out will not decrease your (or your Employer's) premium costs.