IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND

SUB-PLANS FOR APPRENTICES, CONSTRUCTION WIREMEN, CONSTRUCTION ELECTRICIANS, AND INTERMEDIATE JOURNEYMEN

Summary Plan Description (SPD)

September 1, 2023 Edition

Fund Logo

Printer's Union Bug

IBEW-NECA SOUTHWESTERN
HEALTH AND BENEFIT FUND

4101 McEwen Road, Suite 600
Dallas, TX 75244
Telephone: (972) 980-1123
Toll-Free: (800) 527-0320

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Addison, Texas 75002-6316

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IMPORTANT NOTICES

GRANDFATHERED PLAN

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Zenith American Solutions at 4101 McEwen Road, Suite 600, Dallas, TX 75244 or via telephone at (972) 980-1123. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

LIFETIME AND ANNUAL DOLLAR LIMITS ELIMINATED

The lifetime and annual limits on the dollar value of benefits under the IBEW-NECA Southwestern Health and Benefit Fund Sub-Plans for Apprentices and Intermediate Journeymen no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. 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, effective April 1, 2012, 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 (including your spouse) 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 comprehensive medical benefits, mental health and substance abuse benefits, vision benefits, life insurance benefits, and prescription drug 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, http://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 Blue Cross Blue Shield website.

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 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 expense/s were incurred:

IBEW-NECA SOUTHWESTERN
HEALTH AND BENEFIT FUND

P.O. Box 819015
Dallas, TX 75381-9015
Telephone: (972) 980-1123
Toll-Free: (800) 527-0320
FAX: (972) 341-8097
http://inswhealth.zenith-american.com

Participation Rules for the Sub-Plans for Apprentices and Intermediate Journeymen

The IBEW-NECA Southwestern Health and Benefit Fund Sub-Plans for Apprentices and Intermediate Journeymen (the "Sub-Plans") are available for apprentices and intermediate journeymen. These plans apply where local collective bargaining agreements are modified to specifically participate in the Sub-Plans.

Your eligibility for Sub-Plan B-1 or B-2 will be determined based on the contribution rate that is made on your behalf during the time you are classified as an Apprentice or Intermediate Journeyman. The collective bargaining parties in your jurisdiction will determine which of the two Sub-Plan contribution rates you qualify for based 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 will be eligible for Sub Plan B-2. Apprentices and Intermediate Journeymen for whom contributions are made at the lower of the two rates will be eligible for Sub-Plan B-1.

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.

LETTER FROM THE BOARD OF TRUSTEES
OF THE
IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND

4101 McEwen Road, Suite 600
Dallas, TX 75244
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TO ALL ELIGIBLE PARTICIPANTS:

We are pleased to present you with this SPD which has been published to give you an up-to-date description of the benefits provided by the IBEW-NECA Southwestern Health and Benefit Fund for Sub-Plan participants. Also included in this SPD is certain information concerning the administration of the Sub-Plans as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

We urge you to read this booklet carefully. It summarizes the most important features of the Sub Plans. Please understand that no general explanation can adequately give you all of the details of the Sub-Plans. This general explanation does not change or expand or otherwise interpret the terms of the Sub-Plans. Your and your Dependents' rights can be determined only by referring to the full text of the Sub-Plans. In the event of a conflict between the Sub-Plan's Rules and Regulations and this SPD, the Rules and Regulations will control.

Remember: To be official, all communications to you must be in writing and either be signed by us as the Trustees of the Sub-Plans or signed on our behalf by the Plan Administrator.

If you are not sure whether you may be eligible for benefits, or your spouse or children may be eligible for benefits, you should contact the Fund Office, or have someone in the family contact the Fund Office. The staff will be happy to assist you.

THE FUND OFFICE SHOULD BE KEPT ADVISED OF YOUR CURRENT MAILING ADDRESS TO ENSURE THAT YOU RECEIVE ALL REQUIRED COMMUNICATIONS.

Sincerely,

BOARD OF TRUSTEES

NINE WAYS TO CONTROL YOUR HEALTH CARE BILLS

You **can** control your health care expenses. **Start now**. Although you may already be a conscientious user of the health care system, by practicing **all** nine ways to control your health care expenses, you will positively affect your pocketbook and your health.

1. **Treat yourself right**. Many Illnesses and Injuries may be prevented. Major Illnesses such as heart disease are often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet and stress are a few of the factors that can cause heart disease. By eating right, getting enough sleep and exercising regularly, you can be on the road to preventing Illness, both major and minor. Remember to wear your seatbelts when driving and take the time to be careful around your home to avoid unnecessary household accidents.

2. **Ask "dumb" questions**. Actually, the only dumb questions are the ones you **don't** ask.

    - Ask about charges on your Hospital bill if you don't understand them. All Hospitals have people who can help answer your billing questions.

    - Patients who are informed about what to expect during their Hospital confinement usually recover faster and have fewer complications than patients who are uninformed. Many Hospitals have patient information programs to help you. Use them!

    - Inquire about the costs of medications. Generic drugs often cost less than brand name drugs and your Physician will prescribe them if you ask.

    - If you have any doubts or questions about a treatment or procedure your Physician has recommended for you, get a second opinion from another Physician or health care professional.

3. **Don't be in when you can be out**. Ask your Physician about the use of out-patient services in your Hospital or Physician's office for tests, treatments and many types of minor surgeries. Out-patient care is always less expensive than a Hospital confinement and can often accomplish the same objective.

4. **Use the emergency room for "emergencies"**. Your Hospital's emergency room is an expensive place to treat minor aches and ailments. When possible, contact your Physician before deciding to use the emergency room.

5. **Understand your coverage before you must use it**. Make sure you understand your health coverage. Read this booklet. It describes how the benefits will work and what is and what is not covered.

6. **The shorter your Hospital confinement, the less you pay**. When it's practical, have tests performed before you enter the Hospital. Except in emergencies, avoid being admitted to the Hospital at night or on the weekend because you may spend unnecessary

time waiting for surgery or special treatment. Also, it is important to leave the Hospital as soon as your Physician tells you that you are ready.

Remember-your benefits may be reduced if it is determined your Hospital confinement was unnecessary, begins on a weekend or holiday when surgery is not performed within 24 hours of the admission and/or admission at that time is not medically necessary or you remain in the Hospital for more days than have been certified as necessary for your condition.

7. **Don't expect a "free" lunch**. Be a cost-conscious consumer. Even though our Fund or the government may pay for most of your health care needs, the services and treatment you receive are never free. If you make an effort to control how you use health care services, everyone will benefit ... especially you.

8. **Watch for early warnings**! Learn the early warning signs of Illnesses such as heart disease and cancer. Early detection of Illnesses could save your life and will save you money.

9. **Use PPO Providers**. Since the Fund pays 80% of the eligible charges when you and your Dependents use PPO providers, you and the Fund will save money! Therefore, you will have a lower out-of-pocket expense when you use the services of a Hospital, Physician, Laboratory, etc. that participates in the PPO network.

These nine steps may lead you to better health and lower medical expenses!

SCHEDULE OF BENEFITS
As of Septembder 1, 2023

ANNUAL MAXIMUM LIMITS ON HOSPITAL DAYS AND ADMISSIONS

Sub-Plan B-1

Coverage under Sub-Plan B-1 is limited to the **lesser of** (i) 10 days in the hospital (in-patient **OR** out-patient) or (ii) one surgery **OR** admission per calendar year.

Thus, for example, if you are in the hospital for 15 days due to a surgery, the Plan would only cover the first 10 days. The Plan would thus **not cover** the full in-patient stay for that surgery. Likewise, if you are in the hospital for non-surgical reasons for 10 days (such as for a mental health or substance abuse admission), and then later in the year are admitted for a surgery, the Plan would not cover the surgery. Similarly, if you were admitted for a surgery and stayed 5 days in the hospital, the Plan would not cover any additional hospital admittance later in the year, since you already had your one surgery.

Sub-Plan B-2

Coverage under Sub-Plan B-2 is limited to the **lesser of** (i) 20 days in the hospital (in-patient **OR** out-patient) or (ii) two surgeries **OR** admissions per calendar year.

Thus, for example, if you have two surgeries covering 15 days, and then later are admitted for a third time for a non-surgical procedure (such as a mental health or substance abuse admission), the Plan would not cover any additional days (even though you hadn't used up your 20 days), as you already had your 2 surgeries or admissions, and the annual Plan maximum is the **lesser** of the two limits.

Exception for Hospital Admissions for Childbirth

Notwithstanding the above limits, the Plan will always cover in-patient admissions for Members and Spouses for childbirth, for up to 48 hours for a natural childbirth and 96 hours for a C-Section, to the extent required by federal law.

Mental Health and Substance Abuse Benefits Administered by Blue Cross Blue Shield (applicable to both Sub-Plans)

The Fund has an administrative 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.

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 for an in-network PPO referral. A Blue Cross Blue Shield representative will refer you to one of its providers.

To the fullest extent permitted by the Mental Health Parity and Addiction Equity Act, a Blue Cross Blue Shield representative must also pre-certify any in-patient (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 penalty of $250 (or per BCBS provided 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 maximum number of hospital days and admissions that apply to the Sub-Plans' comprehensive medical benefits. These limits are all coordinated together. There are no stand-alone separate deductibles, coinsurance or maximum number of hospital days and admissions for mental health and substance abuse benefits.

This means that the same single, combined $300 individual ($600 family) deductible applies to covered mental health and substance abuse benefits as also applies to the comprehensive medical benefits. In addition, in-patient mental health and substance abuse benefits are subject to the Sub-Plan B-2's $200 non-PPO hospital deductible.

After meeting applicable deductibles, just like the Sub-Plans' comprehensive medical benefits, PPO services for mental health and substance abuse will be covered at the 80% coinsurance rate. Non-PPO services are **not covered** under Sub-Plan B-1, and are covered at the 50% of reasonable and customary cost coinsurance rate for Sub-Plan B-2. Please note that for non-PPO facilities, "Reasonable and Customary" is the lesser of the billed charges or 200% of the Medicare allowable. If you use a non-PPO facility, you will also be responsible for any charges over and above the reasonable and customary limit. Please note that, as "grandfathered plans" exempt from certain portions of the Affordable Care Act, there are no out-pocket maximums under the Sub-Plans.

All combined comprehensive medical and mental health and substance abuse benefits are subject to the maximum limit of the **lesser of** 10 days of hospitalization (in-patient or out-patient) **OR** one surgery or admission per calendar year for Sub-Plan B-1. All combined comprehensive medical and mental health and substance abuse benefits are subject to the maximum limit of the **lesser of** 20 days of hospitalization (in-patient or out-patient) OR two surgeries or admissions per calendar year for Sub-Plan B-2.

Hospital Deductible	$200 per Hospital admission when a Blue Cross Blue Shield facility is **not** used under Sub-Plan B-2
Inpatient Mental Health and Substance Abuse.....	If inpatient services are properly pre-certified and

	determined by Blue Cross Blue Shield to constitute Covered Expenses, and a Blue Cross Blue Shield PPO facility is used, benefits will be provided at eighty percent (80%), after the Eligible Individual satisfies the $300 (or $600 family) annual deductible. There is no out-of-pocket maximum. If a non-Blue Cross Blue Shield PPO facility is used, Sub-Plan B-1 pays no benefits. Sub-Plan B-2 pays a coinsurance rate of 50% of the reasonable customary cost. There is a $250 penalty for failure to pre-certify. No out-of-pocket maximum.
Mental Health and Substance Abuse Annual Limit (when combined with comprehensive medical benefits).....	Sub-Plan B-1 - Lesser of 10 days (in-patient or out-patient) or 1 surgery or admissions. Sub-Plan B-2 - Lesser of 20 days (in-patient or out-patient) or 2 surgeries or admissions.
Care not eligible for reimbursement	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). Services for primary V code conditions as listed in the Diagnostic and Statistical Manual - 4th Revision or its successor. Custodial care or rest cures. Treatment initiated primarily as the result of criminal behavior, or court-ordered treatment that is not determined by the exclusive provider organization to be Medically Necessary. 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.

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

Disability and workers' compensation cases.

Light therapy. Biofeedback therapy. Sleeping disorders.

Therapy related to sex change or transformations.

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).

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

To receive the highest level of benefits, ***ALL*** inpatient (including residential treatment center care) and the outpatient services listed above (including partial hospitalization) must be pre-certified by Blue Cross Blue Shield.

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.- 9:00 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.

Vision Benefits Offered Through VSP Vision Care
(applicable to both Sub-Plans)

You have access to the VSP Vision Savings Pass, which provides discounts on eye exams, contact lenses, frames and contacts.

How to Use Your VSP Vision Savings Pass

1. Find a VSP doctor at **vsp.com** or call **800.877.7195**.
2. Save Immediately on an eye exam[1] and eyewear at the time of service.
3. Take advantage of your VSP Vision Savings Pass over and over--use is unlimited on materials.[3]

Unlimited Annual Material Use[3]

Your VSP Vision Savings Pass can be used as often as you like throughout the year. With the best choices in eyewear, VSP makes it easy to find the perfect frame that's right for you, your family, and your budget. Choose from great brands like Anne Klein, babe, Calvin Klein, Flexon, Lacoste, Nike, Nine West, and more.[4]

Not Covered

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

- Orthoptics or vision training and any associated supplemental testing
- plano 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
- medial 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

For more information on the VSP discount program, call VSP at (800) 877-7195.

Opt-Out

The Sub-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

BENEFITS PROVIDED BY THE FUND

Sub-Plan B-1

LIFE INSURANCE BENEFITS

Active Employees Only:

Life Insurance $5,000

MAJOR MEDICAL BENEFITS

All Eligible Employees and Dependents:

Major Medical Maximums

Annual Maximums:

Overall Plan .....Lesser of 10 days (in-patient or out-patient) or 1 surgery or admission per Eligible Individual

Physical/ Occupational Therapy Maximum .....10 visits maximum per year

Calendar Year Deductible..... $300 per Eligible Individual; $600 per family maximum

Co-Insurance (in-patient/out-patient eligible charges):

PPO Hospitals ..... 80% of eligible charges
..... after the deductible amount[1]

Non-PPO Hospitals ..... **no benefits**[2]
PPO Hospital Room and Board .....Average semi-private rate
Intensive/Cardiac/Critical/Neo-natal Care Units Room & Board .....Hospital's usual charge

Prescription Drug Benefits:

Brand Name Drugs .....75% of eligible charges after the
.....deductible amount. Coverage assumes no Generic equivalent is available[3]
Generic Drugs ..... 90% of eligible charges

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[1] All non-emergency PPO Hospital admissions ***must*** be pre-certified. Emergency admissions that continue after the completion of the emergency services ***must*** be certified within 48 hours following the completion of the emergency services covered by the No Surprises Act. Precertification is also required for the Medical Outpatient services specified below. Failure to comply with these precertification requirements ***will*** result in a penalty of 50% of the benefit, up to a maximum of $250 (or per BCBS provider sanction).

[2] If laboratory tests, X-rays, anesthesia, or emergency room Physician examinations are performed or provided by a Non-PPO provider at a PPO facility, the covered charges will be paid at the higher PPO co-insurance rate.

[3] **If you choose a brand name drug for which an alternative, generic equivalent is available, then the Sub-Plan does not cover the cost at all.**

.... After the deductible amount

Physical/Occupational Therapy:
PPO Provider ..... 80% of eligible charges
..... after the deductible amount

Non-PPO Provider .....no benefits

Durable Medical Equipment:
PPO Provider ..... 80% of eligible charges
..... after the deductible amount

Non-PPO Provider .....no benefits

Maternity Benefit:
PPO Provider ..... 80% of eligible charges
..... after the deductible amount

Non-PPO Provider ..... no benefits

All Other Eligible Charges Expressly Covered in this SPD:
PPO Provider ..... 80% of eligible charges
..... after the deductible amount

Non-PPO Provider .....no benefits

Out-of-Pocket Maximum .....None

Transplants.....Not Covered

Chiropractic .....Not Covered

Dental .....Not Covered

Weekly Disability Benefits..... None

Supplemental Accident Benefits..... None

Hospice.....Not Covered

Wellness / Preventive Care .....Not Covered

Sub-Plan B-2

LIFE INSURANCE BENEFITS

Active Employees Only:

Life Insurance $5,000

MAJOR MEDICAL BENEFITS

All Eligible Employees and Dependents:

Major Medical Maximums

Annual Maximums:

Overall Plan .....Lesser of 20 days
.....(in-patient or out-patient) or 2 surgeries
.....or admissions per Eligible Individual

Physical/Occupational Therapy Maximum .....20 visits maximum per year

Calendar Year Deductible ..... $300 per Eligible Individual
..... $600 per family maximum

Co-Insurance (in-patient/out-patient eligible charges):

PPO Hospitals ..... 80% of eligible charges
..... after the deductible amount[1]

Non-PPO Hospitals ..... 50% of eligible charges
..... after the deductible amount[2]

Hospital Room and Board .....Average semi-private rate

Intensive/Cardiac/Critical/Neo-natal Care Units Room and Board .....Hospital's usual charge

Prescription Drug Benefits:

Brand Name ..... 75% of eligible charges after
.....the deductible amount. **If a Generic**
..... equivalent is available, the Sub-Plan
.....does **not cover any of the costs**.[3]

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[1] All non-emergency PPO Hospital admissions ***must*** be pre-certified. Emergency admissions that continue after the completion of the emergency services ***must*** be certified within 48 hours following the completion of the emergency services covered by the No Surprises Act. Precertification is also required for the Medical Outpatient services specified below. Failure to comply with these precertification requirements ***will*** result in a penalty of 50% of the benefit, up to a maximum of $250 (or per BCBS provider sanction).

[2] If laboratory tests, X-rays, anesthesia, or emergency room Physician examinations are performed or provided by a Non-PPO provider at a PPO facility, the covered charges will be paid at the higher PPO co-insurance rate.

[3] If you choose a brand name drug for which an alternative, generic equivalent is available, then the Sub-Plan does not cover the cost at all.

Generic ..... 90% of eligible charges
..... after the deductible amount

Physical/Occupational Therapy:
PPO Provider ..... 80% of eligible charges
..... after the deductible amount

Non-PPO Provider ..... 50% of eligible charges
..... after the deductible amount

Durable Medical Equipment:
PPO Provider ..... 80% of eligible charges
..... after the deductible amount

Non-PPO Provider ..... 50% of eligible charges
..... after the deductible amount

Maternity Benefit:
PPO Provider ..... 80% of eligible charges
..... after the deductible amount

Non-PPO Provider ..... 50% of eligible charges
..... after the deductible amount

All Other Eligible Charges Expressly Covered in this SPD:
PPO Provider ..... 80% of eligible charges
..... after the deductible amount

Non-PPO Provider ..... 50% of eligible charges
..... after the deductible amount

Out-of-Pocket Maximum ..... None

Transplants..... Not Covered

Chiropractic ..... Not Covered

Dental ..... Not Covered

Weekly Disability Benefits..... None

Supplemental Accident Benefits..... None

Hospice ..... Not Covered

Wellness / Preventive Care ..... Not Covered

NOTE: "Eligible Charges" for a Non-PPO Provider are the Reasonable & Customary charges, which are expressly defined as the **LESSER** of the billed amount or 200% of the

Medicare Allowable. Sub-Plan B-2 pays at 50% of this Eligible Charge for a Non-PPO Provider. Please note that even though certain Non-PPO charges in limited cases are paid at the PPO co-insurance rate, all other Non-PPO rules still continue to apply (such as the 200% of Medicare maximum Reasonable and Customary limit).

Emergency Services

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 (with no further coverage under Sub-Plan B-1), 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.

Prescription Drug Benefits
(applicable to both Sub-Plans)

There is no separate Prescription Drug Benefit under the Sub-Plans. Prescription drugs are covered the same as any other Major Medical Benefit. Thus, for both Sub-Plan B-1 and B-2, after you satisfy the Annual Deductible, the Plan pays 75% of the cost if you select a Brand Name Drug and 90% of the cost if you use a Generic Drug. There is no out-of-pocket maximum.

However, the Plan does **not cover** Brand Name prescription drugs if you select a Brand Name Drug when a Generic is available.

The Plan will also provide you with a Sav-Rx discount card for prescription drugs.

The prescription drug benefit covers only those drugs that require a Physician's written prescription. **Drugs and medicines that may be purchased on an over-the-counter basis are not covered.** When you have a prescription filled or refilled at a pharmacy, you must pay up front and then complete a claim form and submit it along with the receipt for the prescription to the Fund Office for reimbursement.

No benefits are available for a Brand Name Drug for which a Generic equivalent is available. This applies even if your Physician prescribes a Brand Name Drug, for which there is a Generic equivalent available, and indicates "dispense as written."

Injectables and specialty drugs administered in a doctor's office, outpatient infusion center, or via home health care will be covered under the Fund's medical benefits, i.e., at the 80% copayment rate for in-network coverage, and for Sub-Plan B-2 only, 50% for Non-PPO Providers.

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 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 1 (800) 433-3232 (or for mental health or substance abuse issues,

contact Blue Cross Blue Shield 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, you, a family member, your Physician or the Hospital must call Blue Cross Blue Shield at 1 (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.

Outpatient Medical Benefits Requiring Precertification

- Coordinated Home Care (including nurse, social worker, physical therapy, occupational therapy, and speech therapy, and private duty nursing)
- High-Cost Specialty Drugs (to the extent, if any, otherwise covered under the Plan)
- Air Ambulance, fixed-wing, unless emergency services is needed
- Home Hemodialysis
- Home Infusion Therapy
- Lipid Apheresis
- Outpatient Surgical Procedures, including 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
- Ear, Nose & Throat Services (including Cochlear Implant; Bone Conduction Hearing Aids; and Nasal & Sinus Surgery)
- Surgical Deactivation of Headache Trigger Sites
- Orthopedic Stem-Cell Therapy
- Functional Neuromuscular Electrical Stimulation

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 problems.

A Blue Cross Blue Shield representative must pre-certify any non-emergency in-patient services (including acute, rehab, and residential treatment center care) and any intensive outpatient (including partial hospitalization) services relating to mental health or substance abuse tratment. 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 or www.bcbsil.com 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).

What Will Happen If You Do Not Use the Above Pre- and Post-Authorization Programs?

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

The PPO co-insurance reductions also apply to Employees and Dependents covered under Sub Plan B-1; however, the Non-PPO reduction does not apply because no Non-PPO benefits are provided under Sub-Plan B-1.

REMEMBER!

YOU MUST USE THESE CERTIFICATION PROGRAMS ANY TIME YOUR OR YOUR DEPENDENTS INCUR A NON-EMERGENCY HOSPITAL ADMISSION OR YOUR OR YOUR DEPENDENT'S PHYSICIAN RECOMMENDS A NON-EMEREGENCY HOSPITAL CONFINEMENT.

YOU AND YOUR DEPENDENTS MUST ALSO USE THESE PROGRAMS IN THE EVENT OF AN EMERGENCY HOSPITAL ADMISSION (AFTER COMPLETION OF THE EMERGENCY SEREVICES), PREGNANCY, OR SPECIFIED MENTAL HEALTH AND SUBSTANCE ABUSE AND MEDICAL OUTPATIENT SERVICES.

BENEFIT PAYMENT EXAMPLE

Sub-Plan B-1

In-Network Hospital charges (not exceeding 10 days) of $15,000:

In-Network

Hospital Charges*	
Original Bill	$15,000
Repriced Bill	$12,000
Calendar Year Deductible	$300
Reimbursement Percentage	80%
Total Plan Payment	$9,360
Your Payments:	
Deductible	$300
Co-insurance	$2,340
Total	$2,640

*** REMEMBER: If you or your Dependents incur expenses at an out-of-network Hospital, no benefits are payable.**

In-Network Physicians charges of $3,000:

In-Network

Physicians Charges*	
Original Bill	$3,000
Repriced Bill	$2,800
Calendar Year Deductible	$300
Reimbursement Percentage	80%
Reimbursement by Plan	$2,000
Your Payments:	
Deductible	$300
Co-insurance	$500
Total	$800

*** REMEMBER: If you or your Dependents incur expenses for an out-of-network provider, no benefits are payable.**

BENEFIT PAYMENT EXAMPLE

Sub-Plan B-2

Hospital charges (not exceeding 20 days) of $15,000:

Hospital Charges

	In-Network	Out-of-Network
Original Bill	$15,000	$15,000
Repriced Bill	$12,000	N/A
Fund Allowable	$12,000	$12,000
Calendar Year Deductible	$300	$300
Reimbursement	80%	50%
Total Plan Payment	$9,360	$5,850
Your Payments:		
Excess of Allowable	N/A	$3,000
Deductible	$300	$300
Co-insurance	$2,340	$5,850
Total	$3,375	$9,150

Physicians' charges of $3,000:

Physicians Charges

	In-Network	Out-of-Network
Original Bill	$3,000	$3,000
Repriced Bill	$2,600	N/A
Fund Allowable	$2,600	$2,600
Calendar Year Deductible	$300	$300
Reimbursement Percentage	80%	50%
Reimbursement by Plan	$1,840	$1,150
Your Payments:		
Excess of Allowable	N/A	$400
Deductible	$300	$300
Co-insurance	$460	$1,150
Total	$760	$1,850

The discounts shown in the above examples are for illustrative purposes only. These amounts may differ from time to time based on the actual surgical procedure and the number of days spent in the Hospital. These examples assume that you have not exceeded your annual Plan maximum benefits.

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.

A list of the Hospitals and Physicians in the PPO Network may be obtained by visiting www.bcbs.com. If you do not have access to the Internet, then you may call Blue Cross Blue Shield at 1 (800) 810-2583 to receive assistance locating a medical provider near you.

ELIGIBILITY RULES

Apprentices and Intermediate Journeymen

Initial Eligibility

If you are classified as an Apprentice, Construction Wireman, Construction Electrician or an Intermediate Journeyman and contributions to the IBEW-NECA Southwestern Health and Benefit Fund are required to be made on your behalf, they will be made at a rate lower than the Fund's published rate of contribution for Journeymen. Your eligibility for Sub-Plan B-1 or B-2 will be determined based on the contribution rate that is made on your behalf during the time you are classified as an Apprentice, Construction Wireman, Construction Electrician or Intermediate Journeyman. The collective bargaining parties in your jurisdiction will determine which of the two Sub-Plan contribution rates you qualify for based on the tenure of Apprentices and the experience of Construction Wireman, Construction Electrician, and Intermediate Journeymen. Apprentices, Construction Wireman, Construction Electrician or Intermediate Journeymen for whom contributions are made at the higher of the two rates (currently $2.50) will be eligible for Sub Plan B-2. Apprentices, Construction Wireman, Construction Electrician and Intermediate Journeymen for whom contributions are made at the lower of the two rates (currently $1.50) will be eligible for Sub-Plan B-1.

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 (i.e., on the 1st day of the 5th month of contributions).

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	280	December
November	180	460	140	280	January
December	185	465	140	280	February
January	180	460	140	280	March
February	185	465	140	280	April
March	185	465	140	280	May

*** Your Reserve Account will be limited to a maximum of 280 hours after the deduction for the current month's coverage (e.g., 420-140 = 280).**

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 (i.e., on the 1st day of the 8th month of contributions).

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	375	265	November (initial)
October	170	435	140	280	December
November	170	450	140	280	January
December	185	465	140	280	February
January	180	460	140	280	March
February	185	465	140	280	April
March	185	465	140	280	May

*** Your Reserve Account will be limited to a maximum of 280 hours after the deduction for the current month's coverage (e.g., 420-140 = 280).**

Maintenance of Eligibility

A Reserve Account (also known as an Hour Bank) will be established and maintained by the Fund for each Apprentice, Construction Wireman, Construction Electrician and Intermediate Journeyman who works for a Contributing Employer that makes contributions to the Sub-Plan 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 who is a party to a collective bargaining agreement requiring contributions to the Sub-Plan, will be credited to this Reserve Account when the Fund receives the required contributions.

If an apprentice, construction wireman, construction electrician, or intermediate journeyman covered under the Sub-Plan becomes disabled then he will be credited with 140 hours for each month he is disabled, up to a maximum of 6 months.

Beginning January 1, 2016, an apprentice, construction wireman, construction electrician or intermediate journeyman will be allowed to accumulate a maximum of 280 hours in his 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 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, construction wireman, construction electrician 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. If the Sub-Plan's contribution rate increases, or if you move between the various Sub-Plans or between the Sub-Plan and the Main Plan, the Trustees reserve the right

to proportionately adjust (which will typically result in a reduction of) the number of hours in your Reserve Account, based on the difference between the old and new contribution rates that now apply to your ongoing Plan or Sub-Plan coverage.

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.

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;

2. Except as otherwise required by applicable law (as described below under "Special Rules for Military Service"), 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 the 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; or

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 due to 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 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 Sub-Plan's self-payment provisions, described below under "COBRA Self-Payment Provisions for Active Employees and their Dependents."

Once your Reserve Account has 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 enter full-time active duty, whether voluntarily or involuntarily, with 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 under a self-payment program (similar to COBRA) for up to a maximum of 24 months as long as you give the Fund advance notice of the leave (with certain exceptions) and your total leave, when added to any prior periods of military leave from the Company, does not exceed five years (with certain exceptions).

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 for a Contributing Employer within the time period required by law for the maintenance of re-employment rights, your eligibility for benefits will, upon return to work for a Contributing Employer, be reinstated.

The Fund's current design thus 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, your coverage will automatically be continued during such Total Disability for up to 6 consecutive months. After that time, you will be allowed to continue your coverage by self-paying the required amount in accordance with the self-pay provisions of this Plan.

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 Leave, Medical Leave, or Both

If you have completed 12 months or 1,250 hours of employment with an employer that employs 50 or more employees, 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 to the Sub-Plan on your behalf. 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 Sub-Plan by making self-payments to the Plan or your employer.

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 (provided you have sufficient hours in your hour bank) without any additional limits or restrictions imposed on account of your leave. This is also true for any of your Dependents who were covered by the Sub-Plan at the time you took your leave.

Any changes in the Sub-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 Rule for Withdrawing Local Unions and NECA Chapters

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

Moreover, if your IBEW Local Union and/or corresponding NECA chapter chooses to leave the Fund, then 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 eligibility rules at any time.

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 earliest of the following dates:

1. On the date your eligibility terminates.

2. On 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:

1. 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 Sub-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 below. They may 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)(1). A qualifying Child also includes grandchildren, brothers, sisters, nieces and nephews, but only if they 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 semester) or are indentured apprentice in an IBEW program; 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 you 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.

Important Note About the Dependent Eligibility Rules

The Trustees reserve the right to change the rules with respect to Dependent Eligibility at any time.

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, you and/or your eligible Dependents may continue coverage by making self-payments directly to the Fund Office. This right to continue your 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"). The following is an explanation of your COBRA rights.

Your Dependent(s) may continue coverage by making self-payments directly to the Fund Office if coverage is lost due to one of the following reasons:

1. You lose coverage as described above;

2. Your death or divorce;

3. Your eligibility for Medicare 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 stated above.

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 due to insufficient hours.

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(s)s are responsible for notifying the Fund Office of those facts within 60 days of the event. If neither you nor your Dependent(s) notify the Fund Office of the events listed above within 60 days of the event, 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 14 days.

You and/or your Dependent/s will have until the later of 60 days from the date of the notice from the Fund Office or 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 payments will be established by the Board of Trustees and is subject to change at their discretion.

If you, your Dependents, or both, choose to continue your coverage, the Fund will provide you the same medical benefits it provides to Active Employees. In addition, you will have 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 31 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 other coverage terminates.

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 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 shall 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 continuation coverage, you and/or your eligible Dependents become covered under any other group health care plan, or become eligible for Medicare.

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

5. If the loss of coverage is due to your active duty service, 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 Item 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. 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 Item 4 or the 24-month period described in Item 5 above.

7. In the event of your death or divorce, your eligibility for Medicare while continuing coverage in accordance with these provisions, or a Dependent child's ceasing to meet the

definition of Dependent, 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 begins to run from your Medicare eligibility date. If you become eligible for Medicare more than 18 months prior to your loss of coverage, your spouse and eligible Dependents' COBRA rights are limited to 18 months from your loss of coverage.

8. In the event 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.

Payment of Self-Payment Premium for Employee and Dependents.

Your initial self-payment must be paid no later than the 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 1st day of the month for which coverage is intended. Self-payments received at the Fund Office later than 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 COBRA self-payment 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-Payment Eligibility Affected by Multiple Events.

Up to an additional 12 or 18 months 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 or 24 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. Second qualifying events include the death of a covered Employee, divorce or separation from the covered Employee, the covered Employee's enrollment 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.

Notwithstanding anything to the contrary, no person may enjoy any one continuous self-pay coverage extension under the Plan beyond 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.

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.

COBRA Alternatives

Please note that you may have other options available to you when you lose coverage under the Plan. 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.

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

LIFE INSURANCE BENEFITS

In the event of your death while you are insured, the amount indicated in the Schedule of Benefits will be paid to your named Beneficiary, provided that no exclusions apply.

Beneficiary. You may name, by written request, any individual (as a natural person taking in their own right and not in a fiduciary capacity) one you wish as your Beneficiary and you may change your designation at any time. Benefits will be paid in equal shares to your Beneficiaries unless you state otherwise in your Beneficiary designation. The share of a Beneficiary who does not live to receive payment will pass equally to those who survive unless you state otherwise in your Beneficiary designation.

If you do not designate a Beneficiary or if no Beneficiary lives to receive payment, then the benefits will be paid to the person or persons who appear first in the list below and who live to receive payment:

1. Your spouse;
2. Your children;
3. Your parents;
4. Your siblings;
5. Your estate.

COMPREHENSIVE MAJOR 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 "**Area**" means a county or a greater area that is necessary to obtain a representative cross section of the usual charges made.

3. The term "**Complications of Pregnancy**" means:

a. conditions resulting in Hospital confinement (when the pregnancy is not terminated) for one or more diagnoses which are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

b. non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation during which a viable birth is not probable.

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

5. 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 in-patient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control; or

(ii) specialized in-patient 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. the term **"**Hospital" excludes a nursing home or institution that:

(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.

6. The term "**Intensive/Cardiac/Neonatal/Critical 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.

7. The term "**Medically Necessary**" means services, procedures and/or supplies which, as determined in the sole discretion 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.

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

   a. legally licensed Doctor of Medicine ("M.D."), Doctor of Osteopathy ("D.O."), Dentist, Podiatrist, or Ophthalmologist acting within the scope of his practice; or

   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 be qualified as a "Physician" by the Board or its designee.

   The term "Physician" excludes (i) a resident physician; (ii) an intern; or (iii) a person in training.

9. "**Reasonable and Customary**" 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 other 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, 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.

What the Plan Pays For

This Preferred Provider Organization ("PPO") Plan is designed to help you and your Dependent/s with Reasonable and Customary medical services, procedures and/or supplies for an Illness or an Injury that is not work related. A PPO is a network of Hospitals, Physicians, labs and pharmacies. Other than when received from or through a PPO provider, there are no benefits for Eligible Individuals covered under Sub-Plan B-1.

When an Eligible Individual covered under Sub-Plan B-2 uses a provider that is a part of the network, the Plan pays a higher level of benefits than you would receive 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. As a result, not only do Eligible Individuals covered under Sub-Plan B-2 receive a higher benefit percentage, but the covered charges themselves should be reduced.

It is the responsibility of all Sub-Plan B-1 and Sub-Plan B-2 Eligible Individuals to make sure that a provider or facility is currently in the PPO network.

Remember: When an Eligible Individual covered under Sub-Plan B-1 obtains services and/or supplies from a Non-PPO provider, no benefits are payable.

The Calendar Year Deductible

The $300 Calendar Year Deductible shown in the Schedules of Benefits is the dollar amount of out-of-pocket Reasonable and Customary health care expenses that must be incurred by each Eligible Individual before any healthcare (including Comprehensive Major Medical, Mental Health / Substance Abuse and Vision) Benefits are payable. The Calendar Year Deductible maximum is $600 per family.

Annual Maximums

ANNUAL MAXIMUM LIMITS ON HOSPITAL DAYS AND ADMISSIONS

Sub-Plan B-1

Coverage under Sub-Plan B-1 is limited to the **lesser of** (i) 10 days in the hospital (in-patient **OR** out-patient) or (ii) one surgery **OR** admission per calendar year.

Thus, for example, if you are in the hospital for 15 days due to a surgery, the Plan would only cover the first 10 days. The Plan would thus not cover the full in-patient stay for that surgery. Likewise, if you are in the hospital for non-surgical reasons for 10 days (such as for a mental health or substance abuse admission), and then later in the year are admitted for a surgery, the

Plan would not cover the surgery. Similarly, if you were admitted for a surgery and stayed 5 days in the hospital, the Plan would **not cover** any additional hospital admittance later in the year, since you already had your one surgery.

Sub-Plan B-2

Coverage under Sub-Plan B-2 is limited to the **lesser of** (i) 20 days in the hospital (in-patient **OR** out-patient) or (ii) two surgeries **OR** admissions per calendar year.

Thus, for example, if you have two surgeries covering 15 days, and then later are admitted for a third time for a non-surgical procedure (such as a mental health or substance abuse admission), the Plan would not cover any additional days (even though you hadn't used up your 20 days), as you already had your 2 surgeries or admissions, and the annual Plan maximum is the **lesser** of the two limits.

Exception for Hospital Admissions for Childbirth

Notwithstanding the above limits, the Plan will always cover in-patient admissions for Member's and Spouses for childbirth, for up to 48 hours for a natural childbirth and 96 hours for a C-Section, to the extent required by federal law.

No Out-of-Pocket Maximums

There are no out-of-pocket maximums under the Sub-Plans. Thus, the most the Sub-Plans will ever pay is 80% of the cost (assuming a PPO Provider is used). The Sub-Plans never pay at 100%.

Co-Insurance

As explained above, the Trustees have contracted with a PPO to offer you discounted Hospital and Physician rates. After the Calendar Year Deductible, the Fund pays 80% of the PPO Covered Expenses. For those individuals who are covered under Sub-Plan B-2, the Fund also pays 50% of the Reasonable and Customary Non-PPO Covered Expenses (there is no coverage of Non-PPO charges under Sub-Plan B-1).

All other eligible charges after the Calendar Year Deductible has been satisfied will be reimbursed at the co-insurance levels shown in the Schedules of Benefits.

All non-emergency Hospital admissions **must** be pre-certified. Emergency admissions **must** be certified within 48 hours of the completion of the emergency services, if further hospitalization is required. Failure to pre-certify a non-emergency Hospital admission or failure to certify an emergency Hospital admission within 48 hours after 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). Non-emergency pre-certification and post-emergency certification services are performed by Blue Cross Blue Shield. You, a family member or your Physician must contact Blue Cross Blue Shield at 1 (800) 433-3232 to obtain certification.

REMEMBER: Except for Emergency Services covered by the No Surprises Act, there are no Non-PPO Hospital benefits available to Employees and Dependents covered under Sub-Plan B-1.

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 under either Sub-Plan B-1 or Sub-Plan B-2, after the Calendar Year Deductible, maternity-related PPO claims will be paid at 80%. There are no Non-PPO benefits under Sub-Plan B-1. Under Sub-Plan B-2, Non-PPO benefits are paid at 50% after the Calendar Year Deductible.

This includes Covered Expenses for the Hospital's routine nursery and the pediatrician's Hospital Covered Expenses. However, no benefits will be payable in connection with 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 or attempted 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 tests confirm the condition of the fetus.

4. A viable birth is not probable.

The separate Calendar Year Deductible 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 Sub-Plan Deductibles.

This Plan complies with the Federal law requirements of the Newborn's and Mother's Health Protection Act of 1996 (NMHPA) by not restricting benefits for any Hospital length of stay in connection with childbirth for an Employee or dependent Spouse mother or the newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section unless agreed to by the patient in consultation with the attending provider, or requiring a health care practitioner to obtain authorization from This Plan for prescribing a length of stay not in excess of those periods.

Except as required by law, no benefits will be payable for the pregnancy, prenatal or postnatal services, maternity care or delivery expenses **of a Dependent child other than as a result of Complications of Pregnancy as that term is defined by the Plan.**

In addition, no benefits are payable for any illness or treatments relating to a surrogate pregnancy.

Physical/Occupational Therapy

Charges attributable to Physical/Occupational Therapy are limited to a maximum of 10 days of treatment per person per calendar year.

There are no benefits payable for massage therapy.

Prescription Drugs

There is no separate Prescription Drug Program, other than a Sav-Rx discount card. Rather, after the Calendar Year Deductible, Prescription Drugs are covered at 90% for generic drugs and 75% for brand name drugs. The Sub-Plans cover only those drugs approved by the Food and Drug Administration ("FDA") and that require a Physician's written prescription (over-the-counter drugs and medicines are not covered).

***However, the Sub-Plans do not cover brand name drugs if you choose a brand name drug for which an alternative, generic equivalent is available.**

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

You must pay for the prescription up front, and then submit the claim to the Fund Office for reimbursement.

Injectables and specialty drugs administered in a doctor's office, outpatient infusion center, or via home health care will be covered under the Fund's medical benefits, i.e., at an 80% copayment rate for in-network providers, and for Sub-Plan B-2 only, 50% for a Non-PPO Provider.

Prescription Drug Exclusions and Limitations

1. Medications not covered hereunder include smoking cessation products; appetite suppressants; infertility drugs; durable or disposable medical supplies; immunizations; legend vitamins; medications for cosmetic purposes; medications for impotency; prescription drugs that are applicable to the opposite sex; medications 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. Expenses incurred at 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. Prescriptions for more than a 90-day supply.

Skilled Nursing Care Facility Provision

A "**Skilled Nursing Care Facility**" is a facility that is primarily engaged in providing skilled nursing care and other therapeutic services. The facility must be licensed by the state in which it is located and be an eligible provider of Medicare and Medicaid nursing care services.

Benefits will be paid to you for the first 120 days of confinement provided:

1. A Physician prescribes a written treatment plan and supervises the care and treatment;

2. A facility maintains the treatment plan in addition to medical records on each patient;

3. You were confined for at least three days in the Hospital prior to confinement in the Skilled Nursing Care Facility;

4. Services at the facility commenced within three days after release from the Hospital;

5. The services rendered in the facility are for the same Illness or Injury that caused the Hospital confinement; and

6. In the absence of skilled nursing care, you would be required to be an in-patient at a Hospital.

No more than 120 days will be payable in a 12-month period.

Room and board charges by a Skilled Nursing Care Facility may not exceed 50% of the daily charge for a semi-private room in the Hospital where the patient was confined.

In no event, however, will charges in connection with the care or services for drug addiction, chronic brain syndrome, mental retardation, senile deterioration or mental disorders be considered payable under this provision.

Durable Medical Equipment Benefits

Durable Medical Equipment, including rental of a wheelchair, hospital-type bed or other durable equipment used exclusively for treatment of injury or sickness. Certification is not an automatic approval.

Provided the Durable Medical Equipment is purchased or rented from a PPO network provider, after the Calendar Year Deductible, the Plan will pay 80% of the approved cost.

For those individuals who are covered under Sub-Plan B-2, the Fund also pays 50% of the Reasonable and Customary Non-PPO Covered Expenses (there is no coverage of Non-PPO charges under Sub-Plan B-1).

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, sleep apnea monitors, blood sugar monitors, bedside commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Durable Medical Equipment, such as that listed above, must be the least expensive form of treatment or equipment that is considered to be the most appropriate for the condition. 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 and the anticipated rental cost.

Comprehensive Major Medical Charges

Covered Comprehensive Major Medical Charges are the actual, Reasonable and Customary charges incurred by you or your Dependent for medical care, treatment, services, procedures and/or supplies listed below (up to the limits specified in the Schedule of Benefits) which are required in connection with you or your Dependent's care and/or treatment. The medical care, treatment, services, procedures and/or supplies must be furnished upon the recommendation and approval of the attending Physician, must be considered Medically Necessary to treat or diagnose an Illness or Injury, and must not be on the list of exclusions detailed below. The covered care, treatment, services, procedures and/or supplies include only the following:

1. Charges by a Hospital for room and board (including Hospital admission kits) for the average semi-private room rate of the confining Hospital or 90% of the lowest private room rate in the absence of semi-private facilities in the confining Hospital;

2. Charges for Hospital services, procedures and/or supplies other than room and board;

3. Charges by a Physician for medical care;

4. Charges by a surgeon for surgical procedures;

5. Charges for nursing care by a Registered Nurse (R.N.) other than a nurse who ordinarily resides in your home or who is related to you;

6. Charges by a radiologist or by a physiotherapist;

7. Charges for laboratory procedures for diagnosis or treatment;

8. Charges by a Physician, Certified Registered Nurse Anesthetist or professional anesthetist for anesthesia and its administration;

9. Charges for 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.

10. Charges by any person or institution for supplying blood or blood plasma, artificial limbs or eyes, casts, splints, trusses, braces, or crutches, oxygen or the rental of equipment for its administration, registered drugs or medicines, or for the rental of a wheelchair and hospital-type bed; letter of medical necessity is not required for apnea monitors, blood sugar monitors, nebulizers, oximeters, oxygen and supplies, and ventilators.

11. Charges incurred in connection with home photo-therapy for newborns with jaundice;

12. Assuming the newborn is otherwise a Covered Dependent, charges for routine care incurred on behalf of a newborn during the mother's confinement are not covered. Charges will be covered for care and/or services prior to the baby's discharge from the Hospital for an Illness contracted after birth, for an abnormal congenital condition in the newborn child or for a premature birth;

13. Charges for services provided by a Physician's Assistant who is under the supervision of a Physician and is operating within the scope of a license issued by the proper authority provided no Physician charges are submitted to the Plan for the same date of service;

14. Charges are payable at 50% of the allowable Reasonable and Customary Surgeon's charge for procedures performed by an Assistant Surgeon provided the Surgeon needs assistance with a covered surgical or obstetrical procedure and the Assistant Surgeon's duties are not routinely available from a Hospital intern, resident, Physician's Assistant or full-time salaried Physician; or

15. Provided there are no Physician charges for the same service, the Plan will pay the covered expenses resulting from services provided by a Nurse Practitioner.

Charges Not Covered

Benefits for which the Plan will make no payment include but are not limited to the following charges for medical care, treatment, procedures, services and/or supplies and do not count toward satisfaction of the Calendar Year Deductible:

1. Charges not listed as covered by this Plan;

2. Charges for routine wellness medical examination or laboratory tests for check-up purposes not necessary for treatment under the Comprehensive Major Medical Charges;

3. Charges for cosmetic surgery, except for treatment by a Physician for an accidental Injury, where such treatment is begun within six months after the accident, and except for treatment of a congenital anomaly in a child, unless coverage is otherwise required by Federal law as a result of the Women's Health and Cancer Rights Act of 1998 ("WHCRA");

   As provided under the WHCRA, this Plan includes coverage for breast reconstruction surgery as part of a mastectomy procedure. Breast reconstruction surgery in connection with a mastectomy will, at a minimum, provide for:

a. reconstruction of the breast on which the mastectomy has been performed;

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

c. prostheses and physical complications for all stages of mastectomy, including lymphedemas, all in a manner determined in consultation with the consulting Physician and the patient.

As part of this Plan's Schedules of Benefits, this benefit is subject to this Plan's appropriate cost control provisions such as the Calendar Year Deductible, co-insurance provisions and PPO-only coverage under Sub-Plan B-1.

4. Charges for care, treatment and/or services resulting from an Injury arising out of or in the course of your employment or from an Illness entitling you to benefits under any type of Workers' Compensation Law;

5. Charges for care, treatment and/or services resulting from war or act of war, declared or undeclared unless otherwise required by federal law;

6. Charges for dental procedures of any kind, except dental treatment rendered by a licensed dentist or oral surgeon as a result of an accidental Injury, where such treatment is begun within six (6) months after the accident. Covered charges include dental treatment of Injuries to sound natural teeth, including replacement of such teeth, and for setting a jaw fractured or dislocated in the accident provided the dental treatment is begun within 90 days of the Injury and completed within one year following the accident. Services of an oral surgeon for removal of impacted wisdom teeth in a Hospital or Oral Surgeon's office are also covered;

7. 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.

8. Charges for care, treatment and/or services resulting from the commission of or attempt to commit an assault, battery, felony or act of aggression, insurrection, rebellion or riot, but in no event, will this exclusion be interpreted to include charges resulting from acts of domestic violence that may be covered as required by HIPAA;

9. Charges for care, treatment and/or services for temporo-mandibular joint dysfunction (or TMJ) pain syndrome, orofacial, myofascial syndrome whether medical or dental in scope;

10. 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. Services such as sperm processing, pelvic X-rays, insemination and X-rays will serve as an indication that artificial insemination is being performed;

11. 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.

12. Charges for any surgical procedure for the correction of visual refractive problems, including radial keratotomy, PRK, LASIK and similar procedures;

13. Hospital charges incurred on Friday, Saturday or Sunday for a non-emergency confinement that begins on those days or for any days prior to the day before the date of surgery.

14. Charges in connection with treatment of overweight or obesity including diets, prescriptions and treatment by a Physician;

15. 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;

16. Except as shown in the "Vision Benefits Offered Through VSP Vision Care" schedule of benefits, charges for vision care, treatment and/or therapy except following an accidental Injury and/or Illness rehabilitation;

17. Charges resulting from treatment for learning disabilities;

18. Expenses incurred by a participant enrolled in a Medicare-risk contract HMO that are considered ineligible by the HMO because the participant received medical services from a non-network provider;

19. Charges for behavioral modification, marriage, job, education, religious or sex counseling or group therapy;

20. Charges attributable to nursing, speech therapy, or physiotherapy rendered by you, your spouse, or your child, brother, sister or parent of the Active Employee (or former Active Employee) or his spouse;

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

22. 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);

23. 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;

24. Charges for pregnancy, childbirth, or related medical conditions for any Dependent other than the employee's spouse;

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

26. 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;

27. Except to the extent covered under the prescription benefits, if at all, charges for vitamins and nutritional supplements;

28. Charges for medications that can be purchased without a prescription, other than insulin, or for drugs prescribed for purposes not consistent with generally accepted medical practices;

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

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

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

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

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

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

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

36. Expenses for services, supplies or treatment unless prescribed as necessary by a Physician;

37. 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;

38. 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;

39. Charges for genetic testing (unless medically necessary);

40. Transplant benefits;

41. Hospice Care;

42. Wellness or Preventive benefits;

43. Sleep Studies;

44. Chiropractic and/or acupuncture care;

45. Charges for treatment of impotency;

46. Charges for non-emergency care provided outside the United States or Canada; and

47. Treatment that is not expected to materially improve the patient's condition or symptoms.

GENERAL EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations

The Plan will not provide comprehensive medical benefits, prescription drug benefits, mental health and substance abuse benefits, vision benefits or any other 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 comprehensive medical benefits, prescription drug benefits, mental health and substance abuse 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:

1. Not prescribed by a Physician, or

2. 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 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 organization plans, employer-sponsored 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 a parent.

"**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:

1. Motor vehicle insurance is always primary to this Plan. Likewise, government plans are always primary to the Plan, except where otherwise required by law.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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 (4) 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.

7. When rules (1) through (6) 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.

8. 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.

9. 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.

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) 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. 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, 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, 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 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, 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.

Thus, a request to have a Hospital admission pre-certified 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.

If you seek emergency services, and you require further hospitalization after the emergency services are completed, you must certify all further hospitalization within 48 hours after the emergency services are completed.

The Plan also requires precertification of non-emergency in-patient hospitalization (including acute, rehab, and residential treatment centers) and intensive out-patient care and treatment (including partial hospitalization) 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.

If you seek emergency mental health or substance abuse benefit services, and you require further hospitalization after the emergency services are completed, you must certify all further hospitalization within 48 hours after the emergency services are completed.

The Plan also requires precertification of a wide range of outpatient Medical Benefits, including home health care, intensive outpatient procedures, neurological procedures, ear, nose & throat services, and many more 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) 223-4239.

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 be 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 by telephone as soon as

possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim. The determination 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 be decided based on the information available and may be denied. Notice of the decision will be provided 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 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.

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 care, mental health, substance abuse, vision and prescription drug claims must be submitted to the Fund Office. Claim forms may be obtained by contacting the Fund Office or any of the above-named companies, respectively.

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

8. Patient's name;

9. Date of service;

10. 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);

11. Diagnosis or ICD-10 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);

12. Billed charge;

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

14. 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, 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.

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 the claimant responds to the request or the deadline for doing so, whichever is earlier.

Life Insurance Benefit Claims

Claims for life insurance benefits must be submitted in writing to the Fund Office as soon as possible after the individual's death. 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.

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 Benefit Claims must be submitted in writing to the Fund Office within 180 days after you receive notice of the Adverse Benefit Determination. Your appeal must include:

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

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 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, and Urgent 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 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 compensation, 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 documents relevant 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, and Urgent 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, 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 TX, Dallas Division.

External Review Program

Effective as of September 1, 2022, if your Adverse Benefits Determination relates to surprise medical billing, you may have a right to an external review, to the extent required under the federal No Surprises Act. If this situation applies to you, contact the Fund Office for more information.

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.

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 have the right to recover those 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 an Eligible Individual covered by the Fund. The Fund and this SPD are governed by the Fund's Amended and Restated Rules and Regulations. For a complete description of your rights, please see the Amended and Restated Rules and Regulations. In the event of a conflict between the SPD and the Amended and Restated Rules and Regulations, the Amended and Restated Rules and Regulations controls.

QUALIFIED CHILD MEDICAL SUPPORT ORDER (QCMSO)

Benefits will be paid in accordance with a Qualified Child Medical Support Order (QCMSO) as defined in Section 609 of ERISA, and with written procedures adopted by the Trustees in connection with such Orders, which will be binding on all participants, Beneficiaries and other parties. In no event will the existence or enforcement of a Qualified Child Medical Support Order cause the Fund to pay benefits with respect to a participant which requires the Fund to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to the medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).

EFFECT OF MEDICAID COVERAGE ON THIS PLAN

Payment for benefits with respect to an Eligible Individual under This Plan will be made in accordance with any assignment of rights made by or on behalf of the Eligible Individual as required by a State Plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act, as in effect on August 10, 1993 and as may be, from time to time, amended.

In enrolling an Eligible Individual as a person entitled to Medicaid or in determining or making any payments for benefits of a person who is also an Eligible Individual, the fact that the Eligible Individual is eligible for or is provided medical assistance under a State Plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

To the extent payment has been made under a State Plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for procedures, items and/or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to that person to such payment for such items, procedures and/or services.

MEDICAL EXAMINATION

No medical examination will be required of you or your eligible Dependents to secure this coverage initially. However, the Trustees will have the right, through their medical examiner, to examine you or your eligible Dependents as often as they may reasonably require during the pendency of a claim as well as the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

AMENDMENT AND TERMINATION OF THE PLAN

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a Plan dedicated to providing the maximum benefits for you and your Dependents, the Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time but upon a nondiscriminatory basis:

1. To terminate or amend the Plan at any time, including without limitation, amend or terminate the amount or condition with respect to any benefits even though such termination or amendment affects claims which have already accrued;

2. To alter or postpone the method of payment of any benefits; or

3. To amend or rescind any other provisions of the Plan's Amended and Restated Rules and Regulations.

It is important that you understand that the granting of medical coverage is neither a vested nor a contractual right.

SUBROGATION AGREEMENT AND AUTHORIZATION FOR REIMBURSEMENT

In the event of any payment under this Fund, you automatically agree to assign your rights of recover to 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 or 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 it 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 its 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 contract or suffer an Illness or an Injury that is caused by another person or where another party may have a legal obligation to pay for the same (including, without limitation, your own insurance), 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 if you or they receive a 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 is a "**First Dollar**" priority right and lien and comes before all other payments, including payments to your attorney. The Fund's rights apply with respect to all "injured persons," which means an eligible Employee, eligible Spouse, eligible dependent child or the heir, guardians, personal representatives, trustee, estate, or other representative of such Employee, Spouse or dependent 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 also has 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 Subrogation and Reimbursement 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 and 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 on behalf of Mr. Jones or 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 request repayment of the $1,000. 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 and 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 on behalf of in Mr. Jones for the amount of the benefits paid by the Fund. 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 it paid for Mr. Jones' medical and Hospital expenses. 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 Subrogation and 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. The injured person or legal guardian will be required to sign a Subrogation and 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 information. You will be kept 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 and 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 Fund to join the Subrogation and Reimbursement process or to intervene 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, your Dependents and your agents shall 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 Plan to the Fund. 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 and/or your Dependents' future claims. After you and/or your Dependents have received a recovery from the responsible person, corporation, insurance carrier or governmental agency, no further benefits for treatment or services related to that Illness or Injury will be paid by the Fund.

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. The name and type of administration of the Plan; Plan Sponsor:

   The IBEW-NECA Southwestern Health and Benefit Plan and Sub-Plans are administered by a Joint Board of Trustees consisting of Union representatives and Employer representatives. The Board of Trustees is also the Plan Sponsor.

2. The name and address of the Plan Administrator is:

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

3. The names and business addresses of the Trustees as of September 1, 2023 are:

Union Trustees	Employer Trustees
Michael Henderson IBEW Local 301 P.O. Box 490 Nash, TX 75059	David Sanchez Sanbros Corp 6020 Academy Rd., NE #205 Albuquerque, NM 87109
Price Warwick IBEW Local 20 684 W. Tarrant Rd. Grand Prairie, TX 75050	Mark Huston Lone Star Electric 2320 Cullen St. Fort Worth, TX 76107
Alfonso Martinez IBEW Local 611 4921 Alexander Blvd. NE Albuquerque, NM 87107	Cindy Flowers Southern Arizona NECA, Inc. 2500 N. Tucson Blvd., Suite 132 Tucson, AZ 85716
Robert Bausch IBEW Local 226 1620 N.W. Gage Blvd, Suite A Topeka, KS 66614	Duwayne Herrmann Jr. D&H Electrical Services, Inc. 635 Langham Road Beaumont, TX 77707
Josh DeSpain IBEW Local 570 750 S. Tucson Blvd.	Brian McFarland Shawver & Sons, Inc. 144 NE 44th Street

Tucson, AZ 85716

Michael Leonard
IBEW Local 444
615 West Grand
Ponca City, OK 74601

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 Ave., 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 under the provisions of Collective Bargaining Agreements and the Trust Agreement and held in a trust fund for the purpose of providing welfare benefits to covered Participants and defraying reasonable administrative 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 the section entitled "Plan Documents and Reports" if you wish to obtain additional information concerning the Plan's investment of assets and checking accounts.

10. **Insurance Company:** None of the Plan's benefits are currently insured.

11. **Plan Regulations:** All of the types of welfare benefits provided by the Plan are set forth in the Schedules of Benefits set forth in this booklet. Complete terms and provisions of the welfare benefits are set forth in the Plan's Rules and Regulations.

12. **Statement of ERISA Rights:**

As a Participant in the IBEW-NECA Southwestern Health and Benefit Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan including insurance contracts, Collective Bargaining and Participation Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining and Participation Agreements, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

4. Continue health care coverage for yourself, your Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

   In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employees' Welfare

Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare benefit or exercising your rights under ERISA.

If your claim or application for a Welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file a suit in 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 Welfare 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 Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or 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 the court costs and legal fees. If you are successful, the court may order the person you 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, EBSA, 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 hotline of the EBSA. You may contact the nearest area office of EBSA in Dallas, Texas at (214) 767-6831.

13. **Plan Documents and Reports:** You may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

- Trust Agreement;
- Collective Bargaining Agreement/s;

- Plan Documents and all Amendments;

- Form 5500 or full Annual Report filed with the Internal Revenue Service and the Department of Labor; and

- List of Contributing Employers.

You may also obtain copies of these documents by writing for them and paying the reasonable cost of duplication. You should find out what the charge will be before requesting copies. If you prefer, you can arrange to examine these reports, during normal business hours, at your Local Union Office. To make such arrangements, call or write the Fund Office. A summary of the Annual Report which gives details of the financial information about the Plan's operation is furnished free of charge to all Participants.

14. **Type of Plan**. This Fund is maintained for the purposes of providing life insurance, major medical, vision, mental health, substance abuse and prescription drug benefits.

15. **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 IBEW-NECA SOUTHWESTERN 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.

THE TRUSTEES HAVE FULL AND EXCLUSIVE AUTHORITY TO DETERMINE, IN THEIR SOLE DISCRETION, ALL QUESTIONS OF COVERAGE AND ELIGIBILITY, THE LEVEL AND TYPE OF BENEFITS PROVIDED AND THE METHOD/S OF PROVIDING OR ARRANGING FOR BENEFITS. THE TRUSTEES ALSO HAVE FULL AND EXCLUSIVE AUTHORITY TO CONSTRUE AND INTERPRET IN THEIR SOLE DISCRETION THE PROVISIONS OF THE AGREEMENT AND DECLARATION OF TRUST ESTABLISHING THE FUND AND THE RULES AND REGULATIONS ESTABLISHING AND SETTING FORTH THE PLAN. ALL SUCH FOREGOING DETERMINATIONS, CONSTRUCTIONS OR INTERPRETATIONS WILL BE BINDING ON ALL ENTITIES INCLUDING, BUT NOT LIMITED TO, ALL ELIGIBLE INDIVIDUALS.

IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND
OUT-OF-WORK-LIST CERTIFICATION

To whom it may concern:

On this _____ day of _____, 20___, in compliance with the IBEW-NECA Southwestern Health and Benefit Fund's return to work provisions as governed by USERRA, _____ appeared at the Union Hall _____ days after being honorably discharged from active duty service in the _____.

Branch of Service

He presented a copy of his honorable discharge papers showing the date of his discharge. He has indicated that he wishes to be placed on the IBEW-NECA Out-of-Work-List.

_____, was placed on the out-of-work list on the _____ day of _____, 20___. He is available to return to work for a Contributing Employer on _____.

Attested to by:

_____ _____

Union Representative Date

HIPAA PRIVACY NOTICE

IBEW-NECA Southwestern
Health and Benefit Fund
4101 McEwen, Suite 600
Dallas, Texas 75244

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.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA'') and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "Privacy Rules"), the IBEW-NECA Southwestern Health and Benefit Fund (the "Fund") is required to take reasonable steps to ensure the privacy of your "Protected Health Information" or "PHI" (defined below) and to inform you about:

1. The Fund's uses and disclosures of Protected Health Information,

2. Your rights to privacy with respect to your Protected Health Information,

3. The Fund's duties with respect to your Protected Health Information,

4. Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services ("HHS"), and

5. The person you should contact for further information about the Fund's privacy practices.

The Fund is required to maintain the privacy of your PHI, provide you with this HIPAA Privacy Notice ("Notice") of its legal duties and privacy practices, and to follow the terms of this Notice. The Fund, however, reserves the right to change its privacy practices and/or the terms of this Notice at any time and to make new provisions effective for all Protected Health Information that it maintains. You will receive written notice of any changes that are made to the Fund's privacy practices and/or the terms of this Notice. You will also receive a revised Notice within 60 days after any material changes are made.

Please note that the Fund prepared this Notice so any references to "we," "our," or "us" means the Fund.

SECTION 1: YOUR PROTECTED HEALTH INFORMATION

Important Definitions

Protected Health Information. The term "Protected Health Information" or "PHI" includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

Business Associates. Business Associates are individuals and companies who need access to your PHI in order to act on our behalf or to provide us with services. Examples of business associates include third party administrators, managed care networks, preferred provider organizations ("PPOs"), health maintenance organizations ("HMOs"), dental networks, mental health insurers, pharmacy benefits managers, attorneys, consultants and auditors. We may disclose your health information to our business associates, and we may authorize them to use or disclose your health information for any or all of the same purposes for which we are permitted to use or disclose it ourselves, as well as for their own administrative purposes. Our business associates are contractually required not to use or disclose your health information for any other purposes.

When the Fund May Disclose Your PHI

The Privacy Rules provide that the Fund may not use or disclose your PHI without your consent, unless expressly permitted by the Privacy Rules and/or HIPAA. The following is a brief description of some of the situations where the Fund may use or disclose your PHI without your consent. Please note that when using or disclosing your PHI or when requesting your PHI from another entity covered by the Privacy Rules, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

A. ***As required by law.*** The Fund may use or disclose your PHI as expressly permitted or required by HIPAA, the Privacy Rules, a valid court order, or other statutory or governmental rule or regulation.

B. ***As required by HHS.*** The HHS Secretary may require the disclosure of your PHI to investigate or determine the Fund's compliance with the Privacy Rules.

C. ***For treatment, payment or health care operations.*** The Fund may use or disclose your PHI in order to carry out "Treatment," "Payment," or "Health Care Operations." For each of these purposes we list below examples of these kinds of uses and disclosures. These are only examples and are not intended to be a complete list of all the ways we may use or disclose your health information within each of these three categories.

"Treatment" means the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Fund may disclose the name of your treating dentist to your orthodontist so that the orthodontist may ask for your dental x rays from your dentist.

"Payment" includes, but is not limited to, the following examples:

- **Determining your eligibility for benefits.** We may use information obtained from your employer to determine whether you have satisfied the Fund's requirements for active eligibility.

- **Obtaining contributions from you or your employer.** We may send your employer a request for payment of contributions on your behalf, and we may send you information about premiums for COBRA continuation coverage.

- **Pre-certifying or pre-authorizing health care services.** We may consider a request from you or your physician to verify coverage for a specific hospital admission or surgical procedure.

- **Determining and fulfilling the Fund's responsibility for benefits.** We may review health care claims to determine if specific services that were provided by your physician are covered by the Fund.

- **Providing reimbursement for the treatment and services you received from health care providers.** We may send your physician a payment with an explanation of how the amount for the payment was determined. Similarly, a detailed bill or an "Explanation of Benefits" ("EOB") may also be sent to you or to the primary insured that will typically include information that identifies you, your diagnosis, and the procedures you received.

- **Subrogation health claim benefits for which a third party is liable.** We may exchange information about an accidental injury with your attorney who is pursuing reimbursement from another party.

- **Coordinating benefits with other plans under which you have health coverage.** We may disclose information about your benefits to another group health plan in which you participate.

"Health Care Operations" includes, but are not limited to, the following:

- **Business management and administration.** This includes business planning and development, cost management, and customer service.

- **Conducting quality assessment and improvement activities.** For example, a supervisor or quality specialist may review health care claims to determine the accuracy of a processor's work.

- **Case management and care coordination.** For example, a case manager may contact home health agencies to determine their ability to provide the specific services you need.

- **Contacting you regarding treatment alternative or other benefits and services that may be of interest to you.** For example, a case manager may contact you to give you information about alternative treatments which are neither included nor excluded in the Fund's plan of benefits, but which may nevertheless be available in your situation.

- **Contacting health care providers with information about treatment alternatives.** For example, a case manager may contact your physician to discuss moving you from an acute care facility to a more appropriate care setting.

- **Employee training.** For example, training of new claims processors may include processing of claims for health benefits under close supervision.

- **Accreditation, certification, licensing, or credentialing activities.** For example, a company that provides professional services to the Fund may disclose your health information to an auditor that is determining or verifying its compliance with standards for professional accreditation.

- **Securing or placing a contract for reinsurance of risk relating to claims for health care.** For example, except as provided below under "Prohibited Uses and Disclosures" regarding genetic information, your demographic information (such as age and sex) may be disclosed to carriers of stop-loss insurance to obtain premium quotes.

- **Conducting or arranging for legal and auditing services.** For example, your health information may be disclosed to an auditor who is auditing the accuracy of claim adjudications.

- **Formulary development.** For example, benefit utilization information may be used to develop the formulary list of prescription drugs covered by the Fund.

- **Management activities relating to compliance with privacy regulations.** For example, the Privacy Official may use your health information while investigating a complaint regarding a reported or suspected violation of your privacy.

- **Resolution of internal grievances.** For example, your health information may be used in the process of settling a dispute about whether or not a violation of our privacy policies and procedures actually occurred.

- **Sale, transfer, merger, or consolidation.** For example, your health information may be disclosed if the Fund merges with another health plan.

- **De-identification of Health Information.** We may use or disclose your health information for the purpose of creating health information that is no longer identifiable as pertaining to you. Such de-identified health data may then be used for purposes that are not described in this Notice as either permitted or required.

- **Creation of a Limited Data Set.** We may use your health information to create a "limited data set," which excludes most identifiers, but may

include partial addresses (city, state, and zip code), dates of birth and death, and other dates that pertain to your health care treatment. Such a "limited data set" may be disclosed for purposes of research, public health, or health care operations.

D. ***Public health purposes.*** The Fund may disclose your PHI to an authorized public health authority if required by law or for public health and safety purposes. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

E. ***Domestic violence or abuse situations.*** The Fund may disclose your PHI when authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such a case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

F. ***Health oversight activities.*** The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs.

G. ***Legal proceedings.*** The Fund may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a valid court order or a subpoena or discovery request that meets the Privacy Rule's requirements. In certain situations, the Fund may be required to make reasonable efforts to notify you about a request or to obtain a court order protecting your PHI.

H. ***Law enforcement purposes.*** The Fund may disclose your PHI when required for law enforcement purposes. For example, the Fund may disclose PHI about you to law enforcement officials if there is suspicion that your death may have resulted from criminal activity.

I. ***Determining cause of death and funeral purposes.*** The Fund may disclose your PHI when it is required to be given to a coroner or medical examiner to identify a deceased person, determine cause of death or other authorized duties. The Fund may also disclose PHI to funeral directors, consistent with applicable law, as necessary for them to carry out their duties with respect to decedents.

J. ***Organ donation.*** The Fund may disclose your PHI for cadaveric organ, eye or tissue donation purposes.

K. ***Research.*** The Fund may disclose your PHI for certain research, provided that certain restrictions set forth in the Privacy Rules are met.

L. ***Health or safety threats.*** The Fund may disclose your PHI when, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

M. ***Specialized government functions.*** The Fund may disclose your PHI when, consistent with applicable law, the disclosure is required for military purposes, national security, and other specialized governmental functions.

N. ***Workers' compensation programs.*** The Fund may disclose your PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

O. ***Disclosure to the Fund's Board of Trustees.*** The Fund will also disclose your PHI to the Fund's Board of Trustees for purposes related to Treatment, Payment, and Health Care Operations, and has amended the Fund's plan documents to permit this use and disclosure as required by the Privacy Rules. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim. Except as provided below under "Prohibited Uses and Disclosures" regarding genetic information, the Fund may also disclose to the Board of Trustees "summary health information," which includes claims totals without any personal identification, except your zip code, so the Board of Trustees may obtain health insurance premium bids or in connection with their consideration of making amendments to the Fund's plan of benefits.

The Board of Trustees will <u>not</u> disclose your Protected Health Information to your employer for general employment purposes.

P. ***Health-Related services that may be of interest.*** The Fund or its business associates may contact you to provide you information about treatment alternatives or other health related benefits and services that may be of interest to you. For example, you may be contacted by a case management coordinator if you suffer a serious injury or illness.

Q. ***Disclosures to your family and friends.*** The Fund and/or its business associates may, in certain limited situations, disclose your PHI to your family members or friends to the extent that the disclosure is directly relevant to such persons' involvement in your care or payment for your care. Such disclosures will be made only if either of the following conditions is satisfied: (i) if you are present when the disclosure is made and you agree or do not object to the disclosure; or (ii) if you are not present or, as a practicable matter, are unable to consent at the time your PHI is disclosed, such disclosure is in your best interest as determined in the

Fund's or its business associates' professional judgment based on common practice, their experience, and the circumstances surrounding the disclosure.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release and Disclosures that Require Your Written Consent

Opportunity to Agree or Disagree to the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Written Consent

Generally, the Fund must obtain your written authorization before using or disclosing 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 Fund may use and disclose such notes without authorization when the Fund needs to defend itself against litigation filed by you.

We will generally obtain your authorization before the Fund, its business associates (or their agents or subcontractors) use or disclose your Protected Health Information for marketing. Your authorization is not required if the Fund, 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 Fund, 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 your treatment, (d) for the transfer, merger, or consolidation of all or part of the Fund with another Fund, and any due diligence related thereto, (e) for remuneration that is provided by a Fund 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 Fund pursuant to a business associate agreement, (f) to provide you with a copy of your Protected Health Information, as provided below, (g) required by law, or (h) determined by the HHS Secretary in regulations to be necessary and appropriate.

All other uses and disclosures not expressly authorized by HIPAA, the Privacy Rules and/or other applicable law will not be made without your written authorization, which you may revoke at any time as long as you do so in writing. Written notice of your revocation must be sent to the Fund Office at the following address:

IBEW-NECA Southwestern Health and Benefit Fund
4101 McEwen, Suite 600
Dallas, Texas 75244

Prohibited Uses and Disclosures

The Fund, 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 which includes genetic services.
>
> **"Underwriting purposes"** include the determination of enrollment or continued eligibility under the Fund, the determination of benefits payable under the Fund, the calculation of required premiums and premium contributions, and engagement in any other activity related to the creation, renewal, or replacement of your health insurance coverage or benefits.

SECTION 2: YOUR INDIVIDUAL PRIVACY RIGHTS

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out Treatment, Payment or Health Care Operations, or

2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund is not required to agree to your requested restriction. If the Fund agrees to your request, except in certain situations such as an emergency, the Fund may not use or disclose your PHI in violation of the restriction.

To make such a request, you must do so in writing and send it to the Fund Office at the address noted above.

Notwithstanding the above, you may request the Fund 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 Fund must comply with these requests.

You May Request Confidential Communications

The Fund will accommodate your reasonable requests to receive communications of PHI **by alternative means or at alternative locations**. For certain requests, the Fund may require your request to include a statement that absent such change in delivery method or location, such disclosure could endanger you.

All requests must be submitted in writing to the Fund Office at the address noted above.

You May Inspect and Copy PHI

You have the right to inspect and obtain copies of your PHI contained in a "designated record set" for as long as such information is maintained in a designated record set. In certain situations, however, the Fund may deny you access to your PHI. In such a case, the Fund will provide you a written notice of the denial that includes the reason(s) for the denial, whether or not the decision is reviewable, a description of the review procedures if the decision is reviewable, and a description of how you may complain to the Fund or the HHS Secretary about the denial.

In most situations, the Fund must provide the PHI you request in both the form and the format you request. In certain situations, with your approval, the Fund may provide you with an explanation or summary of your PHI; provided that you agree in advance to the fee that may be imposed by the Fund for such summary. If you request copies of your PHI, the Fund may impose reasonable fees covering the cost of the copies, labor, and postage.

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 the Fund denies your request, you will be notified, in writing, why the request was denied, how you can appeal the decision. You will also be provided with a copy of the Fund's procedures on how to do this.

The Fund must provide the requested access or its notice of denial within 30 days. A single 30-day extension is allowed if the Fund is unable to comply with the deadline; provided that the Fund notifies you in writing of the reason for the extension and the date on which the Fund will complete its action within the 30 day period.

To request access to your PHI that is maintained in a designated record set, you must do so in writing and submit it to the Fund Office at the address noted above.

A Designated Record Set includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Fund or other information used in whole or in part by or for the Fund to make decisions about you.

If the Fund 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 Fund 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 Fund may impose a fee to cover the costs of responding to such a request, but the fee will not be greater than the Fund's labor costs in responding to your request.

You Have the Right to Request Amendment of Your PHI

You have the right to request that the Fund amend your PHI or a record about you that is maintained in a designated record set for as long as the PHI is maintained in a designated record set. The Fund may deny your request to amend your PHI if you do not state why you want the information amended or if you refuse to supply the Fund with information it needs to determine if the amendment should be made. In addition, the Fund may refuse to amend the information if:

- the information is not part of the Fund's medical information;
- the information was not created by the Fund, 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 Fund determines that the information is complete and accurate.

The Fund has 60 days after receiving your request to act on it by either making the amendment or denying your request. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60- day deadline. If the Fund denies your request to amend your PHI in whole or in part, the Fund will provide you with a written notice that provides (i) an explanation of the basis for the decision, (ii) a statement of your right to submit a written statement disagreeing with the denial and how you may file this statement, (iii) a statement that if you do not submit a disagreement, you may request your initial amendment request plus the denial to be included with any future disclosures of the PHI subject to the request, and (iv) a description of how you may complain about the denial to the Fund or the HHS Secretary. If you file a written statement of disagreement (or request that your initial amendment request serve as such), the Fund has the right to issue and file a written rebuttal to your statement, in which case, a copy will be provided to you.

All requests to amend your PHI must be submitted in writing to the Fund Office at the address noted above.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will provide you with an accounting of certain disclosures by the Fund of your PHI made up to 6 years prior to your request. Except as explained below regarding an electronic health record, we do not have to provide you with an accounting of disclosures related to Treatment, Payment, or Health Care Operations, disclosures made to you or authorized by you in writing, or in certain other limited situations as provided for in the Privacy Rules. Generally, the accounting will include the date of the disclosure, the name of the person or entity that

received the PHI and their address, if known, a brief description of the disclosed PHI and a brief statement of the reason for the disclosure.

You may also request an accounting of disclosures by the Fund of an electronic health record with respect to your Protected Health Information made during the six years prior to the date on which you request the accounting. However, if your request relates to Treatment, Payment, or Health Care Operations, the Fund 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 Fund 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 Fund, or (ii) a list of all business associates acting on behalf of the Fund, 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 1, 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.

The Fund has 60 days to provide the accounting after receipt of your request. The Fund is allowed an additional 30 days if the Fund gives you a written notice of the reasons for the delay and the date by which the accounting will be provided within the initial 60-day period.

All accounting requests must be submitted in writing to the Fund Office at the address noted above. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Fund Office at the following address:

IBEW-NECA Southwestern Health and Benefit Fund
4101 McEwen, Suite 600
Dallas, Texas 75244

Your Personal Representative

You may exercise your rights described in this Notice through a personal representative. Your personal representative will generally be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Notice of Breach

You have the right to receive written or electronic notification, as you prefer, if the Fund, 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 Fund 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 in a manner that poses to you a significant risk of financial, reputational, or other harm.
>
> ***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.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of HHS pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA Privacy Rules.

This Notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and

- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" to the Board of Trustees for obtaining premium bids or modifying, amending or terminating the Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals covered by the Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA and the Privacy Rules.

Electronic Protected Health Information ("ePHI")

The Fund will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI that it creates, receives, maintains or transmits on behalf of the Plan, which the Plan is required to implement pursuant to the Security Rule of HIPAA.

The Fund agrees that with respect to any ePHI disclosed to it by the Plan, or any other covered entity, the Fund will:

1. Make sure that any agent, including a subcontractor, agrees to implement reasonable and appropriate security measures to protect the information to whom the Fund provides ePHI; and

2. Report to the Plan any security incident of which it becomes aware.

The Fund will only allow employees of the Fund with specific classifications/designations who have been designated to carry out plan administrative functions to have access to and use ePHI, and only then to the extent necessary to perform those administrative functions for the Plan. In the event any of these specified employees do not comply with the requirements of the Security Rule of HIPAA, that employee will be subject to disciplinary action by the Fund. The Fund will establish adequate separation between those authorized access to ePHI and those unauthorized to such access.

SECTION 3: YOUR RIGHT TO FILE A COMPLAINT WITH THE FUND OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Fund Office at the address noted above. All complaints must be in writing.

You also may file a complaint with HHS at the address noted below. Your complaint must (i) be filed in writing, either on paper or electronically, (ii) include the Fund's name, (iii) contain a description of the acts or omissions you believe to be in violation of the Privacy Rules, and (iv) be filed within 180 days of when you knew or should have known that the acts or omissions giving rise to the complaint occurred. (The government may waive the 180-day filing deadline if you can show good cause why you failed to file the complaint in time.) Your complaint should be filed at the following address:

Region VI
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202
Phone: (214) 767-4056
Fax: (214) 767-0432
TDD: (214) 767-8940

The Fund will not retaliate against you in any way for filing a complaint.

SECTION 4: IF YOU NEED MORE INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual at the Fund Office:

IBEW Privacy Information Official
IBEW-NECA Southwestern Health and Benefit Fund
4101 McEwen, Suite 600
Dallas, Texas 75244
Phone: (214) 980-1123
National Toll-Free: (800) 527-0320
Email: lszatkowski@zenith-american.com

SECTION 5: CONCLUSION

PHI use and disclosure by the Fund is regulated by HIPAA and the Privacy Rules. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice is provided to you pursuant to 45 CFR §164.520 and it attempts to summarize some of the Privacy Rules and the Fund's privacy policies and procedures. The Privacy Rules and HIPAA will supersede this Notice if there is any discrepancy between the information in this Notice and the Privacy Rules and/or HIPAA. This notice may be amended or updated as needed.