Working With
YOU
To Provide The Best
Healthcare.

FMCP

Family Medical Care Plan

PLAN 16
SUMMARY PLAN DESCRIPTION

(MAY 1, 2012)

IMPORTANT CONTACT INFORMATION

Benefit Office

NECA/IBEW Family Medical Care Plan
5837 Highway 41 North
Ringgold, GA 30736

1-877-937-9602 or 1-706-937-9600
1-706-937-9601 (FAX)

➪ *The Benefit Office handles medical claims, disability/life/AD&D claims, and eligibility.*
➪ *Call the Benefit Office if you need a medical I.D. card.*
➪ *Send all self-payments to the Benefit Office.*
➪ *Contact the Benefit Office if you or a dependent moves, if your family/dependent status changes, if anyone in your family acquires other coverage, or if you retire or enter active military service.*

Blue Card (Through BCBSGA)—Medical PPO Network

www.anthem.com to find PPO providers
1-800-810-BLUE (2583) to find PPO providers

1-800-676-BLUE (2583) eligibility/benefits (for providers)

➪ *If you use a Blue Card PPO provider, covered services will be paid at the higher in-network benefit level.*
➪ *Providers should file claims through their local Blue Cross affiliate.*
➪ *Your group identification number is on your I.D. card.*

Med-Care Management—Utilization Review

1-800-367-1934 for pre-certification

➪ *Pre-certify inpatient hospitalizations, home health care and durable medical equipment.*
➪ *A $250 benefit reduction applies to each inpatient hospitalization that is not pre-certified.*

MetLife—Dental Claims and Dental PPO Network

MetLife Dental Claims
P.O.Box 981282
El Paso, TX 79998-1282

1-800-942-0854 for customer service or to find a PPO provider
www.metlife.com/mybenefits

➪ *MetLife handles all dental claims. Your group account number is 304133.*

VSP—Vision Benefit Program

VSP
P.O.Box 997105
Sacramento, CA 95899-7105

1-800-877-7195 for customer service & to find providers
www.vsp.com

➪ *Do NOT send vision claims to the Benefit Office or BCBS.*

Sav-Rx—Prescription Drug Program

1-866-233-IBEW (4239) for customer service
www.savrx.com

➪ *Call Sav-Rx if you need a prescription drug card or have questions about your prescription drug program.*

LETTER TO NEW PARTICIPANTS

Notice About Your COBRA Rights - *This letter is intended to inform you, in a summary fashion, of your rights and obligations under the COBRA coverage provisions of the law. More information about COBRA coverage is on pages 23-28.*

Failure to continue your group health coverage by electing COBRA coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and COBRA coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event that is causing your loss of coverage under this Plan. You will also have the same special enrollment right at the end of your COBRA coverage period if you get COBRA coverage for the maximum time available to you.

Qualifying Events and Maximum Coverage Periods - *You (the employee) and your eligible dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"): 1) a reduction in your hours; or 2) termination of your employment.*

If you or an eligible dependent are disabled (as defined by the Social Security Administration for the purpose of Social Security disability payments) on the date of one of the qualifying events listed above, or if you or a dependent become so disabled within 60 days after an 18-month COBRA coverage period starts, the maximum coverage period will be 29 months for all members of your family who were covered under this Plan on the date of that qualifying event. This 11-month extension rule does not apply to dependents during a 36-month maximum coverage period.

Your dependents (spouse or children) are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"): 1) a divorce from your spouse; 2) a dependent no longer meets the Plan's definition of a dependent child; or 3) your death.

If your dependents are covered under an 18-month COBRA coverage period and a second qualifying event (one of the events listed in the paragraph above) occurs, their COBRA coverage maximum coverage period may be extended up to a maximum of 36 months minus the number of months of COBRA coverage already received under the 18-month continuation. The maximum period of time that a dependent can have COBRA coverage is 36 months, even if one or more new qualifying events occur to the person while he is covered under COBRA coverage.

COBRA coverage may not be elected by anyone who was not covered under this Plan on the day before the occurrence of a qualifying event except that, if a child is born to you, adopted by you, or placed for adoption with you after you become covered under an 18-month COBRA period, the child will have the same election rights as your other dependents who were covered on the day before the first qualifying event if a second qualifying event occurs.

Notification Responsibilities - *You, your spouse, or child, as applicable, must provide written notification to the Benefit Office if you get divorced or if a child loses dependent status. Notification must be provided within 60 days of the event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later. If the Benefit Office is not notified within 60 days, the dependent will lose the right to COBRA coverage. If your dependents are covered under an 18-month maximum COBRA period and then a second qualifying event occurs, it is the affected dependent's responsibility to notify the Benefit Office within 60 days after the second qual-*

ifying event occurs. If the Benefit Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

In order to qualify for the 11-month disability extension, the Benefit Office must be notified within 60 days of the disability determination by Social Security and before the end of the initial 18-month period. They must also be notified within 30 days of the date Social Security determines that you or the dependent are no longer disabled.

In order to protect your family's rights, you should keep the Benefit Office informed of any changes in the addresses of family members.

Additional Rules Governing COBRA Coverage - *Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents. A person does not have to show that he is insurable to elect COBRA coverage. If coverage is going to terminate due to termination of your employment or a reduction in your hours and you don't elect COBRA coverage for your dependents when they are entitled to the coverage, your dependent spouse has the right to elect COBRA coverage for up to 18 months for herself and any children within the time period that you could have elected COBRA coverage.*

Electing COBRA Coverage - *If you don't have sufficient employer contributions to continue coverage, or when the Benefit Office is notified of any other qualifying event, you and/or your dependents will be sent an election notice that explains when coverage will terminate. It will also explain your right to elect COBRA coverage, the due dates, and the amount of the self-payments. An election form will be sent along with the election notice. Complete the election form and return to the Benefit Office if you want to elect COBRA. A person has 60 days after he is sent the election notice or 60 days after his coverage would terminate, whichever is later, to return the completed election form. A COBRA election is considered to be made on the date of the postmark on the returned election form. If the election form is not returned within the allowable time period, you and/or your dependents will not be entitled to elect COBRA.*

COBRA Coverage Self-Payment Rules - *COBRA self-payments must be made monthly. The amount of the monthly COBRA self-payment is determined by the Trustees and is subject to change, but not usually more often than once a year. The amount due will be shown on the election notice. A person has 45 days after the date of the election to make the initial self-payment. Your first COBRA self-payment will be applied to your first month of COBRA coverage—not the month in which you make the payment.*

Termination of COBRA Coverage - *COBRA coverage for a covered person will end sooner than the end of the applicable maximum coverage period when the first of the following events occurs: 1) a correct and on-time payment is not made to the Fund; 2) the Fund is terminated and no longer provides group health coverage to any employees; 3) if a person is receiving extended coverage for up to 29 months due to his or another family member's disability, Social Security determines that he or the family member is no longer disabled; 4) after electing COBRA coverage, the person becomes entitled to Medicare benefits; or 5) after electing COBRA coverage, the person becomes covered under another group health plan that does not have a preexisting condition exclusion.*

Sincerely,

Board of Trustees
NECA/IBEW Family Medical Care Plan

TABLE OF CONTENTS

Your Schedule of Benefits starts on page 10.

INTRODUCTORY INFORMATION

About This Booklet

This booklet outlines the health care benefits provided to participants in Plan 16 provided by the NECA/IBEW Family Medical Care Plan (referred to as "the Plan" in this booklet).

If you are a Plan 16 participant who meets the Plan's eligibility requirements (the rules in this booklet), you and your family members who meet the Plan's definition of a dependent (on page 83 of this booklet) will be eligible for the medical benefits described herein.

All Benefits May Not Apply to You

The following benefits are optional, and you will only be entitled to these coverages if they are included in your employer's contract with the Plan:

Dental	Life Insurance
Vision	AD&D Insurance
Weekly Disability	Special Fund

If you are not sure which benefits you are entitled to you, call the Benefit Office at 1-877-937-9602.

Other Benefit Plans Provided by the Fund

The NECA/IBEW Family Medical Care Trust Fund (referred to as the "Fund" in this booklet) also provides other benefit plans for other participants. Those benefit plans are described in separate booklets. The plan of benefits under which an eligible participant will be covered is determined by the collective bargaining agreement or participation agreement between the participant's employer and the Trustees of the NECA/IBEW Family Medical Care Plan.

Does the Benefit Office Have Your Current Address?

Be sure to inform the Benefit Office if you or any of your eligible dependents have a change of address.

When the Benefit Office is informed that your or a dependent's coverage is going to terminate, it is required by law to send you information about your right to make self-payments. Therefore, the Benefit Office should always have the current mailing address for you and all your eligible dependents so that you can be sent this information as well as other important notices which are mailed to Fund participants from time to time.

Pronouns Used in this Booklet

Wherever the term "you" or "your" is used in this booklet, it means an eligible employee or, where applicable, an eligible retiree.

Wherever the term "you" or "your" is used in this booklet, it means an eligible employee or, where applicable, an eligible retiree. And, to avoid awkward wording, male personal pronouns are used to refer to employees and retirees. Feminine pronouns are used when referring to spouses. Whenever a personal pronoun is used in the masculine gender, it shall be deemed to include the feminine also, unless the context clearly indicates the contrary. Similarly, feminine pronouns will include the masculine.

SPECIAL PLAN FEATURES

YOUR BLUE CARD PPO NETWORK

Most hospitals and physicians participate in the national Blue Card network.

Your preferred provider (PPO) network is the national Blue Card PPO network through Blue Cross Blue Shield of Georgia (your "home plan"), an independent licensee of the Blue Cross and Blue Shield Association. The Blue Card network links individual Blue Cross Blue Shield (BCBS) PPO networks to provide you with access to the largest health care network in America.

If you use BCBS PPO network providers, you will receive the PPO (in-network) benefits shown on the Schedule of Benefits.

Your Blue Cross I.D. Card

Your BCBS I.D. card gives you access to BCBS network providers throughout the United States. The PPO-in-a-suitcase logo tells providers that you are part of the Blue Card PPO program. The three-letter alpha prefix that precedes your subscriber number on your I.D. card identifies Blue Cross and Blue Shield of Georgia (BCBSGA) as your home plan.

Preferred and Participating Providers

Call 1-800-810-BLUE (2583) or go to www.anthem.com to locate a PPO provider.

There are two types of health care professionals in the Blue Card program:

- ***Preferred Providers (PPO Providers)*** are part of the regular PPO network. They file claims for you, and your benefits are generally higher when you use their facilities and services.
- ***Participating Providers*** are non-PPO providers who have agreed to perform services at discounted rates for Blue Card PPO members. Typically, you would go to a participating provider if there are no PPO health care professionals in your area who can provide the medical care you need. Participating providers will also file your claims for you.

To Locate a PPO Provider

Call BCBS Network Access at 1-800-810-BLUE (2583) or visit the website www.anthem.com. This information also appears on the back of your I.D. card.

PRE-CERTIFICATION REQUIREMENTS

Call 1-800-367-1934 for pre-certification. This number is also on your I.D. card.

You and your dependents are required to pre-certify each inpatient hospitalization by calling Med-Care Management, Inc. prior to admission. A $250 benefit reduction will apply to each hospitalization that is not pre-certified.

You should also call for pre-certification prior to receiving home health care or durable medical equipment.

Pre-certification does NOT guarantee payment.

Pre-certification is NOT a guarantee of payment. Services are approved only when the appropriateness of the inpatient setting can be substantiated. Actual payment is dependent upon that person meeting the Plan's eligibility rules. See page 45 for more information about the Review Program.

YOUR DENTAL PPO NETWORK

For customer service call MetLife at 1-800-942-0854 (refer to group account number 304133).

MetLife® administers the Plan's dental benefits. In addition to handling your dental claims, MetLife has a network of dentists—called the MetLife Preferred Dentist Program (PDP)—who have agreed to accept MetLife's Maximum Allowed Charge as payment in full. However, you do NOT have to use MetLife dentists to receive dental benefits. The same benefit levels will be provided for both in-network and out-of-network dental services. But you will save money using PDP dentists because of lower fees.

To find a participating dentist, go to www.metlife.com/dental or call the number above.

You do not need any authorization from MetLife or the Benefit Office to choose a dentist.

See page 61 for more information about your dental PPO network.

YOUR VISION PLAN AND VSP PREFERRED PROVIDER NETWORK

Vision Service Plan (VSP) administers the Plan's vision benefits and provides a network of VSP doctors who will provide basic vision services to you at no charge and with no claims to file.

See the *Vision Benefits* section starting on page 67 for more information.

YOUR SAV-RX PRESCRIPTION DRUG PROGRAM

You can contact Sav-Rx for customer service at 1-866-IBEW (4239), or at www.savrx.com.

The Plan provides its prescription drug benefits through a program administered by Sav-Rx. You can use your Sav-Rx card to purchase short-term or acute prescription drugs (such as antibiotics or pain relievers) from any participating retail pharmacy. There is also a mail-order feature allowing you to save even more money on your long-term and maintenance prescription drugs.

See pages 58-60 for more information about your Prescription Drug Program.

Wal-Mart and Sam's Club are NOT part of your network, and the Plan will not cover drugs purchased from their pharmacies.

Note: If your spouse has coverage under another health plan, she must follow the rules of her prescription drug plan first and then file a claim with Sav-Rx for consideration of the remaining charge. The same applies to prescription drugs for any children for whom your spouse's plan pays primary benefits.

THE WORKING SPOUSE RULE

Basic Rule

If your spouse works and is eligible for coverage through her employer, then she is required to enroll in her employer's health plan. If your spouse fails to enroll in her employer's plan, this Plan will only pay 20% of her covered medical and prescription drug expenses.

If your spouse has already declined her employer's plan at the time you become eligible, the penalty reduction will not apply to her claims as long as she opts into her employer's plan during the next open enrollment period

Hardship Exemption

The working spouse rule will NOT apply if your spouse:

1. Has gross annual wages of less than $20,000; or

2. Has gross annual wages greater than or equal to $20,000 but less than $30,000 and must pay more than $150 per month toward the cost of the least expensive health plan offered by her employer.

You are responsible for demonstrating your entitlement to a hardship exemption by submitting a letter attesting to wages and cost of coverage from the employer on company letterhead. The Benefit Office will determine whether a spouse with variable wages qualifies for the hardship exemption by looking at the spouse's average wages over the past 12 months.

Additional Provisions and Exceptions to the 20% Plan Payment Rule

The Working Spouse Rule does not apply to Plan participants whose employers make multi-tiered contributions to this Fund.

1. The Working Spouse Rule does not apply to Plan participants whose employers make multi-tiered contributions to this Fund.

2. The working spouse rule only applies to your spouse's claims, not to claims incurred by your children.

3. The rule only applies to medical and drug expenses. Enrollment in the employer's dental and/or vision plan is not required. (However, if your spouse does enroll in the employer's dental and/or vision programs, this Plan will coordinate benefits and pay secondary to the employer's plan).

4. The working spouse rule applies EVEN IF any of the following apply:
   - The working spouse's employer's plan does not have a single-only coverage option.
   - Medical coverage is an option under a cafeteria plan.
   - The working spouse's employer's plan is an HMO.
   - Your spouse works part-time.
   - You are a retiree, but your spouse is still actively employed.

- The employer offers an incentive to induce employees not to enroll.

5. The working spouse rule will NOT apply in any of the following situations:
   - Your spouse's employer does not offer medical or prescription drug coverage.
   - Your spouse's employer requires your spouse to pay the full cost of the healthcare coverage.
   - Your spouse's only other option for group insurance is retiree coverage.
   - Your spouse's only other option for group insurance is COBRA coverage.
   - Your spouse's only other coverage option is an HMO and your residence is more than 25 miles outside the HMO service area.
   - Your spouse's claim would have been denied under the working spouse's employer's plan (for example, if the claim was for a preexisting condition incurred during the preexisting waiting period).
6. If this Plan pays 20% of your spouse's claims because of this rule, her coinsurance shares will not apply to the Plan's out-of-pocket limits, nor will the claim be paid at 100% if her out-of-pocket limit was previously met by other charges.
7. You are required to provide accurate and timely information to the Fund about your spouse's employment status and benefit entitlement, and the Benefit Office may require verification of this information from your spouse's employer.

Dual Coverage Saves You Money

When your spouse is covered by her employer's plan and this Plan at the same time, the two plans together will usually pay 100% of her covered claims under the coordination of benefits rules. If your spouse requires a hospitalization or surgery, you will generally come out ahead financially from the dual coverage, even after her premiums are taken into account.

HOW TO FILE CLAIMS

Medical Claims

Hospitals and doctors will usually file your claim for you.

Blue Cross PPO providers throughout the country will file your claims for you. When visiting a Blue Cross PPO provider, all you need to do is show your I.D. card. When your provider submits your claim to the local BCBS plan, it is important that the alpha prefix from your I.D. card is included. This prefix is the key to timely and accurate claims processing.

If you need to submit a claim yourself, send it to YOUR LOCAL BCBS PLAN. You can get the address of your local BCBS plan by calling 1-866-304-1881 (BCBSGA customer service), or go to www.anthem.com.

If you need to submit a claim yourself, send itemized bills to your local BCBS plan (the BCBS plan in the provider's state). For example, if you received medical services in Florida, you must submit your claim to Blue Cross Blue Shield of Florida. Your local BCBS plan will transmit the claim to this Plan's home plan (BCBSGA). Be sure to include your BCBS alpha prefix, and your group and individual identification numbers.

The Blue Cross affiliate who receives the claim will forward it electronically to CompuSys, the Plan's claims administrator. CompuSys will pay the Plan's portion of the claim and mail you an Explanation of Benefits (EOB). You will be responsible for any deductible or coinsurance amounts, in addition to any services that are not covered by the Fund.

You may be required to complete claim forms in certain situations, including claims for injuries. CompuSys will send you a claim form and return envelope whenever you submit medical expenses for which a claim form is needed. Claim forms will also be available on the website.

Prescription Drugs

Co-pays are your responsibility. Do not submit claims for co-pays.

There are no claims to file when you use the Plan's prescription drug program (unless another group plan is the primary payor for the person's claims). You pay your co-pay shares directly to the participating retail or mail-order pharmacy.

Dental Claims

Claims should be submitted to MetLife—the dentist will usually file the claim electronically. If you need to file a claim yourself, send it to:

MetLife Dental Claims
P.O.Box 981282
El Paso, TX 79998-1282

Be sure to include your Social Security number and your group account number (304133).

You will receive your benefit payment explanations directly from MetLife, and any questions you have about your claim should be directed to MetLife.

Vision Claims

Vision Service Plan (VSP) handles claims for vision care.

You do not have to file a claim when you use a VSP doctor.

When you use an out-of-network provider:

- Pay the bill in full. Get a paid receipt and itemized bill showing the services performed and supplies provided. The bill must be itemized, especially with regard to showing the type of lenses prescribed, i.e., single vision, bifocal, trifocal or contacts.
- Be sure the bill includes your name, address and Social Security number (if the patient is a dependent, the dependent's name and birth date should also be on the bill).

Please do not send vision bills to the Benefit Office.

Send the itemized paid bill, along with the benefit form, to VSP at the address shown below. Vision claims should be filed within six months after the services or supplies are received.

Send out-of-network vision claims to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

Other Claims

Submit Life Insurance, AD&D and Weekly Disability claims to the Benefit Office at the following address:

NECA/IBEW Family Medical Care Plan
5837 Highway 41 North
Ringgold, GA 30736

PLAN 16 SCHEDULE OF BENEFITS

You will only be entitled to a benefit shown on this schedule if it is included in your employer's contract with the Plan.

LIFE/DISMEMBERMENT INSURANCE

Employee Life Insurance $20,000

Retiree Life Insurance $7,500

Accidental Death & Dismemberment (AD&D) Insurance - principal sum (employees only) $20,000

WEEKLY DISABILITY BENEFIT (Employees Only)

Weekly benefit amount:

Non-occupational disability $250

Occupational disability $125

Maximum period payable per disability .....26 weeks

Benefits start on the following day of disability:

- Accident - 1st day
- Illness - 8th day
- If a disability due to sickness lasts more than 8 weeks, benefits will be retroactively paid for the first 7 days of disability.

MAJOR MEDICAL BENEFIT

Benefits are payable only for covered expenses. Covered expenses do not include amounts in excess of allowable charges, or charges for treatment that is not medically necessary. All benefits are subject to the maximum benefits and limitations stated below and to all Plan conditions and exclusions. All benefits and limitations shown are per covered person unless specifically stated otherwise.

Limitations apply to certain types of benefits—see *Special Benefits and Limitations* starting on page 11.

Calendar year maximum benefit $2,000,000

Calendar year deductibles:

PPO:

Per person $200

Per family (aggregate) $400

Annual deductible does not apply to PPO office visits.

Non-PPO:

Per person $400

Per family (aggregate) $800

Office visit co-pay for PPO physicians $20

Emergency room deductible (per occurrence), waived if visit results in an inpatient admission, applies to emergency room facility fees and emergency room physician fees $100

Your spouse is required to enroll in her employer's health plan.

Benefit reduction for failure to pre-certify an inpatient hospitalization $250

Coinsurance (payment percentages) per calendar year after satisfaction of calendar year deductible:

BCBS PPO expenses 100%

Emergency room treatment at an out-of-network hospital for an emergency medical condition, including professional fees 100%

Professional charges by an out-of-network radiologist, pathologist or anesthesiologist for services provided at a BCBS PPO hospital 100%

Out-of-network expenses (except as stated above) 80%

Non-PPO out-of-pocket limits per calendar year:

Per person $1,000

Per family (aggregate) $2,000

Once a person's out-of-pocket limit is met, most covered out-of-network expenses are paid at 100% during the remainder of the year. Your deductible does not count toward your out-of-pocket limit. Your coinsurance percentage for treatment of substance abuse and mental/nervous disorders do not apply to your out-of-pocket limit, and will not be paid at 100%.

Special Benefits and Limitations

Normal deductibles, office visit co-pays and coinsurance percentages apply unless otherwise stated.

Non-PPO ambulatory surgical centers..... excluded

Preventive care provided by PPO providers..... payable at 100% no deductible or co-pay

No benefits are provided for preventive services provided by non-PPO providers.

Chiropractic care - maximum allowable visits per calendar year.....30

Chiropractic visits are subject to the deductible and coinsurance. The $20 office visit co-pay does not apply.

Hearing aids - maximum allowable hearing aids ..... one per ear per lifetime

Outpatient rehabilitative therapy - maximum allowable visits per calendar year for all physical, occupational and cardiovascular rehabilitation therapy combined (excludes inpatient therapy and speech therapy).....50

Speech therapy for developmental delays and learning disorders is not covered.

Speech therapy - maximum allowable visits per calendar year for speech therapy to restore speech abilities lost due to stroke or trauma 50

Mental or nervous disorders:

Maximum allowable inpatient days per calendar year 30

A day of partial inpatient (PHP) or intensive outpatient (IOP) treatment counts as one-half inpatient day.

Maximum allowable outpatient/office visits per calendar year 60

Substance abuse:

Inpatient - maximum allowable days:

Per calendar year.....30

Per lifetime.....60

A day of partial inpatient (PHP) or intensive outpatient (IOP) treatment counts as one-half inpatient day.

Outpatient/Office - maximum visits:

Per calendar year.....30

Per lifetime.....60

Skilled nursing facility - maximum allowable days per calendar year.....60

Home health care - maximum allowable visits per calendar year 120

PRESCRIPTION DRUG PROGRAM (Through Sav-Rx)

Sav-Rx administers the Plan's Prescription Drug Program.

You pay the following co-pays directly to the participating retail or mail-order pharmacy:

Generics	0%
Formulary brands	20%
Non-formulary brands	30% minimum $40 retail, $80 mail
After co-pay out-of-pocket limit of $1,000 per calendar year per person has been met	0%

Wal-Mart and Sam's Club are NOT in your network.

If you decline a generic substitution, you must pay the cost difference between the brand and generic. The difference does not apply to your out-of-pocket limit and must be paid even after your out-of-pocket limit has been met.

"Generic drugs" are those with multiple manufacturers. You will have to pay the 20% or 30% co-pay for a generic drug sold by only one or two companies.

DENTAL BENEFIT (Through MetLife)

MetLife administers the Plan's Dental Benefits.

Dental Benefits are provided for active employees and their eligible dependents only. These benefits are not provided for retirees or dependents of retirees.

Deductible per calendar year:

Per person	$25
Per family	$75

The deductible does not apply to preventive care or orthodontia.

Maximum payable per person per calendar year $1,500

Maximum does not apply to children under age 19.

Orthodontia lifetime maximum per person (children only) $2,000

Payment percentage of covered charges:

Preventive care	100%
Basic restorative care	80%
Major restorative care (crowns and prosthetics)	60%
Orthodontia	50%

VISION BENEFIT (Through Vision Service Plan)

The Plan's Vision Benefit is administered by Vision Service Plan (VSP).

Vision Benefits are provided for active employees and their eligible dependents only. These benefits are not provided for retirees or dependents of retirees.

Vision Care Services (one per calendar year)	**VSP Doctor**	**Non-Network Provider**
Vision exam	Provided in full	$35
Lenses (per pair):		
Single	Provided in full	$30
Lined bifocal	Provided in full	$40
Lined trifocal	Provided in full	$55
Lined lenticular	Provided in full	$55
Contacts (elective)	Provided up to $120 allowance	$120
Frame	Provided up to $115 allowance	$35
Safety Glasses**		
Frame	Provided up to $65 allowance	$25
Lenses (per pair):		
Single vision	Provided in full	$30
Bifocal	Provided in full	$35
Trifocal	Provided in full	$45
Lenticular	Provided in full	$60

***The safety glass benefit is for employees only. One pair is provided per calendar year in addition to regular eyeglasses.*

ELIGIBILITY FOR HOURLY BARGAINING UNIT EMPLOYEES

This section describes the eligibility rules that apply to active bargaining unit employees whose employers contribute to the Fund based on hours worked.

- The eligibility rules for *monthly bargaining unit* employees are on page 29.
- The rules governing *non-bargaining unit* employees are on page 31.
- The *retiree* eligibility section starts on page 32.
- The rules governing *COBRA* coverage start on page 23.

DEFINITIONS APPLICABLE TO ELIGIBILITY

Benefit Month — A period of one calendar month during which a person is eligible for Plan benefits because he has met the applicable eligibility requirements during the corresponding eligibility (work) month.

Eligibility (Work) Month — A period of one calendar month during which a person meets the applicable eligibility requirements necessary to provide benefit coverage during the corresponding benefit month.

Credited Hour — Any hour: 1) worked by an employee for which an employer contribution is made to the Fund under the terms of a written plan of benefits; 2) worked by a non-bargaining unit employee for which an employer contribution is made under the terms of the employer's participation agreement with the Trustees; 3) credited under the Plan's eligibility during disability provisions; or 4) received or due from another welfare fund having a reciprocity agreement with this Fund.

INITIAL ELIGIBILITY REQUIREMENTS

Initial Eligibility Date

You will become initially eligible on the first day of the benefit month corresponding to the eligibility (work) month in which you first accumulate at least 140 credited hours of employment for which an employer is required to make a contribution to the Fund on your behalf. The date on which you become initially eligible is called your *initial eligibility date.*

Additional Initial Eligibility Rule for New Employees - Individuals who were never covered under the Plan in the past can earn initial eligibility if they have 200 hours during a two-consecutive month period. The lag month still applies. For example, 100 hours in January and 100 hours in February earn initial eligibility effective April 1. The normal 140-hour rule described in the paragraph above also applies—new employees will become initially eligible by satisfying either rule.

When Benefits Start (Effective Date of Benefits)

Your benefit coverage will start on your initial eligibility date. For example, if your employer makes contributions for you for at least 140 credited hours for work performed in January, your coverage will start on March 1.

The Plan's definition of a "dependent" starts on page 83.

If you have dependents on the date your coverage starts, their coverage will start on that same date. If you later acquire a dependent while you are eligible, coverage will start on the date the person became your dependent. Your dependents' eligibility is contingent upon your eligibility.

Legal documentation (such as an original registered marriage certificate, certified government-issued birth certificate or divorce decree) is required by the Benefit Office before any benefits can be paid.

CONTINUING ELIGIBILITY

Once you become eligible, you and your dependents will continue to be covered during each benefit month if you meet the continuing eligibility rules during the corresponding eligibility (work) month. The minimum credited hour requirement for continuing eligibility is 140 hours per eligibility month. The table below shows how eligibility months correspond to benefit months.

Eligibility (Work) Month	➜ Benefit Month
November	January
December	February
January	March
February	April
March	May
April	June

Eligibility (Work) Month	➜ Benefit Month
May	July
June	August
July	September
August	October
September	November
October	December

YOUR HOUR BANK

After you have satisfied the initial eligibility rules, your credited hours in excess of 140 in an eligibility (work) month will be credited to your hour bank.

The maximum you can accumulate in your hour bank is 840 hours (140 hours times six months = 840 hours).

If you fail to have 140 credited hours in an eligibility month, the number of credited hours necessary to make up the difference will be deducted from your hour bank.

If your combined hours from work and your hour bank are less than 140, you may make a self-payment for the hours you are short (see the following section for more information). If you don't make the self-payment but return to work within six (6) months, the hours remaining in your hour bank can be

used to help you re-establish eligibility. If you do not return to work within the 6-month window, any remaining amounts in your hour bank will be forfeited.

Your hour bank is not a vested benefit. The hours in your hour bank may, at any time, be limited, changed or extinguished through Trustee action. Your hour bank also has no monetary value.

SELF-PAYMENTS FOR SHORT HOURS

If you do not have 140 credited hours in an eligibility (work) month even with your banked hours, you can make up to six (6) consecutive monthly self-payments to cover the difference between your credited hours and the number of hours needed to satisfy the 140-hour rule.

An additional 6-month self-pay period will be allowed if you return to covered employment and have at least 100 credited hours during an eligibility (work) month that corresponds with, or immediately follows, a benefit month during which you were eligible because of a self-payment for short hours. Additional 6-month self-pay periods will be allowed without limit as long as you continue to meet the 100-hour requirement.

You are only entitled to a self-pay period if you are an active employee who is already covered under the Plan when your hours shortage occurs.

Self-payment amounts will be determined by multiplying the hours you are short of 140 times the current hourly contribution rate. The due date for short hours self-payments is the last day of the benefit month for which the payment is being made.

ELIGIBILITY DURING DISABILITY

You are NOT entitled to eligibility protection during disability if you are a COBRA continuee or retiree.

If you become totally disabled, your eligibility will continue for up to twelve (12) months under the following rules, provided that you meet ALL three of the following requirements:

1. You must be an eligible active employee on the date your disability starts; AND

2. You must be eligible for the benefit month which next follows the benefit month in which you became disabled; AND

3. You must have worked enough hours and have been credited with sufficient disability hours in the eligibility (work) month in which you became disabled to satisfy the Plan's continuing eligibility rules. This means that the number of any disability hours to which you might be entitled, together with your regular credited hours, must equal or exceed 140 (160 for non-bargaining unit employees who qualify for disability hours) in the month your disability starts.

If you meet the above qualifications, you will be credited with eight disability hours each day of the work week, Monday through Friday, during your period of disability.

Additional Rules Governing Eligibility During Disability

1. If you do not qualify for eligibility during disability as explained above, no credit for disability hours will be granted to you for future use.

You can receive disability hours for non-work-related disabilities and work-related disabilities.

2. You cannot receive disability hours if you are retired or making COBRA self-payments.

3. You can receive disability hours for non-work-related disabilities and work-related disabilities. To receive disability hours for an occupational disability you must have become disabled on the job while you were working for an employer who was making contributions to the Fund on your behalf under a collective bargaining agreement or participation agreement. If you became disabled on the job while working for an employer who was not signatory to a collective bargaining agreement or participation agreement, you will NOT be eligible for disability hours.

4. The maximum period that your eligibility will be continued is 12 benefit months. However, if your eligibility is continued under this provision and you return to employment for a contributing employer before the expiration of 12 benefit months, your eligibility will be continued for the rest of the benefit month in which you return to work on a continuous full-time basis and for the next two succeeding benefit months. This permits your eligibility to be continued without interruption while you are working to earn future eligibility.

5. If you qualify for disability hours and you recover in the same month in which your total disability began, you will be eligible in the benefit month related to the eligibility month in which you were totally disabled, provided you would have been eligible if you had worked full-time for a contributing employer during your period of total disability.

6. If you are covered under this provision for the allowed 12 months and are still disabled and unable to go back to work, or if you recover from your total disability but there is no work available in your jurisdiction, you may be entitled to continue coverage by making COBRA self-payments.

7. If you recover after receiving disability hours and you do not go to work for an employer contributing to the Fund, your coverage will terminate on the date you are no longer disabled or the date your coverage terminates under the Plan's continuing eligibility rules unless you make correct and on-time COBRA self-payments.

If you die while you are covered under this provision and you have not accumulated any further eligibility, your dependents will be covered for three (3) more months starting with the first day of the month following the month in which you die. After the 3-month period, your dependents may be entitled to continue coverage by making COBRA self-payments.

SPECIAL CIRCUMSTANCES

Reciprocity

The Fund is signatory to the Electrical Industry Health and Welfare Reciprocal Agreement. The purpose of the reciprocity agreement is to permit you to retain eligibility when contributions are made for you to another IBEW welfare fund.

If you want this Fund to be your home fund when you travel outside of its jurisdiction, you should register with the Electronic Reciprocal Transfer System (ERTS) at any IBEW Local Union office.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) requires certain employers (but not all) to grant unpaid leave for specific reasons, such as the birth of a child or a serious family illness. Eligibility for this unpaid leave is determined by the employer, not by the Trustees of this Fund.

If you are granted a FMLA leave, you are entitled to a continuation of the Plan's health care benefits if your employer makes the required contributions to the Fund on your behalf. Failure of your employer to submit contributions on a timely basis will result in loss of coverage under this Plan.

Military Leave

If you are called to active military duty in the uniformed services of the United States for *31 days or more*, this Plan allows you to choose between an eligibility freeze and making self-payments.

- Under a freeze, coverage for you and your dependents will stop during your duty period, but the eligibility you accumulated before the call-up will be reinstated if you return to covered employment under circumstances entitling you to re-employment under federal law. For example, if, at the time of your call-up, you would have remained eligible for two months, those two months will be held in reserve for your use immediately after you return to covered employment.
- Instead of the freeze described above, you can run out your accumulated eligibility and then make self-payments to keep your coverage in force while you are on military leave. You will not need health coverage for yourself during a period of military call-up, but you may want to make self-payments to continue coverage for your dependents. The maximum self-payment period during a military call-up is 24 months. When you return, you will need to continue making self-payments until you re-establish eligibility under the regular rules (assuming you haven't previously reached the 24-month limit). You cannot have a freeze and make self-payments at the same time.

The eligibility freeze is the automatic (default) option. You must specifically request a waiver of the freeze if you want to elect the self-pay option.

If you are covered under the Plan and are actively employed, but are absent from covered employment for duty in the U.S. military for *30 days or less*, the Plan will credit contributions to the Plan on your behalf for the hours of employment which you missed, provided you return to covered employment in conformity with governing federal law.

The provisions described above are merely a summary, and other rules may apply depending on your circumstances. If you are called to active military duty, you should call the Benefit Office as soon as possible so that they can explain these options to you in more detail. The eligibility freeze will automatically go into effect unless you tell the Benefit Office that you would like to make self-payments instead.

If you would like more information about your rights during a military call-up, contact VETS at 1-866-4-USA-DOL or visit the government's website at www.dol.gov.vets.

In the Event of Your Death

If you die while you are an eligible employee (who is not making COBRA self-payments), Plan coverage for your surviving dependents may be continued according to the rules explained below.

1. Your surviving dependents may be entitled to an automatic continuation of coverage as follows:

   a. If you were covered under the eligibility during disability provisions at the time of your death, your dependents will continue to be covered for three months starting with the first day of the month following the month in which you die; or

   b. If you were NOT covered under the eligibility during disability provisions at the time of your death, your dependents will continue to be covered through the end of the benefit month for which you had earned eligibility before your death.

2. After that, your dependents can continue their coverage by making COBRA self-payments, or by making survivor self-payments. If your spouse chooses to make COBRA self-payments, the rules governing COBRA coverage will apply. Note that if she elects COBRA, she will not be entitled to make survivor self-payments at any future date. Similarly, if she chooses the survivor self-payment option, she will lose the right to elect COBRA coverage at any future date.

Rules Governing Survivor Self-Payments

If your surviving spouse is under age 62, she can make self-payments to continue coverage for herself and any of your surviving dependent children in accordance with the following rules:

1. The amount of the monthly self-payment is determined by the Trustees and may be changed at any time. By making the self-payments, your

spouse will remain eligible for the same benefits she was eligible for when you died.

2. Your spouse must make her first self-payment on or before the date on which a self-payment to maintain continuous coverage is due. There must be no lapse in coverage.

3. Each subsequent payment must be postmarked no later than the 15th day of the month preceding the benefit month for which she is paying. Payments postmarked after the 15th will not be accepted.

4. If your spouse fails to make a self-payment on or before the date it is due, her eligibility and the eligibility of any of your surviving dependent children will terminate at the end of the benefit month for which she had already paid. She will not be allowed to make any future self-payments.

5. Once a self-payment has been accepted by the Benefit Office, it will not be returned.

6. Your spouse can continue to make self-payments until she remarries or until one of the other events specified in No. 8-c on page 23 occurs.

7. If your spouse doesn't elect to make survivor self-payments when she is first entitled to do so, she will not be permitted to make self-payments at any future date.

8. When your spouse becomes age 62, her coverage as a dependent of an active employee will terminate and she will then be able to make self-payments for the Plan's Retiree Benefits.

Coverage for your surviving dependent children will terminate if your surviving spouse's coverage under this provision terminates for any reason. It will also terminate the day the child no longer meets the Plan's definition of a dependent (for example, when the child hits the Plan's limiting age).

TERMINATION OF ELIGIBILITY

Termination of Employee Benefits

You will cease to be eligible for benefit coverage under the Plan on the earliest of the following dates unless you are entitled to COBRA coverage and a correct and on-time COBRA election and self-payment is made by you or on your behalf:

1. The date the Trustees terminate the benefits provided by this Plan;

2. The date you enter the armed forces of any country on a full-time basis, unless you make correct and on-time self-payments to continue your coverage;

3. If you fail to meet the continuing eligibility requirements, at the end of the last day of the benefit month corresponding to the last eligibility (work) month for which you did meet the requirements, unless you are

terminated or retire and make correct and on-time self-payments for COBRA coverage or Retiree Benefits;

4. If your coverage is being continued under the eligibility during disability provisions, on the date you fail to meet the applicable requirements;

5. If you are making COBRA self-payments, at the end of the last day of the applicable maximum coverage period to which you were entitled and for which correct and on-time self-payments have been made or, on the date of occurrence of any of the events stated in *Termination of COBRA Coverage* on page page 28, whichever occurs first; or

6. The date of your death.

Termination of Dependent Benefits

A dependent of yours will cease to be eligible for benefits from this Plan on the earliest of the following dates unless the dependent is entitled to COBRA coverage and a correct and on-time COBRA election and self-payment is made by or on behalf of the dependent:

1. The date the Trustees terminate dependent benefits (or all benefits) under the Plan;

2. The date the dependent enters the armed forces of any country on a full-time basis;

3. The date the dependent becomes eligible for Plan benefits as an employee;

4. The date you cease to be eligible for benefit coverage for reasons other than your death;

5. For your spouse, the date of your divorce;

6. For a child who fails to meet this Plan's definition of a dependent child, on the date of loss of dependent status;

7. If COBRA self-payments are being made by or on behalf of the dependent, at the end of the last day of the applicable maximum coverage period to which the dependent is entitled and for which correct and on-time self-payments have been made, or on the date of occurrence of any of the events stated in *Termination of COBRA Coverage* on page 28, whichever occurs first; or

8. In the event of your death:

   a. At the end of the last day of the last benefit month for which you had earned eligibility before your death; or

   b. If your eligibility was being maintained under the eligibility during disability provisions, at the end of the last day of the third benefit month following the month in which your death occurred; or

c. If your surviving spouse is making survivor self-payments to continue coverage for herself and any of your surviving dependent children, on the first of the following dates:

- The date any of the events in No. 1, 2 or 3 above occurs;
- The last day of the last benefit month for which a correct and on-time self-payment was made by or on behalf of your surviving spouse;
- The first day of the month following the month in which your surviving spouse attains age 62 (however, she will then be offered the opportunity to make self-payments for Retiree Benefits);
- The date your surviving spouse becomes covered under another health care plan;
- For a surviving dependent child, the date the child ceases to meet this Plan's definition of a dependent child; or
- The date your surviving spouse remarries.

TERMINATION UPON EMPLOYER WITHDRAWAL

The following rules apply if an employer withdraws from the NECA/IBEW Family Medical Care Trust Fund. A withdrawal occurs when an employer's collective bargaining agreement ceases to require contributions to the Plan for active employees. The Trustees in their sole discretion may also deem that a withdrawal has occurred if an employer ceases to make required contributions to the Plan for two consecutive months. A withdrawal can also occur when a local union negotiates health benefit coverage for a substantial number of its members under a plan other than this Plan.

When a withdrawal occurs, persons having Plan coverage because of current or past employment with the employer that has withdrawn will cease to be eligible for coverage under this Plan on the date the employer withdraws from the Plan. This includes active employees, employees (and dependents) making self-payments, individuals on COBRA coverage (unless federal law requires the Plan to continue the person's COBRA coverage), individuals maintaining coverage due to reciprocity, non-bargaining unit employees of the affected employers, and dependents. Termination of eligibility also cancels all of an employee's credited hours. Therefore, no extended eligibility otherwise available under the Plan because of credited hours will be available. The Plan has no responsibility for claims incurred after the date of withdrawal from the Plan.

COBRA COVERAGE

Federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), gives you (the employee) and your eligible dependents the right to be offered an opportunity to make self-payments for continued health care coverage if coverage is lost for certain reasons. This continued coverage is

called "continuation coverage," "COBRA continuation coverage," or "COBRA coverage." Below is an outline of the rules governing COBRA coverage. If you have any questions about COBRA, call the Benefit Office.

Failure to continue your group health coverage by electing COBRA coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and COBRA coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event that is causing your loss of coverage under this Plan. You will also have the same special enrollment right at the end of your COBRA coverage period if you get COBRA coverage for the maximum time available to you.

Qualifying Events/Maximum Coverage Periods

1. **18-Month Maximum Coverage Period -** You and/or your eligible dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for a maximum period of up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"):
   - A reduction in your hours.
   - Termination of your employment (which includes retirement).

Refer to page 19 for information about your self-payment rights when you leave covered employment for active duty in the U.S. military.

2. **29-Month Maximum Coverage Period -** If you or an eligible dependent is disabled (as defined by the Social Security Administration for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or an eligible dependent becomes so disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The COBRA self-payment may be higher for the extra eleven (11) months of coverage for the family. Also, you must notify the Benefit Office within 60 days of such a determination by the Social Security Administration and within the initial 18-month period, and within 30 days of the date Social Security determines that the person is no longer disabled.

3. **36-Month Maximum Coverage Period -** Your dependents (spouse or children) are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following qualifying events:

- Your divorce from your spouse.
- A dependent child's loss of dependent status.
- Your death.

Special Medicare Entitlement Rule - A special rule provides that if you (the covered employee) become entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of hours, the period of coverage for your spouse and dependent children will be 36 months measured from the date of your Medicare entitlement, or 18 months from the date you lose coverage because of a reduction in hours or termination of employment, whichever is longer.

4. **Multiple Qualifying Events -** If your dependents are covered under COBRA coverage under an 18-month maximum coverage period due to termination of your employment or a reduction in your hours and then a second qualifying event occurs, their COBRA coverage may be extended as follows:
   - If you die, or if you are divorced, or if a child loses dependent status while your dependents are covered under an 18-month COBRA coverage period, your dependent(s) who are affected by the second qualifying event are entitled to COBRA coverage for up to a maximum of 36 months minus the number of months of COBRA coverage already received under the 18-month continuation.
   - Only a person (spouse or child) who was your dependent on the day before the occurrence of the first qualifying event (termination of your employment or a reduction in your hours) is entitled to make an election for this extended coverage when a second qualifying event occurs. Exception: If a child is born to you (the employee), or adopted by you, or placed with you for adoption during the first 18-month COBRA period, that child will have the same election rights when a second qualifying event occurs as your other dependents who were eligible dependents on the day before the first qualifying event.

   It is the affected dependent's responsibility to notify the Benefit Office within 60 days after a second qualifying event occurs. If the Benefit Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

Benefits Provided Under COBRA Coverage

When you or a dependent elect and make self-payments for COBRA coverage, you will be eligible for the same medical, prescription drug, dental and vision coverage you had when your qualifying event occurred. COBRA coverage does not include Life and AD&D Insurance, or Weekly Disability Benefits.

Notification Responsibilities

1. If you get divorced, or if your child loses dependent status, you, your spouse or child must notify the Benefit Office and request a COBRA election notice. The Benefit Office must be notified within 60 days of the date of the qualifying event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later.

2. For purposes of extending an 18-month maximum coverage period to 29 months, the Benefit Office must be notified of the person's determination of eligibility for Social Security disability benefits within 60 days of the Social Security notice of such determination and before the end of the initial 18-month period. The Benefit Office must also be notified within 30 days of the date Social Security determines that the person is no longer disabled.

3. It is your employer's responsibility to notify the Benefit Office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you or a dependent should also notify the Benefit Office and request a COBRA election notice any time any type of qualifying event occurs.

In order to protect your family's rights, you should keep the Benefit 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 Benefit Office or that the Benefit Office sends to you.

Electing COBRA Coverage

1. When the Benefit Office is notified of a qualifying event, and you request notification about your COBRA rights, an election notice will be sent to you and/or your dependent(s) who would lose coverage due to the event. The election notice tells you about your right to elect COBRA coverage, the due dates, the amount of the self-payments, and other pertinent information.

2. An election form will be sent along with the election notice. This is the form you or a dependent fill in and return to the Benefit Office if you want to elect COBRA coverage.

3. The person electing COBRA coverage has 60 days after he is sent the election notice or 60 days after his coverage would terminate, whichever is later, to return the completed election form. An election of COBRA coverage is considered to be made on the date the election form is personally delivered or mailed back to the Benefit Office (the postmark date will govern the date of mailing).

4. If the election form is not returned to the Benefit Office within the allowable period, you and/or your dependents will be considered to have waived your right to COBRA coverage.

COBRA Self-Payment Rules

1. COBRA coverage self-payments must be made monthly and must be received by the Benefit Office in a timely manner. Your self-payment will be considered on time if it is personally delivered or mailed by the due date. (Postmarks affixed by the U.S. Postal Service will be considered proof of date of mailing. Postage meter imprints or any other evidence of mailing date, including date imprints by overnight courier services such as UPS or Airborne, will not be considered proof of date of mailing unless payment is actually delivered to the Benefit Office no later than the first business day immediately following the mailing date shown.)

2. Self-payment amounts are determined by the Trustees based on federal regulations. The amounts are subject to change, but not more often than once a year unless substantial changes are made in the benefits.

3. A person electing COBRA coverage has 45 days after the signed election form is returned to the Benefit Office to make the initial (first) self-payment for coverage provided between the date coverage would have terminated and the date of the payment. (If a person waits 45 days to make the initial payment, the next monthly payment may also fall due within that period and must also be paid at that time.)

4. The due date for each following monthly self-payment is the first day of the month for which payment is made. A monthly self-payment will be accepted if it is received by the Benefit Office within a 30-day grace period after the due date. Your self-payment will be considered on time if it is personally delivered or mailed by the due date.

5. If a self-payment is not made within the time allowed, COBRA coverage for all affected family members will terminate. You may not make up the payment or reinstate coverage by making future payments.

Additional COBRA Coverage Rules

1. COBRA coverage may not be elected by anyone who was not eligible for Plan benefits on the day before the occurrence of a qualifying event.

2. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage.

3. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents.

4. If coverage is going to terminate due to your termination of employment or reduction in hours and you don't elect COBRA coverage for your dependents when they are entitled to the coverage, your dependent spouse has the right to elect COBRA for up to 18 months for herself and

any children within the time period that you could have elected COBRA coverage.

5. A person who is already covered by another group health plan or Medicare may elect COBRA coverage. However, if a person becomes covered under another group health plan or Medicare after the date of the COBRA election, his COBRA coverage will terminate (unless he has a preexisting condition that would cause the other plan to limit or exclude benefits).

6. You do not have to show proof that you and/or your dependents are insurable in order to be entitled to COBRA coverage.

Termination of COBRA Coverage

Normally, COBRA coverage for a person will terminate at the end of the last month of the maximum period to which the person was entitled and for which correct and timely payments were made. However, COBRA coverage for a covered person will terminate before the end of the maximum period when the first of the following events occurs:

1. A correct and timely payment is not made to the Fund.

2. After an election of COBRA coverage, the person becomes entitled to Medicare benefits.

3. After an election of COBRA coverage, the person becomes covered under another group health care plan. Exception: This termination rule will not apply if the person has a preexisting medical condition that would cause benefits to be excluded or limited under the other plan.

4. This Plan no longer provides group health coverage to any employees.

5. The person was receiving extended coverage for up to 29 months due to his or another family member's disability, and Social Security determines that he or the other family member is no longer disabled.

ELIGIBILITY FOR MONTHLY BARGAINING UNIT EMPLOYEES

A "monthly bargaining unit employee" is a person who works for an employer whose collective bargaining agreement with the Trustees requires the employer to make contributions to the Fund for a specified amount per employee per month. Some employers make multi-tiered contributions to the Fund, meaning that they pay different rates for employee-only compared to family coverage. The terms and amount of the required contributions are established by the Trustees and set forth in the employer's collective bargaining agreement.

Employee Coverage

If you are a monthly bargaining unit employee, your initial and continuing eligibility will be determined by the terms of the collective bargaining agreement.

When you are eligible for benefits in accordance with that agreement, the benefits that you will be able to receive are the same medical and prescription drug Plan benefits provided for hourly bargaining unit participants. Your employer's contract with the Plan may also include one or more of the Plan's supplemental benefits, such as dental and vision coverage.

You will be able to make COBRA self-payments if your coverage terminates due to a COBRA qualifying event. (Your employer's failure to make a timely and correct contribution to the Fund is not in itself a qualifying event.)

When you retire, you may participate in the Retiree Benefits program under the same terms and conditions as hourly bargaining unit participants.

If you die while eligible under the Plan, coverage for your surviving dependents will be provided under the provisions that apply to hourly bargaining unit participants.

The hour bank provisions, short-hours self-payment rules, and the eligibility during disability provisions do NOT apply to you.

Dependent Coverage

Coverage for monthly bargaining unit employees generally includes dependent coverage. However, an employer making multi-tiered contributions must make the required payments to the Fund for your dependents.

If your employer is making multi-tiered contributions, and you initially decline dependent coverage because your dependent is covered under another group health plan either as an employee or a dependent, or under a private health insurance policy, then you can add that family member to your coverage later. You may also postpone enrollment of a dependent who is covered under Medicaid or a State Children's Health Insurance Plan (CHIP). To add your dependent after the other coverage terminates, you

must make application within 30 days of the date the other coverage ends (60 days if the other coverage was Medicaid or CHIP). You must include written documentation from the other employer or health plan showing the effective date and termination date of the other coverage. In addition, if you initially decline dependent coverage, you may enroll your dependent later if the dependent becomes eligible for premium assistance through a state Medicaid or CHIP program. You must request enrollment, and provide written proof of the dependent's Medicaid or CHIP eligibility, within 60 days of the date the other coverage starts.

ELIGIBILITY FOR NON-BARGAINING UNIT EMPLOYEES

Contributions for non-bargaining unit participants must be made to the Plan in accordance with the provisions of the employer's participation agreement with the Trustees. Some agreements require the employer to contribute based on a certain number of hours and others require a specified contribution amount per month.

If this applies to you, your initial and continuing eligibility will be determined by the terms of the participation agreement. The benefits you and your covered dependents will be able to receive are also determined by the terms of this agreement.

If your employer is contributing based on hours (this applies to industry-related staff employees of IBEW Unions, or their related funds and credit unions), you may not make short-hours self-payments to continue coverage, but if the participation agreement so provides, the hour bank provisions will apply if your employment terminates, and the eligibility during disability provisions will apply if you become totally disabled.

If your employer is contributing on a monthly basis (this applies to all other non-bargained-for employees, including contractors and employees of contractors, and employees of NECA chapters), the hour bank provisions, short-hours self-payment rules, and the eligibility during disability provisions do not apply to you.

Whether your employer contributes based on hours or specified monthly amounts, you will be able to make COBRA self-payments if your coverage terminates due to a COBRA qualifying event. (Your employer's failure to make a timely and correct contribution to the Fund is not in itself a qualifying event.)

In addition, you may participate in the Retiree Benefits program under the same terms and conditions as hourly bargaining unit participants, and if you die while eligible under the Plan, coverage for your surviving dependents will be provided under the provisions that apply to hourly bargaining unit participants.

RETIREE ELIGIBILITY

You will only be entitled to Retiree Benefits if and to the extent they are included in your employer's contract with the Plan.

You may have a choice of two types of continued Plan coverage for yourself and your dependents when you retire:

1. **COBRA Coverage -** You may be entitled to make COBRA self-payments for up to 18 months; OR
2. **Retiree Benefits -** You can make self-payments for Retiree Benefits as long as you meet the eligibility requirements and make on-time self-payments.

COBRA COVERAGE FOR RETIREES

Retirement is a *qualifying event* under COBRA coverage. When you retire, you may be entitled to make self-payments for up to 18 months for continued coverage under the COBRA coverage rules. If you are receiving pension benefits and elect COBRA coverage, you CANNOT get into the Retiree Benefits plan later, regardless of the length of your COBRA coverage period.

For more information see "COBRA Coverage" starting on page 23.

Medicare entitlement is a *terminating event* under COBRA coverage. A person who is not eligible for Medicare when the election of COBRA coverage is made but who later *becomes* eligible for Medicare will lose the right to make any additional self-payments for COBRA coverage.

RETIREE BENEFITS

The privilege of making self-payments by either you or your spouse to maintain eligibility for Retiree Benefits is not an "accrued benefit." The right to change, reduce or eliminate any and all aspects of benefits provided for retirees and their dependents, including the right to increase the retiree self-payment rate, is a right specifically reserved to the Trustees.

When You Retire

When you retire, if you qualify for Retiree Benefits, your bank hours will be used to maintain your eligibility as an active employee until your hours are exhausted. When your bank hours have been exhausted, your coverage under the Retiree Benefits plan will start. Thereafter, if your employer contributed into the Special Fund, your Special Fund Account may be used to make your self-payments for Retiree Benefits (see page 71 of this booklet for a description of the Special Fund program). You need not use your Special Fund account for this purpose, but you may hold it in reserve to cover eligible medical expenses not covered by the regular plan (see "What Your Account Can Be Used for" starting on page 71).

Remember, only bargaining unit participants, which includes business managers, are entitled to bank hours or Special Fund Accounts. Non-bargained participants in the Plan, such as office employees, unless they are organized

or work under a collective bargaining agreement, as well as NECA representatives or employees, are non-bargained participants in the Plan.

Eligibility Requirements for Retiree Benefits

To be eligible to make self-payments for Retiree Benefits, you must meet the following requirements:

Early and Normal Retirements

1. You must be at least age 55; AND
2. You must be retired from any and all employment in the electrical industry or any organization affiliated with the electrical industry; AND
3. You must be receiving retirement benefits either from an industry plan or Social Security; AND
4. You must be eligible for benefits from this Plan on the day immediately preceding the effective date of your Retiree Benefits; AND
5. You must have been eligible for coverage under this Plan or a predecessor plan for 48 of the 60 months preceding the effective date of your Retiree Benefits (the 48 coverage months do not have to be consecutive).

Disability Retirements

1. You must be receiving disability retirement benefits either from an industry plan or Social Security; AND
2. You must be eligible for coverage under this Plan on the day immediately preceding the date your disability pension becomes effective.

Retiree Benefits Coverage

Retirees are eligible for medical and prescription drug benefits, and a $7,500 Life Insurance benefit. Retiree Benefits do NOT include Dental, Vision, Weekly Disability Benefits, or AD&D Insurance.

Retiree Benefits are identical to Plan 16 medical benefits, including prescription drug coverage. A $7,500 Life Insurance benefit is also provided for covered retirees. Dental Benefits, Vision Benefits, AD&D Insurance and Weekly Disability Benefits are NOT provided for retirees or their dependents.

Note: Your medical benefits do not “start over” when you retire. Any amounts previously applied to any annual, lifetime or per-cause limits and maximums will carry over and count against those same benefit caps under your Retiree Benefits. (This applies to your dependents also.)

Any family member who was an eligible dependent of yours on your retirement date will also be eligible for Retiree Benefits. You can drop dependent coverage when you retire but if you do your dependent’s coverage cannot be reinstated at a later date.

You cannot add a dependent after your Retiree Benefits start.

If your spouse is an eligible dependent on the date of your death, your spouse may continue making self-payments to continue her coverage (see "Benefits for Surviving Dependents of Retirees" on page 36.)

Living Well Health Management Program

The Plan provides a program called the Living Well Health Management Program to help retirees under age 65 and their spouses with diabetes, cardiovascular disease or obesity to improve their quality of life. This program, which is administered by Med-Care Management, Inc., is explained in a separate brochure available from the Benefit Office. If you would like to enroll in the Living Well Health Management Program, call 1-866-844-4222 and a nurse will enroll you. There is no cost to you, and all information you share with the nurses is confidential.

Postponement due to Spousal Coverage

- You can postpone Retiree Benefits coverage for your spouse if your spouse has employer-provided group health coverage. You can also suspend Retiree Benefits coverage for your spouse if, after you retire and elect spousal coverage, your spouse becomes eligible under another employer-provided plan. During the time your spouse has the other coverage, you will only need to pay the single rate for Retiree Benefits for yourself, provided you have no other eligible dependents. Then, when your spouse's coverage terminates (for example, when your spouse retires), you can start paying the higher rate for both you and your spouse.
- To postpone or suspend coverage for your spouse, you must provide proof of your spouse's other coverage to the Benefit Office. To reinstate spousal coverage, you must submit proof that the other coverage has ended. Proof must be submitted within one month after the other coverage terminates. There cannot be a coverage gap of more than one month.
- Your spouse's Retiree Benefits coverage cannot be reinstated unless and until her other coverage terminates.

This rule does not apply to retirees—it is only for spouses. However, if a retiree has a dependent child who is also covered by the spouse's plan, Retiree Benefits coverage for that child can be postponed or suspended, and later reinstated, along with the spouse's.

Coordination of Benefits with Medicare Parts A and B

It is important that you and your spouse enroll in Medicare Part A AND Part B when you are first eligible to do so.

If you and/or your spouse are eligible to participate in Medicare, this Plan's benefits will be calculated as though benefits under Medicare Part A AND Part B have been paid, whether or not you are actually enrolled in both Parts. You and your spouse should enroll in both Medicare Part A AND Part B when eligible to do so.

Medicare Part D Prescription Drug Plans

Medicare prescription drug coverage is available to everyone with Medicare. This coverage is provided through private plans approved by Medicare (often referred to as "Medicare Part D plans"), and you must pay a monthly premium for Part D coverage.

Medicare-eligible retirees (and Medicare-eligible spouses of retirees) have the option of dropping this Plan's prescription drug coverage and switching to a Medicare Part D plan.

- You cannot choose dual coverage.
- Your self-payment amount to this Fund will not go down if you elect to pay premiums for a Part D plan.
- This Fund will not pay your Part D plan premiums.
- You and your spouse can be covered under different drug plans.
- You must inform the Benefit Office if you or your spouse chooses Part D coverage. If you do not provide timely notification, and if the Plan continues to pay your drug expenses, you will have to repay the Fund for the amount it paid. Your double coverage could also cause problems and overpayment situations with your Part D plan.
- If you elect a Medicare Part D plan, you will still be eligible to receive all of your medical (hospital and physician) benefits from this Plan.
- You can get back into this Plan's prescription drug program later, but only after you drop your Part D plan.

Please note that this Plan's prescription drug coverage for retirees is at least as good or better than the coverage provided under a standard Part D plan. Because of this you can keep this coverage and not have to pay an extra late enrollment penalty if you later decide to enroll in Medicare Part D coverage. However, the Medicare Part D late enrollment penalties *will* apply if there is a gap of 63 days or more between your termination date under this Plan and the start of your Part D plan.

SELF-PAYMENT RULES FOR RETIREE BENEFITS

1. You must make your first self-payment on or before the date on which a self-payment to maintain continuous coverage is due. There must be no lapse in coverage between active employee coverage and your Retiree Benefits coverage.

2. The amount of the monthly self-payment is determined by the Trustees and may be changed at any time. Self-payment amounts for retirees are based on the retiree's dependent status and whether or not the retiree and/or his dependents are eligible for Medicare.

3. You must mail your self-payments to the Benefit Office. Each payment must be postmarked no later than the 15th day of the month preceding the benefit month for which you are paying in order to be accepted by the Benefit Office. For example, to be covered during the March benefit month, your self-payment must be postmarked no later than February 15th.

4. If you fail to make a self-payment on or before the date it is due, your eligibility for Retiree Benefits will terminate at the end of the benefit month for which you have already paid. You will not be allowed to make any future self-payments.

5. Once a self-payment has been accepted by the Benefit Office, it will not be returned.

6. If you die while making self-payments for Retiree Benefits, your surviving spouse can continue coverage for herself and any dependent children by making self-payments as explained in the next section.

If You Return to Work

If you return to active employment and have sufficient credited hours to reestablish your eligibility, you will become covered as an active employee and your Retiree Benefits will be suspended. You will not have to make self-payments as long as your active coverage remains in effect. You can resume making retiree self-payments when you return to retired status.

If you do not have enough credited hours to reestablish eligibility, your hours will not be used to offset your self-payments for Retiree Benefits, nor can you make self-payments to make up the shortage.

BENEFITS FOR SURVIVING DEPENDENTS OF RETIREES

If your death occurs while you are making self-payments for Retiree Benefits, your surviving spouse can continue to make retiree self-payments for herself and any dependent children, subject to the following rules:

1. The self-payments must be made according to the same provisions that applied to the self-payments made by you.

2. Your surviving spouse can continue to make self-payments until the earlier of the date on which she remarries or dies unless coverage terminates earlier according to the termination rules stated in the next section.

3. If there is no surviving spouse, or if your spouse dies while making self-payments for continued Retiree Benefits, your surviving dependent children or a legal guardian can make self-payments for continued Retiree Benefits on behalf of the children, subject to the following rules:

   a. Self-payments may be made on behalf of the children for up to a maximum of 36 months, minus any self-payments made by you

before your death and/or any self-payments made by your surviving spouse before her death. If you and/or your spouse have already made a total of 36 self-payments for Retiree Benefits, no self-payments may be made by or on behalf of the children.

b. The self-payments must be made according to the provisions of Self-Payment Rules for Retiree Benefits as though the self-payments were being made by you.

c. Benefits for a surviving dependent child will terminate at the earlier of the end of the allowable maximum coverage period or the date the child fails to meet the Plan's definition of a dependent, unless coverage terminates earlier in accordance with the following termination rules.

TERMINATION OF RETIREE BENEFITS

Retirees

You will cease to be eligible for the applicable benefits provided by the Plan for retirees on the first to occur of the following dates:

1. The date the Trustees terminate Plan benefits;

2. The date the Trustees terminate Plan benefits for retirees;

3. The last day of the benefit month preceding the benefit month for which you fail to make a correct and on-time self-payment;

4. If you go to work for an employer in the electrical industry who is not required to make contributions on your behalf to an IBEW-NECA-sponsored health and welfare fund, on the last day of the month that precedes the month that your electrical industry employment begins; or

5. The date of your death.

Dependents of Retirees

A dependent of yours will cease to be eligible for Plan coverage on the first to occur of the following dates:

1. The date your eligibility for Plan coverage terminates for any reason other than your death;

2. The date the Trustees terminate Plan coverage for dependents of retirees;

3. The date the dependent enters the armed forces of any country on a full-time basis;

4. The date on which the dependent ceases to meet this Plan's definition of a dependent unless the dependent is entitled to COBRA coverage and a

correct and on-time election and self-payment is made by or on behalf of the dependent according to the rules governing COBRA coverage;

5. In the event of your death while you are making self-payments for Retiree Benefits:

   a. At the end of the last day of the last benefit month for which you had made a self-payment before your death unless self-payments are made by or on behalf of the dependent according to the rules governing benefits for surviving dependents of retirees; or

   b. If your surviving spouse is making self-payments to continue Retiree Benefits for herself and any dependent children:

      - If a correct and on-time self-payment fails to be made by or on behalf of the dependent, at the end of the last day of the last benefit month for which a correct and on-time self-payment was made by or on behalf of the dependent;
      - The date the dependent fails to meet the definition of a dependent;
      - With respect to the surviving spouse, the date on which she remarries or dies, whichever occurs first; or
      - With respect to a dependent child in the event of the surviving spouse's death, at the end of the last day of the benefit month in which the spouse's death occurs unless self-payments are made by or on behalf of the child;

   c. If Retiree Benefits for a dependent child are being continued by self-payments by or on behalf of a dependent child because there is no surviving spouse or because of the surviving spouse's death:

      - If a correct and on-time self-payment fails to be made by or on behalf of the child, at the end of the last day of the last benefit month for which a correct and on-time self-payment was made by or on behalf of the child;
      - The date the child fails to meet the definition of a dependent; or
      - At the end of the last day of the last month of the allowable maximum coverage period to which the child was entitled and for which correct and timely self-payments have been made according to the rules governing benefits for surviving dependents of retirees.

EMPLOYEE AND RETIREE LIFE INSURANCE

You will only be entitled to this benefit if it is included in your employer's contract with the Plan.

Life Insurance is provided under a group term life insurance policy issued by a life insurance company selected by the Trustees. Life Insurance benefit payments are governed by the terms of the insurance policy. If there is an inconsistency or question of interpretation between the policy and this booklet, the terms of the policy will prevail.

$20,000 in employee Life Insurance is provided for active eligible employees. $7,500 in Life Insurance is provided for eligible retirees.

If you die while eligible for Life Insurance, your death benefit will be payable to the person you have named as your beneficiary regardless of the cause of your death.

A certified copy of your death certificate must be submitted to the Benefit Office within twelve months after the date of your death in order for your beneficiary to receive the benefit.

YOUR BENEFICIARY

It is your responsibility to see that the person you want to receive your Life Insurance has been named as your beneficiary and is on file in the Benefit Office. You can obtain a beneficiary designation form from the Benefit Office.

If you name more than one beneficiary and you don't identify how much each is to get, or if you don't identify "contingent" beneficiaries, the named beneficiaries will share equally. If you haven't named a beneficiary (or if your beneficiary dies before you do), your Life Insurance benefit will be paid to your first survivor in the following successive classes: your spouse, children, parents, brothers and sisters or your estate. If there is more than one survivor in the class payment is made to, the survivors in that class will share equally.

CONTINUATION OF LIFE INSURANCE DURING TOTAL DISABILITY

Your Life Insurance may be continued at no cost to you if you become totally and permanently disabled while you are eligible for Plan benefits. The amount of your continued Life Insurance is the amount you were eligible for on the date you became disabled. The conditions for receiving this continuation are as follows:

1. Your total disability must start before your 60th birthday.

2. You must be totally and completely unable to perform any and all work in any occupation or business for wage, compensation, or profit.

3. Your total disability must last for at least nine (9) months (or up to the date of your death if death occurs within 9 months from the date you become disabled).

4. You must provide the Trustees with acceptable medical proof that your disability has lasted for at least 9 months. The proof must be furnished after you have been disabled for at least 9 months and before your disability has lasted for twelve months. If the Trustees so request, you must agree to be examined periodically (but not more often than is reasonable) by a doctor chosen by the Trustees.

5. Annually thereafter, if requested by the Trustees, you must provide proof that you remain disabled.

Your Life Insurance will be continued as long as you are disabled. When your disability ends, or if you retire, or if you fail to comply with the above proof requirements, your Life Insurance will no longer be continued.

CONVERSION PRIVILEGE

If your Life Insurance is going to terminate because your eligibility terminates, because of retirement, or because the group insurance policy terminates, you can convert all or a portion of your life insurance benefit to an individual policy without having to submit proof of good health.

The amount of insurance you can convert varies, and is based on the provisions in the Fund's contract with the insurance company. The premium rates for the conversion policy will be the insurance company's premium rates in effect for the amount and type of policy elected, and will be further based on your age and class of risk.

If you wish to apply for an individual policy under this provision, you must submit a written application and make your first premium payment within 31 days from the date your Plan coverage terminates. Please contact the Benefit Office for more information about how to complete the application process.

AD&D INSURANCE

You will only be entitled to this benefit if it is included in your employer's contract with the Plan.

Accidental Death and Dismemberment (AD&D) Insurance is provided for active eligible employees only.

AD&D Insurance benefits are payable if you suffer any of the losses listed on the Table of Losses below while you are eligible for AD&D Insurance. The loss must have resulted from an accident that occurred while you were eligible for AD&D Insurance, and the loss must have been suffered within 365 days of the accident.

AMOUNT OF AD&D BENEFIT

The principal sum of your AD&D Benefit is $20,000. The total amount payable for all losses resulting from any one accident cannot exceed this amount. If you suffer any combination of the losses on the Table of Losses as the result of one accident, only one amount (the largest) is payable for all losses. The amount paid for accidental death is in addition to your Life Insurance.

TABLE OF LOSSES	
	Amount Payable
Loss of Life	Principal Sum (Paid to your beneficiary)
Loss of Limb(s)	
Two hands, two feet, or sight of two eyes	100% of Principal Sum
One foot and sight of one eye; or One hand and sight of one eye; or One hand and one foot	100% of Principal Sum
One hand, one foot, or sight of one eye	50% of Principal Sum
One thumb or index finger	50% of Principal Sum
Paralysis	
Quadriplegia	100% of Principal Sum
Paraplegia or hemiplegia	50% of Principal Sum
Uniplegia	25% of Principal Sum

Loss of a hand or foot means complete severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger of the same hand or four fingers of the same hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Paralysis or paralyzed means total loss of use of a limb. A physician must determine the loss of use to be complete and irreversible.

Quadriplegia means total paralysis of both upper and both lower limbs.

Paraplegia means total paralysis of both lower limbs or both upper limbs. *Hemiplegia* means total paralysis of the upper and lower limbs on one side of the body.

Severance means the complete and permanent separation and dismemberment of the part from the body.

Your beneficiary for loss of life under this benefit is the same as for your Life Insurance. If you change your beneficiary for your Life Insurance, you automatically change your beneficiary for this benefit.

AD&D EXCLUSIONS AND LIMITATIONS (LOSSES NOT COVERED)

No AD&D Insurance will be paid for any loss that occurs more than 365 days after the date of the accident causing the loss; or that is caused directly or indirectly or contributed to by any of the following:

1. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane (except in Missouri where this applies only while sane).
2. Sickness, disease or bodily infirmity; medical or surgical treatment; or bacterial or viral infection, no matter how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental bodily injury or accidental food poisoning.)
3. An accident occurring while you are on full-time active duty for more than 30 days in the armed forces. Reserve or national guard active duty or training are not excluded unless it extends beyond 31 days.
4. Commission of a felony.
5. Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of a doctor. This includes use of alcohol, non-prescriptive drugs or controlled substances, such as PCP (also known as “angel dust”), LSD or any other haullucinogens, cocaine, heroin or any other narcotics, amphetamines or other stimulants, barbiturates or other sedatives or tranquilizers, or any combination of one or more of these substances. (Accidental ingestion of a poisonous substance is not excluded.)
6. War or an act of war, whether or not declared.
7. Travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft you are flying, are learning to fly, or if you are part of the crew of; a military aircraft, other than transport aircraft flown by the U.S. Air Mobility Command (AMC) or a similar air transport service of another country; an aircraft owned or leased by or for a contributing employer, its subsidiaries or affiliates, or if you are a member of his or her household; an aircraft that does not have a valid FAA normal or transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license.

WEEKLY DISABILITY BENEFITS

You will only be entitled to this benefit if it is included in your employer's contract with the Plan.

Weekly Disability Benefits are designed to help replace lost wages when you are totally disabled and unable to work. No Weekly Disability Benefits are payable for any period of time during which you are able to work or while you are a COBRA continuee. Weekly Disability Benefits are NOT provided for retirees or dependents.

ELIGIBILITY FOR WEEKLY DISABILITY BENEFITS

To be eligible for Weekly Disability Benefits, you must meet the following requirements:

1. You must be totally disabled as a result of an accidental bodily injury or sickness and be completely unable to perform each and every duty of your occupation or employment;

2. You must be covered under the Plan on the date your disability begins; and

3. Your must be continuously under the care of a physician.

AMOUNT OF BENEFIT

The amount of your weekly benefit is $250 per week for non-occupational disabilities and $125 per week for occupational disabilities. The weekly benefit will be paid on the basis of a regular five-day work week, Monday through Friday. No benefits are paid for Saturdays and Sundays. If benefits are payable for a partial week, you will receive one-fifth of the weekly benefit for each day of disability.

In accordance with federal law, the Fund will withhold FICA taxes from each weekly payment, and you must include your weekly benefits in your gross income for federal income tax purposes. If you have a question about this, or about exclusions in the law, you should check with a competent tax advisor or attorney.

PERIOD OF PAYMENT/WHEN BENEFITS START

Weekly benefits are payable for up to 26 weeks during any one continuous period of disability.

Weekly benefits will begin:

1. On the first day of disability due to an accidental injury; or

2. On the eighth day of disability due to illness. However, if your disability due to illness lasts eight weeks or more, benefits will be paid retroactively for the first seven days of your disabilities.

If your first visit to a physician is more than three days after your disability starts, benefits will not be paid for the period before you are first examined and determined by the physician to be totally disabled.

If a female employee is disabled due to maternity or a pregnancy-related condition, the disability will be treated as a disability due to illness.

Successive Periods of Disability

Two or more periods of disability due to the same or related causes will be considered one period of disability unless you return to full-time work for a continuous period of at least two weeks between the periods of disability. Successive periods of disability separated by less than two weeks of active full-time work will be considered one period of disability unless the second disability is entirely unrelated to the causes of the first disability and begins after you return to full-time work for at least one full day.

If you have successive periods of disability due to one accident, only the first period of disability will be considered as caused by an accident. All other periods of disability due to that accident will be considered as due to a sickness.

EXCLUSIONS AND LIMITATIONS

No Weekly Disability Benefits will be paid for:

1. Any disability which results from a sickness or injury for which you are not under the direct care of a doctor.
2. Any period of disability after 26 weeks of benefits have been paid.
3. Any period after you reach age 65 or have retired.
4. Any period for which you are eligible to receive Social Security retirement or disability benefits.
5. A disability caused by an act of war.
6. Any disability or days of disability caused by substance abuse:
    a. If you are not undergoing a covered course of treatment;
    b. Beyond the date the covered course of treatment is completed; or
    c. For which Major Medical Benefits are not payable by the Plan, including a course of treatment that is terminated before it is completed.

MAJOR MEDICAL BENEFIT

REVIEW PROGRAM

Med-Care Management, Inc. administers the Plan's Review Program.

Inpatient Hospitalizations

Med-Care's toll-free telephone number is 1-800-367-1934.

You and your dependents are required to pre-certify each inpatient hospitalization by calling Med-Care Management, Inc. prior to admission. The hospital or physician will usually make the call for you, but it is your responsibility to see that the call is made. In case of an emergency admission, Med-Care should be contacted within 48 hours of the admission. The pre-certification requirement and Med-Care's telephone number are on your medical I.D. card.

A $250 benefit reduction will apply to hospitalizations that are not pre-certified.

Pre-certification is a requirement for both in-network and out-of-network hospitalization benefits. Pre-certification is NOT a guarantee of payment. Admissions are approved only when the appropriateness of the inpatient setting can be substantiated. Actual payment is dependent upon the person's meeting the Plan's eligibility rules.

Home Health Care and Durable Medical Equipment

You or your doctor should also call Med-Care prior to your receiving home health care or durable medical equipment. Med-Care will pre-certify the medical necessity of the treatment and will often be able to negotiate better rates for the services, equipment and supplies. Pre-certification is NOT a guarantee of payment.

DEDUCTIBLES AND BENEFIT REDUCTIONS

Calendar Year Deductibles

Calendar year deductibles apply to all medical expenses, unless a specific exception is noted on the Schedule of Benefits.

1. ***$200 PPO Deductible*** **-** Each year you pay the first $200 of your covered PPO medical expenses. These are the charges made by PPO doctors and hospitals for covered services and supplies. A family maximum of $400 applies to all PPO deductibles that must be met by your covered family members in a year.

2. ***$400 Non-PPO Deductible*** **-** A $400 deductible applies to your covered non-PPO (out-of-network) medical expenses each year. A family maximum of $800 applies to all non-PPO deductibles that must be met by your covered family members in a year.

Amounts applied to PPO deductibles also apply toward non-PPO deductibles, and vice versa. If you incur both PPO and non-PPO covered medical expenses during a calendar year, the most you will have to pay in individual deductibles is $400.

These deductibles are based on an accumulation period of a calendar year, and you must satisfy new PPO and non-PPO deductibles each year before the Plan will pay its coinsurance percentage of your covered medical expenses. Only covered medical expenses can be used to satisfy a deductible. The calendar year deductible does not apply to office visits with a PPO physician, and your $20 PPO office visit co-pays do not apply to your deductible.

Emergency Room Deductible

A $100 deductible applies to each occurrence of hospital emergency room treatment, whether the treatment is for an accident or illness, and whether the hospital is a PPO or non-PPO hospital. Emergency room deductibles apply to the facility fees and the emergency room physician's fees. No deductible will apply if the patient is admitted to the hospital as an inpatient directly from the emergency room. These deductibles are in addition to the regular calendar year deductible and do not apply to the out-of-pocket limit.

Benefit Reduction for Failure to Pre-Certify

A $250 benefit reduction will apply to each inpatient hospitalization you or any of your dependents incur that has not been pre-certified in accordance with the Review Program requirements. If a reduction applies, $250 will be subtracted from the covered expenses incurred during the hospitalization before any other applicable deductible or coinsurance is taken. $250 benefit reductions are in addition to the calendar year deductible and do not apply to your out-of-pocket limit.

Office Visit Co-Pays

You must pay the first $20 toward the cost of an office visit with a PPO physician. The Plan pays the balance of the covered expenses at 100%. The office visit co-pay only applies to the physician's charge for the office visit. Charges for supplemental services, such as tests, x-rays, injections, etc. are paid under the regular coinsurance provisions (see the following section).

COINSURANCE (PLAN PAYMENT PERCENTAGES)

The Plan pays the following percentages for covered medical expenses after satisfaction of any applicable deductible:

PPO expenses 100%

Out-of-network (non-PPO) expenses:

Emergency room treatment at an out-of-network hospital for an emergency medical condition, including professional fees..... 100%

Professional charges by a radiologist, pathologist or anesthesiologist for services provided at a BCBS PPO hospital 100%

Other out-of-network expenses 80%

The coinsurance percentages described above do not apply to prescription drugs; refer to the *Prescription Drug Program* section for information about prescription drug benefits.

Non-PPO Out-of Pocket Limit

If your annual combined 20% coinsurance amounts for covered non-PPO medical expenses total $1,000, the Plan payment percentage will be 100% for the covered non-PPO expenses you incur during the remainder of the calendar year.

If the combined 20% coinsurance amounts of two or more of your eligible family members total $2,000 in a calendar year, all covered non-PPO expenses incurred by your eligible family members will be paid at 100% during the remainder of that year.

Deductibles, benefit reductions, and any charges that are not payable due to the Plan's coverage limitations or exclusions do not apply toward meeting these limits. Also, your coinsurance percentages for treatment of substance abuse or mental/nervous disorders do not apply to your out-of-pocket limit, and will not be paid at 100% if your out-of-pocket limit was previously satisfied.

MAXIMUM BENEFITS

A maximum benefit is the most the Plan will pay for a person for a particular type of treatment. Maximums apply to each eligible family member separately, and do not start over if the person's eligibility is interrupted, or if his status changes—for example, when an employee becomes a retiree.

The Plan's maximums and limitations are shown on the Schedule of Benefits. Any amounts paid toward the maximum for a specific benefit also apply to your calendar year Major Medical maximum.

COVERED MEDICAL EXPENSES

Covered medical expenses are the actual charges incurred for the following types of services and supplies which are medically necessary. Except where specifically stated otherwise, the services and supplies must be required in connection with the treatment of a person's injury or sickness. The amount payable is subject to the maximum benefits and limitations shown on the Schedule of Benefits and to all other limitations and exclusions that apply. Only the amount of a charge that is considered an allowable charge is considered a covered medical expense.

1. **Hospital services and supplies**

   a. *Daily room and board*, if semi-private or ward accommodations are used, and general duty nursing care, excluding professional services of doctors, private duty nurses or any individual nursing care, regardless of what it is called. Charges for intensive care or cardiac care units are also covered. If you are admitted to a hospital that has only private rooms, covered charges are based on the hospital's most prevalent room rate.

   b. *Other hospital services and supplies* furnished to a person which are medically necessary and required for treatment of the person's medical condition.

Out-of-network ambulatory surgical center services are NOT covered.

2. **PPO ambulatory surgical center** services and supplies furnished as a result of outpatient surgery.

3. **Other freestanding medical facilities** - services provided by licensed urgent care centers, immediate care facilities and clinics.

4. **Surgery** by a physician. A surgical assistant's fees will also be covered when medically necessary.

5. **Anesthetics** and their administration by a physician.

6. **Doctors' professional services** rendered either in or out of a hospital for medical care and treatment.

Benefits for chiropractic care are limited to 30 visits per person each calendar year.

7. **Chiropractic care** in accordance with the following provisions:

   a. Covered chiropractic expenses include the medically necessary services and supplies provided by a chiropractor for treatment of a non-occupational injury or sickness, including diagnostic x-rays, laboratory tests and imaging services.

   b. Up to 30 chiropractic care visits are allowable every calendar year.

8. **Professional services by other covered providers** - professional medical services provided by the following types of licensed providers when the services are within the Plan's normal covered expense provisions and are rendered within the scope of each such individual's

license and specialty, and if payment would have been made under this Plan to a doctor for the same services:

a. An advanced practice nurse (a registered nurse) with a Master's or better degree who is licensed to practice in a clinical setting, for example, an N.P., L.N.P., C.N.P, C.N.S., or C.R.N.A.);

b. For mental/nervous disorders and substance abuse treatment: a licensed clinical psychologist, a licensed Masters-level clinical social worker, a licensed Masters-level professional counselor, a licensed psychoanalyst, or a clinical specialist psychiatric nurse;

c. A physician's assistant (P.A.);

d. A surgical assistant;

e. A registered nurse first assistant;

f. A licensed midwife (for pregnancy-related services only);

g. A doctor of dentistry (D.D.S.);

h. A podiatrist (D.P.M.); and

i. A doctor of optometry (O.D.).

9. **X-ray, laboratory** examinations, and diagnostic imaging and tracing services (such as EKGs, MRIs, computerized scans, sonograms, mammograms, etc.), including services of radiologists and pathologists.

10. **Chemotherapy and radiation**, radioisotope and nuclear medicine therapy.

11. **Rehabilitative therapy** (other than speech therapy) provided on an outpatient basis for the following:

The Plan allows up to 50 visits for all rehabilitative therapy per calendar year.

a. *Physical therapy* rendered by a registered physical therapist, or a licensed physical therapy assistant working under the supervision of the physical therapist on an inpatient or outpatient basis, provided the therapy is recommended by the attending doctor.

b. *Occupational therapy* prescribed by a physician and performed by an accredited occupational therapist, or licensed occupational therapy assistant working under the supervision of the occupational therapist. The therapy must provide task-oriented therapeutic activities designed to significantly improve or restore physical functions lost or impaired as a result of a disease, or injury; or to relearn daily living or performance skills or compensatory techniques in order to improve the level of independence. Driver training is not covered, nor are any services related to learning disabilities, developmental delays, mental retardation, brain damage not caused by accidental injury or illness, minimal brain dysfunction, or dyslexia.

c. *Cardiovascular rehabilitation therapy* that is rendered through a supervised medical cardiac rehabilitation program prescribed by a physician within six months after an acute cardiovascular incident

for a patient with modifiable coronary risk factors or poor exercise tolerance.

The Plan allows up to 50 visits for all covered rehabilitative therapy combined per calendar year.

Speech therapy for developmental delays and learning disorders is excluded.

12. **Speech therapy** to restore speech abilities lost due to stroke or trauma. Benefits are limited to 50 visits per person per calendar year.

13. **Preventive care** - The Plan covers a wide variety of preventive services and supplies provided by PPO providers. The complete list is in a separate document provided to all participants.

14. **Breast reconstructive surgery** on the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

15. **Dialysis treatment**.

16. **Diabetic treatment -** equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional counseling for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by the physician.

17. **Ambulance -** local service to a hospital in connection with care for a medical emergency or if otherwise medically necessary. The Plan also covers your transfer from one hospital to another, and air ambulance, if medically necessary.

18. **Mental or nervous disorders** treatment as follows:

Benefits for mental/nervous disorders are limited to 30 days of hospital confinement and 60 outpatient visits per calendar year.

a. *Hospital inpatient treatment* - When treatment is rendered as an inpatient, covered expenses include the hospital's daily room and miscellaneous charges, including diagnostic x-rays and laboratory work. Benefits are payable for up to 30 days of inpatient treatment per calendar year.

b. *Partial inpatient/intensive outpatient treatment* - The Plan covers partial inpatient and intensive outpatient treatment, which is defined as treatment provided at a facility for at least three hours but less than twelve hours per day. Two days of such treatment count toward the 30-day limit as one inpatient day.

c. *Outpatient or office treatment* - When individual treatment is rendered to a patient who is not hospital confined, covered expenses include up to 60 outpatient or office visits per calendar year.

Prescription drugs for mental/nervous disorders are payable under the Prescription Drug Program.

Benefits for substance abuse treatment are subject to annual and lifetime limitations.

19. **Substance abuse treatment** at an approved substance abuse treatment facility as follows:

    a. *Inpatient treatment* - up to 30 days of inpatient treatment during a calendar year and up to 60 days during the person's lifetime.

    b. *Partial inpatient/intensive outpatient treatment* - The Plan covers partial inpatient and intensive outpatient treatment, which is defined as treatment provided at a facility for at least three hours but less than twelve hours per day. Two days of such treatment count toward the 30-day limit as one inpatient day.

    c. *Outpatient or office treatment* - up to 30 visits during a calendar year and up to 60 visits during the person's lifetime.

    Prescription drugs for substance abuse treatment disorders are payable under the Prescription Drug Program.

20. **Dental treatment,** limited to:

    a. Treatment of accidental injury to sound natural teeth, including the initial replacement of such teeth and any necessary dental x-rays, provided the first treatment is received within twelve months of the accident causing the injury.

    b. General anesthesia and associated hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following:

    - A patient who is age 7 or younger;
    - An individual for whom a successful result cannot be expected by local anesthesia due to neurological disorder; or
    - An individual who has sustained extensive facial or dental trauma (other than for a work-related injury).

    The services listed above are the only dental-related procedures covered under the Major Medical Benefit. The only other benefits payable by the Plan for dental procedures, including oral surgery and removal of impacted teeth, are provided under the provisions of the Dental Benefit.

21. **Maternity expenses** for prenatal care and delivery in a hospital, and medically necessary services and supplies provided in connection with delivery in a birthing center or at home. Routine well-newborn nursery care and pediatric visits during the initial confinement are also covered. The Plan covers pregnancy-related expenses for employees and their dependent spouses only.

    Note About Length of Maternity Confinements: An eligible female, and her newborn infant, are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarean section. (The attending

provider may, however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section.) Benefits are payable for the covered medical expenses incurred by an eligible female during the prescribed time periods, subject to the applicable deductibles, coinsurance and maximum benefits shown on the Schedule of Benefits.

22. **Vasectomies** and other sterilization procedures for employees and dependent spouses.

23. **Certain infertility-related services -** diagnostic testing to determine the cause of a person's infertility, and surgical or medical treatment to treat the underlying medical cause of the infertility. Services to promote conception, including but not limited to the following, are NOT covered: 1) hormone therapy; 2) artificial intrauterine insemination; or 3) the implanting of a fertilized egg, gamete or zygote by any means, including but not limited to in vitro fertilization, gamete intrafallopian transfer, or zygote intrafallopian transfer.

24. **Obstructive sleep apnea treatment.** (Treatment of snoring without sleep apnea is not covered.)

The Plan covers one hearing aid per ear during a person's lifetime.

25. **Hearing aids,** including their fitting by a licensed professional - one hearing aid per ear during the person's lifetime.

26. **Cochlear implants** when medically necessary and appropriate for a person with severe-to-profound sensorineural hearing impairment who can obtain limited benefit from a conventional hearing aid, up to one per person per lifetime.

27. **Organ/tissue/bone marrow transplants** as described in the *Benefits for Transplants* section starting on page 55.

Up to 120 home health care visits are covered per calendar year.

28. **Home health care -** up to 120 visits per calendar year (a visit consists of up to four hours of care), for part-time or intermittent nursing care provided by a home health agency, subject to the following requirements:

    a. The services and supplies must be provided by or through a home health agency as defined in the *Definitions* section;

Home health care requires pre-certification.

    b. A program of home nursing care must be established and approved in writing by the patient's doctor within seven days after an inpatient hospital stay;

    c. The doctor must certify that the home nursing care is for the same or related condition for which the patient was hospitalized and that proper and medically necessary treatment of the patient's condition would require hospital confinement in the absence of the services and supplies provided as part of the program of home nursing care; and

d. The home health care program must be pre-certified.

Covered home health care services - The following services are covered by the Plan:

a. Visits by an R.N. or L.P.N.

b. Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.

c. Visits to render services and/or supplies of a licensed medical social services worker when medically necessary to enable the patient to understand the emotional, social, and environmental factors resulting from or affecting the patient's illness.

d. Visits by a home health nursing aide when rendered under the direct supervision of an R.N.

e. Nutritional guidance when medically necessary.

f. Administration of prescribed drugs.

g. Oxygen and its administration.

The Plan pays up to 60 days per calendar year for covered skilled nursing facility care.

29. **Inpatient skilled nursing facility care,** including room and board and medically necessary services and supplies for up to 60 days per person per calendar year, subject to all the following requirements:

a. A doctor must certify that the confinement and nursing care are necessary for the patient's recuperation from an injury or sickness.

b. The patient must require continuous 24-hour-a-day nursing care.

c. The confinement must be provided in a facility which meets the Plan's definition of a skilled nursing facility.

30. **TMJ treatment** and treatment for other jaw disorders, including hospital and doctors' services, and other medically necessary services and supplies provided for or in connection the treatment.

31. **Durable medical equipment -** rental charge up to the purchase price of the equipment. The equipment must be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the patient's medical condition.

Durable medical equipment requires pre-certification.

The equipment must meet all the following criteria:

a. It is related to the patient's physical disorder.

b. It is appropriate for in-home use.

c. It can stand repeated use.

d. It is manufactured solely to serve a medical purpose.

e. It is not merely for comfort or convenience.

f. It is normally not useful to a person not ill or injured.

g. It is ordered by a physician.

h. The physician certifies in writing the medical necessity for the equipment. The physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing medical necessity of any item.

32. **Prosthetic appliances** and devices to improve or correct conditions resulting from accidental injury or illness and that are ordered by a physician. Covered prosthetic devices include: artificial limbs and accessories; artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); external breast prostheses used after breast removal, limited to one prosthetic per side and two brassieres per calendar year. Exclusions include but are not limited to penile implants, corrective shoes and foot orthotics.

33. **Medical supplies**, such as:

    a. *Drugs and medicines* which may only be legally dispensed by a registered licensed pharmacist according to a doctor's written prescription which includes the name of the drug, and certain diabetic supplies not requiring a doctor's prescription. Refer to *Prescription Drug Program* on page 58 for more information about obtaining prescription drugs.

    b. *Whole blood* (if not donated or replaced) or blood plasma and the administration of such substances.

    c. *Bandages, surgical dressings, casts, splints, trusses, crutches and orthopedic braces.*

    d. *Surgical supplies*, including the first charge incurred for surgical supplies required to aid any impaired physical organ or part in its natural body function.

    e. *Oxygen* and rental of the equipment for the administration of oxygen.

34. **Hospice** services as follows, when provided by an organization meeting the Plan's definition of a hospice to an eligible person who is terminally ill (medical prognosis indicates a life expectancy of six months or less):

    a. Nursing care by an R.N. or L.P.N. and services of home health aides (such services may be furnished on a 24-hour basis during a period of crisis or if the care is necessary to maintain the patient at home).

b. Chaplaincy and medical social services, counseling services and/or psychological therapy by a social worker or a psychologist.

c. Physical and occupational therapy and speech language pathology.

d. Short-term inpatient care to provide respite care, palliative care or care in periods of crisis. The maximum allowable number of respite care days is eight per lifetime.

BENEFITS FOR TRANSPLANTS

A "transplant" means a procedure or series of procedures by which an organ or tissue is either removed from the body of one person (called a "donor") and implanted in the body of another person (called a "recipient"); or removed from and replaced in the same person's body (called a "self-donor").

Covered Transplants

In order to be covered, a transplant must be a medically appropriate transplant of one of the following organs or tissues only, and no others:

1. Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.

2. Autologous (self-donor) bone marrow transplants with high-dose chemotherapy is considered eligible for coverage on a prior approval basis, including covered donor costs, but only if required in the treatment of one of the following conditions:

   a. Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB.

   b. Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB.

   c. Neuroblastoma, Stage III or Stage IV.

   d. Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have an HLA-compatible donor available for allogenic bone marrow support.

   e. Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds.

   f. Metastatic breast cancer that has not been previously treated with systemic therapy, is currently responsive to primary systemic therapy, or has relapsed following response to first-line treatment.

   g. Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse.

3. Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of one of the following:
   a. Aplastic anemia.
   b. Acute leukemia.
   c. Severe combined immunodeficiency exclusive of acquired immune deficiency syndrome (AIDS).
   d. Infantile malignant osteoporosis.
   e. Chronic myelogenous leukemia.
   f. Lymphoma (Wiscott-Aldrich syndrome).
   g. Lysosomal storage disorder.
   h. Myelodysplastic syndrome.

Pre-Certification Requirement

All transplant procedures must be pre-certified by Med-Care Management for type of transplant and be medically appropriate according to criteria established by the Plan. The pre-certification requirements are a part of the benefit administration of the Plan and are not a treatment recommendation. The actual course of medical treatment the patient chooses remains strictly a matter between the patient and his physician.

Live Donors

If the transplant involves a living donor, covered donor costs are as follows:

- If a patient receives a transplant and the donor is also covered under this Plan, payment for the recipient and the donor will be made under each individual's coverage.
- If the donor is not covered under this Plan, benefits will be limited by any payment which might be made under any other hospitalization coverage plan.
- If the participant is the donor and the recipient is not covered under this Plan, benefits will be limited by any payment which might be made by the recipient's hospitalization coverage with another company. No payment will be made under this Plan for the recipient.

General Provisions and Definitions

"Covered donor costs" means all costs, direct and indirect (including administration costs), incurred in connection with medical services required to remove the organ or tissue from either the donor's or the self-donor's body; preserving it; and transporting it to the site where the transplant is performed.

Benefits for antirejection drugs are payable under the Prescription Drug Program.

Covered services include certain services and supplies not otherwise excluded in this SPD booklet and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (donor costs), post-operative care (including antirejection drug treatment) and transplant-related chemotherapy.

INDIVIDUAL CASE MANAGEMENT

The Trustees may authorize coverage of services, supplies or treatment settings not normally covered by the Plan on the basis that, in the opinion of the Trustees, such treatment is cost effective for the Plan and clinically appropriate for the individual. The Trustees may rely on the opinion of a health care professional who is qualified to render advice on the issue as to whether a service or supply not normally covered by the Plan is medically necessary, medically appropriate and cost-effective for the Plan in a particular case. Any alternative services covered under this provision shall be specific to the individual case and shall in no event set a precedent with respect to other similar claims.

PRESCRIPTION DRUG PROGRAM

Packets containing two prescription drug cards and additional information about your prescription drug program are sent to all participants when they first become eligible for benefits.

YOUR PRESCRIPTION DRUG CO-PAYS

Sav-Rx administers the Plan's prescription drug. You can contact Sav-Rx for customer service at 1-866-IBEW (4239), or at www.savrx.com.

You pay the following co-pay amounts for covered prescription drugs purchased at a participating retail pharmacy or the Sav-Rx mail-order pharmacy:

Generics 0%
Formulary brands..... 20%
Non-formulary brands ..... 30% minimum $40 retail/$80 mail

Your brand name co-pay will be $0 for the remainder of any calendar year in which your co-pays have reached a combined total of $1,000.

This out-of-pocket limit applies separately to each covered family member, and applies to all covered retail and mail-order drugs purchased through the prescription drug program.

If you decline a generic substitution, you must pay the cost difference between the brand and generic. That difference does not apply to your out-of-pocket limit.

If you decline a generic substitution, you must pay the cost difference between the brand and generic. The difference does not apply to your out-of-pocket limit and must be paid even after your out-of-pocket limit has been met.

"Formulary" brands are medications that have been evaluated by physicians and pharmacists, and have been determined to be the most effective treatments for most patients. These drugs are also reasonably priced. For the most recent information about the formulary or the status of a specific drug, contact Sav-Rx.

"Generic drugs" are those with multiple manufacturers. You may have to pay the 20% or 30% co-pay for a drug sold by one or just a few manufacturers even if that drug is called "generic."

The Prescription Drug Program is separate from the Major Medical Benefit. Your prescription drug co-pays do not apply to your Major Medical deductible or out-of-pocket limit.

DRUG CARD PROGRAM

Your Sav-Rx drug card is recognized at most pharmacies nationwide. Most of the major pharmacy chains are in the network.

You pay your co-pay amount directly to the participating pharmacy—there are no claims to file. You can get up to a 30-day supply at one time.

Wal-Mart and Sam's Club are NOT in your network. No benefits will be paid for drugs purchased at these chains.

You should use the retail drug card program ONLY for short-term prescription drugs such as an antibiotics or pain relievers. Your out-of-pocket costs

will be lower if you use the mail-order program for your long-term prescription drug needs.

MAIL-ORDER PHARMACY

You will save money when you use the mail-order pharmacy.

When you order your covered prescription drugs through the Sav-Rx mail-order pharmacy, you pay your co-pay amount directly to the mail-order pharmacy. You can receive up to a 90-day supply of each prescription or refill, and your medications will be delivered to your home, postage paid.

STEP THERAPY PROGRAM

Under a step therapy program, certain medications are grouped into "steps." Generic medications, which are the most cost effective, fall into the "first-step" category, formulary brand-name medications fall within the "second-step" category, and non-formulary brand-name medications, which are the least cost-effective, fall into the "third-step" category. A step therapy program steers participants to take first-step medications prior to coverage of a second-step medication, and to take a second-step medication prior to coverage of a third-step medication.

This Plan currently has step therapy programs for proton pump inhibitors (PPIs), which are for gastric acid, and statin drugs, which are for high cholesterol.

Drug Type	1st Step	2nd Step*	3rd Step*
Proton pump inhibitors (for gastric acid)	Omeprazole Pantoprazole Lansoprazole	Nexium	Aciphex Dexilant Prevacid Prilosec Protonix
Statins (cholesterol-lowering)	Lovastatin Pravastatin Simvastatin	Lipitor Advicor Vytorin Simcor Atorvastatin	Crestor Lescol XL Mevacor Pravachol Zocor

** Prior authorization required.*

Second and third step PPIs and statins will NOT be covered unless your medication history shows compliance with the Step Therapy Program, or unless you obtain a prior authorization from the Sav-Rx clinical team. Your physician should call Sav-Rx to request prior authorization.

Remember that you pay a higher co-pay for brand medications compared to generics, and for non-formulary brands compared to formulary brands, even if they are pre-authorized.

This program applies to drugs purchased at retail pharmacies or through the mail-order pharmacy.

SPECIALTY DRUGS

Specialty drugs are medications that are used to treat complex conditions, such as cancer, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. They are often self-injected or administered under professional supervision, and require special handling by the pharmacy.

All specialty drugs require prior authorization and utilization review by Sav-Rx, whether the medication is purchased at a retail pharmacy or through the mail-order pharmacy.

Each fill of a specialty drug will be limited to a 30-day supply.

WHEN YOUR SPOUSE HAS OTHER COVERAGE

If your spouse has coverage under another health plan, she must follow the rules of her prescription drug plan first. A claim can then be filed with Sav-Rx for payment consideration of any amount not paid by her plan under the Major Medical Benefit. This same process must be followed for any children for whom your spouse's plan pays primary benefits.

COVERED PRESCRIPTION DRUGS

Covered drugs and medications under the Prescription Drug Program are the same as those covered under the Major Medical Benefit, and the *Exclusions and Limitations section* starting on page 75 apply to this program. For example, the Plan does not cover over-the-counter (non-prescription) or experimental/investigative drugs, vitamins or nutritional supplements, or drugs for birth control, infertility, obesity, sexual dysfunction or smoking cessation, even if you have a doctor's prescription.

DENTAL BENEFIT

You will only be entitled to this benefit if it is included in your employer's contract with the Plan.

The Plan's Dental Benefits are provided through **MetLife**—MetLife handles all dental claims and administers a preferred provider network of dentists that provides negotiated fee discounts to Plan participants.

Dental Benefits are not provided for retirees or their dependents.

YOUR DENTAL PPO NETWORK

This dental plan gives you access to dentists through the MetLife Preferred Dentist Program (PDP). Dentists participating in the PDP have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service.

Maximum Allowed Charge means the lesser of: 1) the amount charged by the dentist; or 2) the maximum amount which the in-network dentist has agreed with MetLife to accept as payment in full for the dental service.

This means you may be able to reduce your out-of-pocket costs by using an in-network dentist.

To find a participating dentist, go to www.metlife.com or call 1-800-942-0854.

However, the Plan pays benefits for covered services performed by either in-network dentists or out-of-network dentists. You are always free to receive services from any dentist.

You do not need any authorization from MetLife or the Benefit Office to choose a dentist. You do not have to sign up for services from a particular dentist, you can change dentists at any time, and you can receive services from more than one dentist during a year.

ANNUAL DENTAL DEDUCTIBLE

Each calendar year you must pay the first $25 out of your own pocket before benefits are payable for your remaining expenses. The dental deductible is based on an accumulation period of a calendar year, and you must satisfy a new deductible each year. Only covered dental expenses can be used to satisfy a deductible.

The deductible does not apply to preventive services.

After three or more persons in your family have had amounts applied to their individual dental deductibles that together equal $75 for a particular calendar year, your family dental deductible will have been satisfied for that year, and no further individual deductibles will be required of you or your eligible dependents for the rest of that calendar year.

CALENDAR YEAR MAXIMUM BENEFIT

The Plan pays up to a maximum of $1,500 for all the covered dental expenses you incur in a calendar year. (The maximum does not apply to children under age 19.) No deductible applies. Once you have received $1,500 for services and supplies performed during a calendar year, you will not be entitled to any further dental benefits for services and supplies obtained during the rest of that year. The maximum applies even if your eligibility is interrupted, or if your status changes—for example, when you retire.

COVERED DENTAL EXPENSES

Covered dental expenses are the reasonable and customary charges you or your eligible dependents incur for the following services and supplies which are necessary for treatment of a dental condition.

For in-network dental expenses, your benefit will be based on the covered percentage of the Maximum Allowed Charge. For out-of-network dental expenses, your benefit will be based on the covered percentage of the reasonable and customary charge.

Preventive Care (100%)

1. Routine oral examinations and prophylaxis (scaling and cleaning of teeth, including periodontal maintenance prophylaxis), up to two per calendar year.

2. Emergency palliative treatment.

3. Dental x-rays, including full mouth x-rays (once in a period of 36 consecutive months), supplementary bitewing x-rays (up to two sets per calendar year), and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

4. For dependent children under age 19 (only):

   a. Topical application of fluoride once per calendar year.

   b. Space maintainers that replace prematurely lost teeth.

   c. Sealants on permanent molars and bicuspids, no more than once every five years.

Basic Restorative Care (80%)

1. Extractions.

2. Oral surgery.

3. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.

4. General anesthetics when medically necessary and administered in connection with oral surgery.

5. Treatment of periodontal and other diseases of the gums and tissues of the mouth.

6. Endodontic treatment, including root canal therapy.

7. Injection of antibiotic drugs by the attending dentist.

8. Repair or cementing of crowns, inlays, onlays, bridgework, implants or dentures, up to one repair per prosthetic every twelve months; or relining or rebasing of dentures.

Major Restorative Care (60%)

1. Inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration.

2. Initial installation of fixed bridgework (including inlays and crowns as abutments).

3. Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation).

4. Replacement of an existing partial or full removable denture, fixed bridgework, an inlay, an onlay or a single crown by a new denture, bridgework, inlay, onlay or crown, or the addition of teeth to an existing partial removable denture, but only if satisfactory evidence is presented that:

   a. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;

   b. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve months from the date of initial installation of the immediate temporary denture; or

   c. The existing denture, bridgework, inlay, onlay or single crown cannot be made serviceable and at least five years have elapsed prior to its replacement.

   Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, charges for such bridgework will be included as covered dental expenses.

5. Tooth implants, but no more than one per tooth position every five years (60 months).

ORTHODONTIA BENEFITS (Dependent Children Only)

This benefit covers diagnostic procedures, including cephalometric x-rays, and appliance therapy (braces). Benefits are only payable for dependent children of active employees.

Covered orthodontia expenses are payable at 50% up to a maximum of $2,000 per child per lifetime. No deductible applies and orthodontia benefits do not apply to the child's regular annual dental maximum.

No benefits are payable for orthodontic therapy that was incurred when the patient was not eligible for orthodontia benefits. The initial treatment is considered incurred on the date the dentist takes the initial x-rays, impressions or other measurements for the purpose of designing a corrective treatment plan. The Plan will not cover treatment (including scheduled monthly payments for treatment already in progress) rendered (or due) after the patient's eligibility for benefits has terminated. Replacement or repair of a lost or broken removable orthodontic device is also excluded.

DENTAL EXCLUSIONS AND LIMITATIONS

No Dental Benefits are payable for:

1. Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a dentist. The Plan also covers services performed by a denturist who is licensed as a denturist in the state in which the services are performed.

2. Services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.

3. Orthodontia-related services for an employee, retiree, or spouse of an employee or retiree.

4. The replacement of a lost, missing, or stolen removable prosthetic device unless no benefits were paid by this Plan for that prosthetic device.

5. Any duplicate prosthetic device or any other duplicate appliance.

6. Oral hygiene, dietary instruction, or a plaque control program.

7. Tooth re-implantation at the same tooth position unless the prior implant is more than five years (60 months) old.

8. Occlusal adjustments.

9. Splints; or appliances (such as night guards) used to control harmful habits.

10. Services performed by a denturist who is not licensed as a denturist in the state in which the services are performed.

11. Treatment of conditions related to the temporomandibular jaw joint (TMJ).

12. Treatment for opening of vertical dimension.

13. Services or supplies received as a result of dental disease, defect, or injury due to war, declared or undeclared, or any act of war or aggression.

14. Dental care or services paid for or furnished by or at the direction of any governmental agency, but only to the extent paid for or furnished.

15. Dental procedures that are included as covered medical expenses under the Major Medical Benefit.

16. Prosthetic devices (including bridges and crowns), and the fitting of such devices, which are ordered while the individual is not eligible for Dental Benefits.

17. Prosthetic devices (including bridges and crowns), and the fitting of such devices, which are ordered while the person is eligible for Dental Benefits but which are finally installed or delivered to the person more than 90 days after termination of eligibility.

18. Treatment incurred while a person is not eligible for Dental Benefits.

    a. For full or partial dentures, treatment is considered incurred when the impression is taken for the appliances.

    b. Root canal therapy is considered incurred when the tooth is opened.

    c. Fixed bridgework, crowns, and other gold restorations are considered incurred when the tooth is first prepared.

ADDITIONAL PROVISIONS GOVERNING DENTAL BENEFITS

Extension of Dental Benefits

Dental Benefits will be available for a person for 90 days after his eligibility terminates for covered dental expenses incurred for:

1. Fillings, bridgework, crowns or gold restorations, provided the tooth was prepared while the person was eligible for Dental Benefits; or

2. Full or partial dentures, provided the impression for the appliance was taken while the person was eligible for Dental Benefits; or

3. Endodontic treatment, provided the tooth was opened for root canal therapy while the person was eligible for Dental Benefits.

Predetermination of Benefits Procedure

If the dentist's charges will be $200 or more, your claim should be submitted to MetLife for predetermination of benefits before the work is started.

If you don't request a predetermination, you can just submit your claim after the dental work is done. However, you may be confronted with a large unexpected out-of-pocket cost.

Note: A predetermination of benefits does not guarantee payment of dental benefits. Coverage is valid only upon determination of eligibility.

Alternate Courses of Treatment

If MetLife determines that a service, less costly than the covered service the dentist performed, could have been performed to treat a dental condition, benefits will be paid based upon the less costly service if such service: 1) would produce a professionally acceptable result under generally accepted dental standards; and 2) would qualify as a covered service.

VISION BENEFIT

You will only be entitled to this benefit if it is included in your employer's contract with the Plan.

The Plan's Vision Benefits are provided through a contract with an organization called **Vision Service Plan (VSP).** VSP provides a preferred provider network and claims administration services.

Vision Benefits are not provided for retirees or their dependents.

HOW THE VSP PROGRAM WORKS

The VSP program provides different levels of coverage depending on whether you choose a VSP doctor or an out-of-network doctor. To maximize your vision coverage, use a VSP doctor. Out-of-network reimbursement rates do not guarantee full payment, and VSP cannot guarantee your satisfaction when services are received from out-of-network doctors.

1. You Can Use a VSP Doctor

VSP has a large network of private practice doctors, and most participants will be able to find a VSP doctor in their area.

If you use a VSP doctor, the covered vision services listed in the schedule below are provided at no cost to you. If you select lenses or a frame that costs more than the amount allowed by VSP, you pay an additional discounted charge directly to the VSP doctor.

To find a VSP doctor call 1-800-877-7195 or go to www.vsp.com

VSP guarantees your satisfaction when services are provided by a VSP doctor. VSP doctors provide examinations, professional services, lenses, and offer a wide selection of frames to choose from. The VSP doctor bills VSP directly, so you have no claim forms to complete. You can pay the VSP doctor directly for any additional non-covered services and/or materials. Note that many services, such as progressives, scratch-resistant and anti-reflective coatings, are discounted for VSP participants.

Benefits for <u>VSP Network</u> Vision Care

Vision exam	Provided in full
Lenses (per pair):	
Single	Provided in full
Lined bifocal	Provided in full
Lined trifocal	Provided in full
Lined lenticular	Provided in full
Contacts (elective)	Provided up to $120 allowance
Frame	Provided up to $115 allowance
Safety Glasses*	Provided up to $65 frame allowance.

* *The safety glass benefit is for employees only. One pair is provided per calendar year in addition to regular eyeglasses.*

Participants who use VSP doctors can receive discounts on additional pairs of eyewear, and VSP provides a disposable contact lens program. These services are NOT part of your NECA/IBEW Family Medical Care Plan of Benefits—they are provided by VSP and their participating providers.

2. You Can Use an Out-of-Network Provider

You can go to any optometrist, ophthalmologist and/or dispensing optician for your vision care. You must pay the provider in full and then file a claim with VSP for reimbursement. You will be reimbursed according to the following schedule.

Benefits for Out-of-Network Vision Care

Vision exam	$35
Lenses (per pair):	
Single	$30
Lined bifocal	$40
Lined trifocal	$55
Lined lenticular	$55
Contacts (elective)	$120
Frame	$35
Safety Glasses*	
Frame	$25
Single vision	$30
Bifocal	$35
Trifocal	$45
Lenticular	$60

* *The safety glass benefit is for employees only. One pair is provided per calendar year in addition to regular eyeglasses.*

COVERED VISION EXPENSES

Whether you use a VSP doctor, an out-of-network provider, or a combination of both, you can receive benefits for:

1. *One vision examination* per calendar year.
2. *Either* of the following per calendar year:
   a. *One frame* with a pair of corrective lenses; OR
   b. *Contact lenses.* The contact lens allowance includes the lens fitting and evaluation fee. As long as your contact lenses contain a prescription, your allowance remains the same for all types of contact lenses ($120). If the contact lenses, fitting and evaluation fees exceed $120, you are responsible for the payment of any remaining balance. VSP has guidelines and limitations regarding certain disposable

contact lens materials. Please contact VSP at 1-800-877-7195 for more information.

3. *One pair of safety glasses per calendar year for active eligible employees.* VSP doctors will use materials certified as safe for a work environment by meeting the required test standards as set forth by the American National Standards Institute (ANSI).

Note: Visually necessary contact lenses received from a VSP doctor are provided in full subject to prior authorization from VSP. "Visually necessary contact lenses" are prescribed for treatment following cataract surgery, to correct extreme vision problems not correctable with prescription glasses, and for certain conditions of anisometropia and/or keratoconus. An allowance of $210 is provided when visually necessary contacts are purchased from an out-of-network provider. Coverage is subject to review and authorization from VSP's optometric consultants, regardless of whether the lenses are obtained from a member doctor or out-of-network provider.

VISION BENEFIT LIMITATIONS AND EXCLUSIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When you select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you will pay the additional costs for premium options, including but not limited to:

- Anti-reflective, color, mirror or scratch coating;
- Blended, cosmetic, laminated or oversize lenses;
- Progressive multifocal lenses;
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2;
- UV (ultraviolet) protected lenses;
- A frame that costs more than the stated allowances;
- Contact lenses (except as stated); or
- Optional cosmetic processes.

In addition, Vision Benefits are not payable for:

1. Examinations or materials more frequently than once every calendar year (except for disposable contact lenses).

2. Vision analysis or examination that does not include refraction.

3. Lenses, frames or contact lenses which are lost or broken except at the normal interval when benefits are available.

4. Two pair of glasses instead of bifocals.

5. Special procedures such as orthoptics or visual training.

6. Nonprescription lenses, or frames that do not include prescription lenses.

7. Services or supplies related to medical or surgical treatment of the eyes.
8. Correction of refractive errors or astigmatism by laser or surgery. (This is not payable under ANY Plan benefit.)
9. Services or supplies furnished or billed by a person who is not a legally qualified or licensed ophthalmologist, optometrist or optician.

INDIVIDUAL SPECIAL FUND ACCOUNTS

You will only be entitled to this benefit if it is included in your employer's contract with the Plan.

Your Special Fund Account is not a savings account from which you can withdraw at will. You are not "vested" in any part of the balance of your Special Fund Account. Any of the provisions of the Special Fund portions of the Plan, like all Plan provisions, may be altered or amended by the Trustees at any time and for any reason. In addition, the list of covered expenses and any of the Special Fund's rules and procedures can be changed at any time by the Board of Trustees. You do not have a present right to payment of any amount of the balance of the Special Fund Account, other than for reimbursement of covered expenses.

WHAT IS THE SPECIAL FUND?

This Fund offers a Special Fund program. Under this program, participating employers contribute specified amounts per hour of work into a Special Fund Account in the individual employee's name. The amounts that accumulate in this account can then be used by the employee for certain specified expenses that are not otherwise covered by the Plan.

Contributions to your account and the reimbursements paid from it will not be considered taxable income to you. You should understand that tax law and regulations, as well as interpretations, change from time to time and you should contact your tax advisor concerning the taxation of Special Fund reimbursements.

The Special Fund can save you substantial amounts of money by allowing you to cover a wide range of expenses with untaxed income rather than after-tax income.

Your account balance can be carried forward from year to year—even after you retire.

You cannot make self-payments into your Special Fund Account. If you make self-payments under the Plan's regular eligibility or COBRA rules, no part of that self-payment will be credited to your Special Fund Account.

Non-bargaining unit employees may not participate in the Special Fund Account program.

WHAT YOUR ACCOUNT CAN BE USED FOR

You can request reimbursement for the following expenses from your Special Fund Account. The expenses must have been incurred on or after the date your coverage under the NECA/IBEW Family Medical Care Plan first became effective.

1. Self-payments for active or retiree coverage.
2. Deductibles and co-pays from the regular benefit plan.
3. Medical, dental or vision expenses not covered by or in excess of the regular benefit plan.

4. Surgery or laser treatments to correct vision.
5. Hearing aids and examinations.
6. Smoking cessation programs.
7. Weight loss programs, but not food or dietary supplements.
8. Certain transportation expenses for medical treatment.
9. Christian Science practitioners.
10. Acupuncture.
11. Certain over-the-counter (OTC) products as follows, provided you have a written physician's prescription:

Allowed	Not Allowed
Allergy medications	Acne treatments
Antacids	Cosmetics
Anti-diarrhea medicine	Dietary supplements
Antibiotic ointments	Fiber supplements
Calamine lotion	Herbs
Cold medicine	Lip balm
Cough drops and throat lozenges	Shampoos and soaps
First aid creams	Suntan lotion
Motion sickness pills	Toiletries
Nicotine medications and nasal sprays	Weight loss drugs
Pain relievers	Vitamins
Sinus medications and nasal sprays	Expenses for which you have been reimbursed by some other source.
Sleep aids	
Suppositories/creams for hemorrhoids	
Wart removal medication	

You may only claim OTC products that are not reimbursed from any other source and that are used for yourself and your eligible family members.

NON-COVERED EXPENSES

You cannot receive reimbursement from your account for the following:

1. Cosmetic surgery and treatments.
2. Health club memberships or expenses.
3. Child and elder care.
4. Household help.
5. Maternity clothes.

6. Non-prescription drugs, medicines and vitamins, unless specifically listed as a Special Fund covered expense.
7. Premiums for long-term care insurance.
8. Expenses for which you have been reimbursed by some other source.
9. Benefit reductions because you failed to pre-certify a hospital admission.

HOW TO USE YOUR SPECIAL FUND ACCOUNT

A claim will NOT be honored if it is submitted more than two years after the expense was incurred.

If you have any of the reimbursable expenses shown above, you must fill out a Special Fund claim form and return it to the Benefit Office along with copies of the bills. The form authorizes the Benefit Office to make a payment from your account.

- If you have a sufficient account balance, the Benefit Office will issue you a check for the amount of the expense, and your account will be reduced by the amount you were reimbursed. If your request is for a self-payment and you have a sufficient amount in your Special Fund Account to cover the payment, the Benefit Office will deduct the amount from your account and apply the payment toward your continuing eligibility.

Your Special Fund reimbursement request cannot be processed if you only send a cancelled check—you must submit an itemized bill or EOB with your request form.

- You may submit a reimbursement request at any time, but **the minimum amount requested should be $50.** If you accumulate less than $50 in a year, you may request reimbursement at the end of the year.
- If you wish to use your account to make a self-payment, please write to the Benefit Office and direct them to subtract it from your account.
- Claims for over-the-counter medications must include a copy of the physician's prescription, and store receipts on which the name of the product has been imprinted by the cash register, as well as the date of purchase and amount. Non-imprinted, or hand-annotated cash register receipts will NOT be accepted. It is your responsibility to purchase these products at stores that properly document the name of the product purchased.
- A reimbursement request will be honored only if it is submitted within two years of the date the expense was incurred.
- Reimbursement requests can be submitted by you or your spouse.

IN THE EVENT OF YOUR DEATH

In the event of your death, your surviving dependents can use the balance remaining in your account to make self-payments for coverage under this Plan as long as they are eligible to do so. (Your surviving dependent's eligibility to continue coverage under the Plan is subject to the rules governing survivor eligibility described in the eligibility sections of this Summary Plan Description booklet.) A surviving dependent of yours can also use your

account balance for reimbursement of covered Special Fund expenses, provided the dependent remains covered under the Plan.

If you have no eligible surviving dependents, the balance in your account will revert to the Plan upon your death.

FORFEITURE OF SPECIAL FUND ACCOUNT BALANCE

Your Special Fund Account balance currently carries over from year to year, your Special Fund Account balance will be reduced to zero in the following circumstances:

- **If your account balance is less than $100 -** If, in a period of *two consecutive calendar years*, no employer contributions have been made into your Special Fund Account and you have not made a withdrawal, your account balance will be reduced to zero.
- **If your account balance is $100 or more -** If, in a period of *four consecutive calendar years*, no employer contributions have been made into your Special Fund Account and you have not made a withdrawal, your account balance will be reduced to zero.

EXCLUSIONS AND LIMITATIONS

No payment will be made by this Plan for loss sustained as a result of, or for charges incurred for or as a result of, any of the following:

These exclusions apply to all benefits provided by the Plan, except the Special Fund. Additional exclusions apply to particular benefits and are listed in the section describing that benefit.

1. Treatments, care, services or supplies that are **not medically necessary** (as defined in the *Definitions* section).

2. Under the Major Medical Benefit, any amount in excess of the **allowable charge**; or with respect to the other benefits provided by the Plan, any charge or portion of a charge that is determined to be in excess of the **reasonable and customary** charge.

3. **Cosmetic treatment or surgery** on the body (including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue), or surgery to correct prior cosmetic surgery. This exclusion applies to breast reductions, reshapings and enhancements.

   Exceptions: This exclusion does not apply to:

   a. Cosmetic surgery for the correction of defects incurred through traumatic injuries sustained as a result of an accident within one year of the accident;

   b. The correction of congenital defects; or

   c. Breast reconstruction following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance.

4. **Experimental or investigative** treatment, care, services, supplies, procedures or facilities.

Obesity (bariatric) surgery is not covered.

5. **Obesity,** morbid obesity, or any overweight condition, including charges for bariatric surgery.

6. **Developmental delays,** including charges for development and neuro-educational testing or treatment, hearing therapy, therapy for learning disability, communication delay, perceptual disorders, sensory deficit, developmental disability and related conditions, or for other special therapy not specifically included as a covered expense elsewhere in this booklet, whether or not such disorder is the result of an injury or sickness.

7. **Reversal** of, or attempts to reverse, a previous elective sterilization.

8. **Pregnancy** or a pregnancy-related condition of any person other than a female employee or the spouse of a male employee.

Infertility treatment is not covered.

9. **Infertility**, including but not limited to hormone therapy, artificial insemination, or any other direct attempt to induce or facilitate fertility or conception. (The Plan does cover the initial diagnostic tests to determine the underlying cause of the infertility.)

10. **Sex transformations** or transsexual surgery.

11. **Sexual dysfunction** or impotency of any kind, including any complications arising from such conditions or treatments. This exclusion applies to Viagra and similar products, penile implants, regardless of the person's physical or mental condition.

12. **Abortions** except when medically necessary to protect the life of the mother (employee or spouse only).

13. **Premenstrual syndrome** (P.M.S.)

14. **Contraceptive devices or medications**, or any other method of contraception other than covered surgical sterilization (except when prescribed to treat an illness).

15. **Marriage or family counseling.**

The Plan does not cover LASIK surgery (except under the Special Fund).

16. **LASIK surgery**, or any other surgical or laser procedures to correct nearsightedness, farsightedness or astigmatism.

17. **Over-the-counter drugs** or medicines which are drugs that are not legally required to be dispensed by a registered pharmacist according to the written prescription of a doctor (except for certain non-prescription diabetic supplies).

18. **Nutritional supplements,** food supplements, vitamins (other than prescription prenatal vitamins) or any other items of a like nature, whether or not prescribed by a physician, unless specifically listed as a covered preventive service.

19. **Growth hormone** therapy or any treatment for growth hormone deficiency or short stature.

20. **Snoring**.

21. **Excessive sweating**.

22. **Orthoptics** or vision training.

23. **Corns, bunions** (except capsular or related surgery), calluses, toenail removal (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.

24. **Travel** or transportation, whether or not recommended by a doctor, unless specifically listed as a covered medical expense.

25. **Physical therapy for chronic pain**.

26. **Rehabilitative therapy** or any other type of therapy if either the prognosis or history of the person receiving the treatment or therapy does not indicate to the Trustees that there is a reasonable chance of improvement.

27. **Organ and tissue transplants** unless preapproved by the review organization and performed through the BCBS human organ transplant program.

28. **Artificial organs.**

29. **Smoking cessation** services or supplies, including but not limited to medications (prescription or non-prescription) and therapy or counseling of any type.

30. **Individual or private nursing care** unless specifically listed as a covered medical expense.

31. **Rental or purchase of any durable medical equipment** other than as specifically provided under the Major Medical Benefit, including but not limited to equipment that is not used solely for therapeutic treatment of a single individual's injury or illness. The following items related to durable medical equipment are also excluded:

    - Air conditioners, humidifiers, dehumidifiers, or purifiers;
    - Arch supports and orthopedic or corrective shoes;
    - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
    - Sterile water;
    - Deluxe equipment, such as motordriven chairs or beds, when standard equipment is adequate;
    - Rental or purchase of equipment if you are in a facility which provides such equipment;
    - Electric stair chairs or elevator chairs;
    - Physical fitness, exercise, or ultraviolet/tanning equipment;
    - Residential structural modification to facilitate the use of equipment;
    - Other items of equipment which do not meet the listed criteria.

32. **Any of the following items** or items of a similar nature or purpose, regardless of intended use:

    - Blankets, mattresses, pillows or covers for these items, even if orthopedic or hypo-allergenic
    - Breast pumps
    - Communication devices
    - Continence aids (either anal or urethral)
    - Devices or implants to simulate natural body contours
    - Emergency alert equipment
    - Exercise equipment
    - Health club memberships

- Scales
- Swimming pools
- Thermometers
- Whirlpools, saunas or Jacuzzis
- Wigs

33. **Alternative medical treatments**, including, but not limited to, hypnotism, biofeedback, holistic medicine, acupuncture, massage therapy, rolfing, music therapy, hippotherapy, health education, homeopathy, reiki, myo-fractional therapy, sleep therapy, and programs intending to provide personal fulfillment or harmony.

34. **Personal convenience items** such as telephones, TVs, cosmetics, newspapers, magazines, laundry, guest trays, or beds or cots for guests or other family members, or any other personal comfort items or items that are not medically necessary.

35. **Home health care** charges for: a) food, housing, homemaker services, sitters, child care or home-delivered meals; b) any non-skilled level of care, or any services and/or supplies which are not included in the home health care plan as described; c) any services for any period during which the patient is not under the continuing care of a physician; d) convalescent or custodial care where the patient has spent a period of time for recovery of an illness or surgery and where skilled care is not required; e) services that are only for aid in daily living, i.e., for the convenience of the patient; f) dietitian services; g) maintenance therapy; or h) dialysis treatment, or purchase or rental of dialysis equipment.

36. **Skilled nursing facility** services for: a) any period of confinement after the patient reaches the maximum level of recovery possible and no longer requires other than routine care; b) care that is primarily custodial, or that does not require definitive medical or 24-hour-a-day nursing service; c) mental illness including drug addiction, chronic brain syndromes and alcoholism, unless there is a specific medical condition that requires care in a skilled nursing facility; or d) a patient with senile deterioration, mental deficiency or retardation, who has no medical condition requiring care.

37. **Military service-connected** injuries or sicknesses.

38. **Genetic testing** unless the result of the test will directly impact the treatment being delivered to a patient who has a diagnosed medical condition.

39. **Surrogacy or surrogate fees.** This exclusion applies to, but is not limited to, charges in connection with: a) the medical or other expenses of a surrogate who carries and delivers a child on behalf of a person covered under this Plan; or b) a female employee's or dependent's carrying and delivering a child for someone else. Any child born of a

covered person acting as a surrogate mother will not be considered a dependent of the surrogate mother or her spouse. This exclusion does not apply to complications of pregnancy incurred by a surrogate who is an eligible employee or eligible dependent under this Plan.

40. **Court-ordered treatment** or classes.

41. **Occupational-related conditions** as follows:

    a. Accidental bodily injury, sickness or disease sustained while the person was performing any act of employment or doing anything pertaining to any occupation or employment; or

    b. Accidental bodily injury, sickness or disease for which benefits are or may be payable in whole or in part under any workers' compensation act or any occupational diseases act or any similar law.

    (This exclusion does not apply to the Weekly Disability Benefit).

42. **Education,** training or room and board while a person is confined in an institution which is primarily a school or institution of learning or training.

43. **Special education**, regardless of the type or purpose of the education, the recommendation of the attending doctor or the qualifications of the individual providing the education. This applies to special education or instruction for a learning disabled or handicapped child. (This exclusion does not apply to diabetic education for a person diagnosed with diabetes mellitus.)

44. **Custodial care**, which is care designed primarily to assist an individual in meeting the activities of daily living. This exclusion applies to all such care regardless of what the care is called (unless the care is provided to a person under an approved hospice care program).

45. Care or treatment rendered to you or a dependent which is provided by a person who is **a relative in any way to you** or to the dependent receiving the care or who ordinarily lives in your home or in the home of the dependent receiving the care.

46. Services or supplies provided while a person is confined in an institution which is primarily a **place of rest**, a place for the aged, or a nursing home (unless provided during an approved confinement in a facility that meets the definition of a skilled nursing facility).

47. Treatment, care, services, supplies or procedures provided while a person is confined in a hospital operated by the **U.S. Government** or its agencies, provided, however, that if charges are made by a Veterans Administration (V.A.) hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service-related disability, to the extent required by law such charges will be considered

covered medical expenses to the extent that they would have been considered covered medical expenses had the V.A. not been involved.

48. Charges incurred by an eligible family member which you or the family member are **not legally required to pay**. This includes any portion of a provider's fee or charge which is ordinarily due from the patient but which has been waived. If a provider routinely waives (does not require the participant to pay) a deductible or an out-of-pocket amount, the Claims Administrator will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.

49. The **replacement of a lost, missing, or stolen device** unless no benefits were paid by this Plan for the original item.

50. Completing of **claim forms** (or any forms required by the Plan for the processing of claims) by a doctor or other provider of medical services or supplies.

51. Bodily injury, disease or sickness caused by any act of **war,** whether war is declared or undeclared, any act of international armed conflict or any conflict involving the armed forces of any international body, or insurrection.

52. Services or supplies furnished, paid for or otherwise provided due to past or present service of any person in the **armed forces** of a government.

53. Treatments, care, services or supplies which are **not recommended, ordered or approved by the attending doctor**.

54. Unless specifically stated otherwise, any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection with, a **specific sickness,** illness or accidental bodily injury.

55. Any care or treatment of a person once the person has already received Plan benefits totaling the **maximum benefit** for that type of care and treatment as specified on the Schedule of Benefits.

56. Injury or sickness for which you or an eligible dependent, whether or not a minor, have a right to recover payment from a **third party**, except to the extent provided in the Plan's subrogation rules.

57. Injury or sickness resulting from or **occurring during a crime** committed by the patient.

58. Services or supplies provided to a **person who is not covered under the Plan**.

59. Charges which would not have been made **if this Plan did not exist**.

60. Services or supplies required by an employer as a **condition of employment,** or which an employer is required to provide under a labor agreement, or which are required by law.

61. Services, treatment or supplies which were ordered **before the person's effective date of coverage or** which are performed or provided **after the date a person's eligibility terminates.**

The above is not an all-inclusive listing of excluded services and supplies. It is only representative of the types of services and supplies for which no payment is made and of the types of situations in which loss may be sustained or in which expenses may be incurred for which no payment is made.

GENERAL PROVISIONS AND INFORMATION

DEFINITIONS

Allowable Charge

The maximum covered charge for a service rendered or supply furnished by a health care provider that will be considered for payment. You will be responsible for amounts in excess of the allowable charge even if the allowable charge is less than some determinations of what is reasonable and customary. Allowable charge limitations apply to out-of-network services only.

Ambulatory Surgical Center

A free-standing facility which is wholly owned and operated by a hospital on the same basis as the outpatient department of its main facility or a legally constituted institution which meets all of the following requirements: 1) it is established, equipped and operated primarily for the purpose of performing surgical procedures; 2) it is equipped with at least two operating rooms, at least one post-anesthesia recovery room, and has the ability to perform diagnostic x-ray and laboratory procedures as required in conjunction with the surgery to be performed; 3) it continually provides nursing services by registered nurses for patient care in the operating rooms and the post-anesthesia recovery room(s); and 4) it is licensed by the appropriate state agency and recognized by the local medical society.

The Plan does not cover services by out-of-network ambulatory surgical centers except when Medicare is primary and covers that facility.

Approved Treatment Facility for Substance Abuse

A rehabilitation facility for the treatment of individuals suffering from substance abuse. To be an approved treatment facility, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or meet certain requirements specified by the Trustees.

Association

The National Electrical Contractors Association, Inc. (NECA).

Bargaining Unit Employee

An employee who is a member of a collective bargaining unit represented by a Union and who is a full-time employee of a contributing employer.

Calendar Year; Year

The twelve-month period starting on January 1 of any year and ending on December 31 of that year.

Chiropractic Care

Any services or supplies that are provided or ordered by a chiropractor, or that are provided in connection with a course of treatment by a chiropractor.

Claims Administrator

The organization designated by the Trustees for handling claims. CompuSys of Utah, Inc. is the Claims Administrator for medical claims (excluding prescription drugs). The dental Claims Administrator is MetLife Dental. Vision Service Plan (VSP) is the vision Claims Administrator. Sav-Rx is the Claims Administrator for prescription drug claims. CompuSys is the Claims Administrator for Weekly Disability, Special Fund, Life Insurance and AD&D Insurance claims.

Collective Bargaining Agreement

The negotiated labor agreement between a Union and an employer or Association requiring the employer or Association to make contributions to the Fund on behalf of its bargaining unit employees.

Contributions

Payments made to the Fund by contributing employers on behalf of their employees.

Cosmetic

Treatment or surgery to improve or preserve physical appearance.

Covered; Covered Under the Plan

A term used to indicate that a person is eligible to receive the benefits from this Fund which apply to his status as an employee, a retiree or a dependent under the Plan 16 Schedule of Benefits.

Dependent

For the purposes of the following definition, "your" means an eligible employee or eligible retiree.

A dependent is one of the following:

1. Your spouse (from whom you are not divorced).
2. Your child who is less than 26 years old, except that the Plan will exclude a child age 19 or older with other coverage available through the child's employment or his or her spouse's employment.
3. Your unmarried child who is age 26 or older and who is permanently and totally disabled because of mental retardation, mental incapacity or physical disability as certified by a doctor. The child must have become disabled before becoming age 26; must remain disabled and be incapable of self-sustaining employment and be dependent upon you for the major portion of his financial support and maintenance, and specifically not provide more than 50% of his own support during any calendar year. Within 31 days after the child's 26th birthday, you must furnish, at your own expense, initial proof of the child's disability and that he became disabled before he became age 26. Subsequent proof of the child's continued disability may be required by the Trustees, but not more often than once a year.

You must submit legal documentation of dependent status before claims can be paid for that person.

You must submit legal documentation of dependent status before claims can be paid for that person.

Definition of Child - For purposes of this definition, a "child" means any of the following:

1. A child born of a valid marriage of yours, including a child legally adopted by you or placed in your home for adoption.
2. A child not born of a valid marriage of yours, of whom you have been determined to be the legal parent.
3. A stepchild of yours, meaning any child of your spouse who was born to your spouse or who was legally adopted by your spouse before your marriage to your spouse.

4. A foster child, meaning an individual who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

5. A child who is determined to be an "alternate recipient" under the terms of a court order which the Trustees determine to be a Qualified Medical Child Support Order (QMCSO). The Trustees, in consultation with the Fund legal Co-Counsel, have adopted procedures for determining whether a particular court order qualifies as a QMCSO. If you would like a copy of the Plan's QMCSO procedures, please call or write the Benefit Office. If you are a responsible party in a court action involving a child, you should request a copy of the Plan's procedures BEFORE the final order is entered.

Payment of benefits for any dependent is subject to the terms of the Plan's Coordination of Benefits provisions.

A person covered under the Plan as an employee or retiree cannot be covered as the dependent of another Plan employee or retiree.

If both you and your spouse are covered under the Plan as employees (or retirees), a child will be considered a dependent of both of you.

A child who is eligible for benefits under the Plan as an employee is not considered a dependent under the Plan. If a child is a full-time active member of the military or armed forces of any country, the child is not considered a dependent under the Plan.

Durable Medical Equipment

Equipment that: 1) can withstand repeated use; 2) is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and 3) is not disposable or non-durable.

Eligible Dependent

An individual who meets Plan's definition of a dependent and who is eligible to receive the Plan 16 benefits provided for dependents.

Eligible Employee

A person who has met and continues to meet the eligibility requirements for coverage under the Plan as an employee.

Eligible Family Member

You, the eligible employee or eligible retiree and any person in your family or household who meets the definition of a dependent.

Eligible Retiree

A retired employee who has met the eligibility requirements established by the Trustees and who is entitled to receive the benefits provided for Plan 16 retirees.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 (or, with respect to a pregnant woman, the health of the woman or

her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part.

Employee

An "employee" is any of the following:

1. Any person covered by a collective bargaining agreement between an employer and a Union who is engaged in employment with respect to which the employer is obligated to make contributions to the Fund;
2. Any person employed by an employer who has a written agreement with a Union or the Trustees who is engaged in employment with respect to which the employer is obligated to make contributions to the Fund;
3. Any person employed by an employer with a collective bargaining relationship with the Union where the employer has an ongoing legal obligation by operation of law to make contributions to the Fund; or
4. Any person employed by a Union, a local Association chapter, this Fund or another trust fund established by a Union and local Association chapter, on whose behalf the Union, Association chapter or fund has agreed to make contributions to this Fund.

Employer

An "employer" is a person, firm, association, partnership or corporation that:

1. Is bound by a collective bargaining agreement or other written agreement with a Union or the Trustees, or has a collective bargaining relationship with a Union or the Trustees, that requires payment of contributions to the Fund on behalf of its eligible employees;
2. Is a Union or local Association chapter that has agreed to make contributions to the Fund on behalf of its eligible employees; or
3. Is the Board of Trustees, or the board of trustees of any jointly sponsored trust fund between a Union and a local Association chapter, who has agreed to make contributions to the Fund on behalf of its eligible employees.

Experimental or Investigative

A treatment, procedure, facility, equipment, drug, device or supply will be considered to be experimental or investigative if it falls within any one of the following categories:

1. It is not yet generally accepted among experts as accepted medical practice for the patient's medical condition.
2. It cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other federal agency, and such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized.
3. It is the subject of ongoing Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of ongoing Phase III

clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses, or if the prevailing opinion among experts regarding any such treatment, procedure, facility, equipment, drug, device, or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses.

Determination of whether a treatment, procedure, facility, equipment, drug, device or supply is experimental or investigative shall be determined solely by the Trustees, in their sole discretion and judgment, in consultation with medical experts of their choosing.

Fund

The NECA/IBEW Family Medical Care Trust Fund.

Home Health Agency

A public agency or private organization (or a subdivision of such agency or organization) which meets all of the following requirements: 1) it is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients; 2) it has policies (established by a group of professional personnel associated with the agency or organization) governing the services which it provides; 3) it provides for the supervision of its services by a doctor or a registered professional nurse; 4) it maintains clerical records on all of its patients; 5) it is licensed according to the applicable laws of the state in which the patient receiving the treatment lives and of the locality in which it is located or in which it provides services; and 6) it is eligible to participate in Medicare.

Hospice

A public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of services at home or in outpatient or institutional settings to persons suffering from a terminal medical condition. The agency or organization: 1) must be eligible to participate in Medicare; 2) must have an interdisciplinary group of personnel that includes the services of at least one doctor and one R.N.; 3) must maintain clerical records on all patients; 4) must meet the standards of the National Hospice Organization; and 5) must provide the following services, either directly or under other arrangement: nursing care, homemakers and home health aides, medical social services, counseling services and/or psychological therapy, physical, occupational and speech therapy, and palliative care.

Hospital

An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. “Hospital” does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

Medically Necessary

Only those services, treatments or supplies provided by a hospital, a doctor, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an eligible individual's injury or sickness and which:

1. Are consistent with the symptoms or diagnosis and treatment of the individual's injury, disease or sickness, including premature birth, congenital defects and birth defects;
2. Are appropriate according to generally accepted standards of good medical practice;
3. Are not mainly for the convenience of the patient, doctor, hospital or other provider;
4. Are not experimental or investigative; and
5. Are the most appropriate services, supplies or level of services required to provide safe and adequate care. When applied to confinement in a hospital or other facility, this means that the covered person needs to be confined as an inpatient due to the nature of services rendered or due to the person's condition, and that the person cannot receive safe and adequate care through outpatient treatment.

The fact that the treating doctor finds that the treatment is medically necessary is not binding on the Trustees.

Mental or Nervous Disorder (Mental/ Nervous Disorder)

A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of whether such condition, disease or disorder has causes or origins which are organic, physiological, traumatic or functional.

Non-Bargaining Unit Employee

An employee who is not a member of any collective bargaining unit represented by a Union and who is a full-time employee of a contributing employer, a local Association chapter, a Union or the Fund.

Non-PPO Provider

A medical facility or provider who does not have an in-force negotiated fee agreement with the Plan's preferred provider organization.

Physician; Doctor

A legally qualified doctor or surgeon who is a Doctor of Medicine (M.D.) a Doctor of Osteopathy (D.O.), or a Doctor of Chiropractic (D.C.), provided

that any such individual renders treatment only within the scope of his license and specialty.

Plan; Benefit Plan; Plan of Benefits

The self-funded program of health and welfare benefits described in this booklet that are provided by the NECA/IBEW Family Medical Care Plan.

Plan 16

The health and welfare benefits described in this booklet which are provided to Plan 16 participants based on the terms of the collective bargaining agreement under which contributions are paid to the Fund.

PPO Provider

A medical facility or provider who has an in-force negotiated fee agreement with the Plan's preferred provider organization.

Reasonable and Customary Charge

The maximum allowable charge to be considered a covered expense under this Plan. The amount of a reasonable and customary (or usual and customary) charge is determined by comparing a charge with the charges made by persons with similar professional training and experience in the locality concerned (zip code area in which the service is performed) for comparable services and supplies provided to persons of similar age, sex, and medical, dental or orthodontic condition.

For dental services, "reasonable and customary" means the least of:

- The amount charged by the dentist for a covered service;
- The usual amount charged by the dentist for dental services which are the same as, or similar to, the covered service; or
- The usual amount charged by other dentists in the same geographic area for dental services which are the same as, or similar to, the covered service.

For retirees and their dependents who are entitled to Medicare, "reasonable and customary" means only that amount which is an allowable charge under Medicare's benefit rules.

Self-Payments

Payments made to the Fund by employees, retirees and dependents on their own behalf for the purpose of maintaining coverage under the Plan in accordance with the applicable eligibility rules.

Skilled Nursing Facility

An institution, or a distinct part of an institution, which complies with all licensing and other legal requirements and which, to be approved for the purposes of this Plan, meets all of the following criteria: 1) it is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services for patients who are convalescing from injury or sickness and who require medical or nursing care to assist the patients to reach a degree of body functioning to permit self-care in essential daily living activities; 2) it provides 24-hour-a-day supervision by one or more doctors or one or more R.N.s responsible for the care of its inpatients, it provides 24-hour-a-day nursing services by licensed nurses under the supervision of an R.N., and it has an R.N. on duty at least eight hours a day;

3) every patient is under the supervision of a doctor, and it has available at all times the services of a doctor who is a staff member of a general hospital; 4) it maintains daily medical records on all patients, and it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; 5) it has a utilization review plan; 6) it has a transfer agreement with one or more hospitals; 7) it is eligible to participate under Medicare; and 8) it is not, other than incidentally, an institution which is a place for rest, for custodial care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or a similar institution.

Substance Abuse

Alcoholism, alcohol abuse, drug addiction, drug abuse or any other type of addiction to, abuse of or dependency on any type of drug, narcotic or chemical (except nicotine).

TMJ

Temporomandibular joint syndrome, craniomandibular disorders and other conditions of the joint linking the jaw bone and the skull, along with the complex of muscles, nerves, and other tissues related to that joint. For the purposes of the Plan, the term *TMJ* includes all of these conditions.

Totally Disabled; Total Disability

1. An employee will be considered totally disabled if he is completely prevented from engaging in any occupation or employment for compensation, wages or profit solely as the result of accidental bodily injury or sickness.

2. A retiree or dependent is considered totally disabled if he is prevented from engaging in substantially all of the normal activities of a person of like age or sex in good health as a result of non-occupational accidental bodily injury or sickness.

If a person receives an award of disability benefits from the Social Security Administration, that person is automatically considered to have met the definition of "totally disabled."

Trustees

The individuals responsible for the operation of the NECA/IBEW Family Medical Care Plan in accordance with the terms of the Trust Agreement, together with such Trustees' successors. Trustees appointed by the Association are Employer Trustees; Trustees appointed by the Unions are Union Trustees.

Union

Any local union affiliated with the International Brotherhood of Electrical Workers, AFL-CIO, which has entered into a collective bargaining agreement requiring contributions to the Fund.

SUBROGATION

In the event the Fund pays or is obligated to pay benefits on behalf of a participant or his or her dependents for illness or injury to the participant or dependents and the participant or dependents have the right to recover the

amounts of such benefits from any other person, corporation, insurance carrier or governmental agency, including uninsured or underinsured insurance coverage, or any other first-party or third-party contract or claim, the Fund shall be subrogated to all of the participant's or dependents' right of recovery against such person, corporation, insurance carrier, governmental agency or uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, to the full extent of payments made by the Fund.

The participant or his or her dependents or the participant acting on behalf of a minor dependent shall execute and deliver such documents and papers (including but not limited to an assignment of the claim against the other party or parties, assignment to the minor child of any parental claim to recover medical expenses of the minor child, and/or a Subrogation Agreement) to the Fund as the Fund may require. The participant or dependents shall do whatever else is necessary to secure the rights of the Fund including allowing the intervention by the Fund or the joinder of the Fund in any claim or action against the responsible party or parties or any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim. The participant or dependents may not release or discharge any claim or responsible party, effect any settlement, nor dismiss any legal action against another source who may be responsible for paying damages or providing compensation, nor will such person effect satisfaction of any judgment resulting from any legal action without first notifying the Fund's legal Co-Counsel and tendering to the Fund's attorneys the full amount of reimbursement due to the Fund.

If the participant or dependents do not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated, the Fund shall, if in the Fund's best interest and at its sole discretion, be entitled to institute legal action or claim against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all amounts paid to the participant or dependents or paid on their behalf.

In the event of any recovery by judgment or settlement against the responsible party or parties or by payment by any uninsured or under-insured insurance coverage or any other first-party or third-party contract or claim, the Fund's attorneys' fees expended in the collection of the subrogation lien, if any, shall first be deducted. The Fund's subrogation interest, to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, shall next be deducted. The remainder or balance of any recovery shall then be paid to the participant or dependents and their attorneys if applicable.

In the event of any failure or refusal by the participant or dependents to execute any document requested by the Fund or to take other action requested by the Fund to protect the interests of the Fund, the Fund may withhold payment of benefits or deduct the amount of any payments from future claims

of the participants or dependents. After making a claim for benefits from the Fund, the participant or dependents shall take no action which might or could prejudice the rights of the Fund.

In the event the participant or dependents recover any amount by settlement or judgment from or against another party or by payment from any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, the Fund will request repayment of the full amount of benefits paid by the Fund. If the participant and/or dependents refuses or fails to repay such amount, then, in that event, the Fund shall be entitled to recover such amounts from the participant and/or dependents by instituting legal action against the participant and/or dependents and/or by deducting such amounts as may be due on future claims submitted by the participant and dependents. Once a settlement or judgment is reached on the claim additional bills cannot be submitted with respect to the same injury.

The participant or dependent shall be required to pay their own legal fees and costs and to hire only attorneys who agree to waive the common fund doctrine and to remit the gross rather than the net proceeds from litigation. The Fund shall have a lien on any and all recoveries received by the participant or dependent from any responsible party, enforceable as a provision of this Fund, either before or after an adjudication of liens, for the full amount of benefits paid by the Fund. In the event a court awards the Fund less than the full amount of benefits, through an "adjudication of liens" or otherwise, the specific proceeds received by the participant or dependent shall be subject to a "constructive trust" or "equitable lien" in favor of the Fund in the amount of the difference between the full amount of benefits paid by the Fund and the amount paid the Fund pursuant to the court's award and this Plan provision establishing a "constructive trust" or "equitable lien" may be enforced through any available equitable remedy to ensure that the proceeds subject to the "constructive trust" or "equitable lien" are turned over to the Fund.

While not affecting the Fund's right to receive the full amount of benefits paid, the Fund may elect, in an appropriate case to pay a portion of the participant's or dependent's attorney's fees in exchange for the waiver of the terms of the common fund doctrine by the involved attorney and the participant or dependent. The Fund shall pay no legal costs or fees without receiving a recovery and then only within the terms of this provision. In the event that an attorney is hired by or on behalf of the participant or dependent and the Fund is given notice and an opportunity to pursue its own subrogation recovery, the Fund shall not be required to hire an attorney. If the attorney representing the participant or dependent nevertheless wishes to proceed, and creates a common fund in which subrogated amounts are paid, the Fund may agree to pay up to 10% to include legal fees, provided that the participant or dependent and the attorney waive any other payment or agreement to reduce recovery from the Fund including, but not limited to, any rights under the common fund doctrine. Said 10% shall also include any prorated portion of the cost of recovery. If the attorney representing the participant or dependent receives either a payment or an agreement to reduce recovery

from the Fund (whether in the form of cash payment or reduction of the Fund's right to the full amount of benefits paid by the Fund), the attorney and the participant or dependent will be considered to have waived the common fund doctrine.

The Fund's right of subrogation is from the first dollar received by the participant or dependent and takes effect before the whole debt is paid to the participant or dependent.

If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage (or should have been covered because of state law), including, but not limited to, no-fault or similar legislation, no-fault, no-fault-type, uninsured motorist, underinsured motorist or personal injury protection to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second, regardless of whether those laws or insurance policies preclude payment of medical benefits.

If motor vehicle coverage is required by state law but has lapsed or was not obtained by the eligible individual, this Plan would provide benefits less the amounts that would/should have been paid by the motor vehicle coverage had the eligible individual been covered by motor vehicle coverage.

(If you want more information about Subrogation, contact the Benefit Office.)

COORDINATION OF BENEFITS

The coordination of benefits provision is referred to as "C.O.B."

Benefits are coordinated when both you and your spouse (and/or your dependent children) are eligible for benefits from this Plan and another group health plan (usually your spouse's plan). Coordination allows benefits to be paid by two or more plans up to but not to exceed 100% of the allowable expenses on the claim.

This Plan has a separate but related rule, called the Working Spouse Rule (see page 6), that requires spouses to enroll in their employers' health plans. If a spouse fails to enroll in her employer's plan, this Plan will only pay 20% of the covered medical and prescription drug expenses she incurs. If she does enroll in her employer's plan, the C.O.B. rules described below govern the order and manner in which the two plans will pay their benefits.

General C.O.B. Rules

1. Benefits are coordinated on all employee, retiree and dependent claims. C.O.B. applies only to medical, prescription drug and dental benefits—it doesn't apply to vision benefits, Life Insurance, AD&D Insurance or Weekly Disability Benefits.

2. The Benefit Office may release or receive necessary information about your claim to or from other sources. You must furnish the Benefit Office with any information they need to process your claim.

3. You must file a claim for any benefits you are entitled to from any other source. Whether or not you file a claim with these other sources, the benefits payable by this Plan will be calculated as though you have received any benefits you are entitled to from the other source(s).

4. Benefits are coordinated with other group plans, including group Blue Cross and Blue Shield plans, motor vehicle insurance, and blanket insurance plans. If you or your spouse are covered under another plan, you can contact the Benefit Office to find out whether that plan fits the definition of a group plan.

5. Benefits are also coordinated with Medicare. If a person is eligible for Medicare, this Plan's benefits will be calculated as though he is enrolled in both Part A AND Part B of Medicare, even if he has not actually enrolled in both Parts.

6. When anyone in your family who is covered under another group health plan has a claim, be sure that you file claims with all plans and provide all required information about other coverage on all claim forms.

7. Benefits are paid under C.O.B. for allowable expenses, which are expenses that are eligible to be considered for reimbursement.

8. If there is a difference between the amount the primary plan allows and the amount allowable by this Plan, this Plan will coordinate its benefits using the higher amount. However, if the primary plan has a contract with the provider (HMOs and PPOs usually have such contracts with their providers), the combined payments of both plans will not be more than the primary plan's contract calls for. Exception: If both plans have a contract with the same provider, the allowable expense will be the higher of the two contracted or negotiated fees.

9. If a person is covered under one or more other plans in addition to this Plan, this Plan will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Plan will not pay benefits for expenses which would have been covered by another plan but which are not covered by the other plan because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim on time.

10. If you and your spouse are both covered as employees under this Plan and one of you (or child who is a covered dependent of both of you) has a claim, the Plan will coordinate benefits on the claim (two claims must be submitted—one by you and one by your spouse).

Order of Benefit Payments

A plan that is required to pay its normal benefits on a claim before another plan pays its benefits is the primary plan, or pays first. The plan that makes payments based on the amount that is not paid by the primary plan is the secondary plan, or pays second. When a person who has a claim is covered under one or more other plans, this Plan will determine and pay its benefits in accordance with the first of the following rules that applies:

1. If a person is covered under another group plan that doesn't have C.O.B. rules, that other plan will pay its benefits first and this Plan will pay second.

2. When the other plan does have C.O.B. rules, the plan covering the person (for whom the claim is filed) as an employee will pay first, and the plan covering the person other than as an employee will pay second.

3. If a person who is covered under a plan as a retired worker is also covered under a plan covering the person as a dependent of an actively working spouse, the benefits of the plan covering the person as a retired worker will pay first, and the plan covering the person as a dependent will pay second. However, if the person is also entitled to Medicare, then the order of payment is reversed, so that the plan covering the person as a dependent will pay before the plan covering the person as a retired worker.

4. If a person who has COBRA coverage is also covered under another plan as an employee, retiree or dependent, the COBRA coverage is secondary.

5. On claims for children, the following rules apply:

   a. The primary plan is the plan of the parent whose birthday is earlier in the year (called the "birthday rule") if:

      - The parents are married; or
      - The parents are not separated (whether or not they ever have been married to each other); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health coverage.

      If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

   b. If the parents are not married and not living together, or are separated or divorced and no court decree allocates responsibility for the child's health care expenses, the order of benefits for all possible plans is:

- The plan of the custodial parent;
- The plan of the non-custodial parent;
- The plan of the spouse (if any) of the custodial parent; and then
- The plan of the spouse (if any) of the non-custodial parent.

c. If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, then the responsible parent's plan is primary. If the legally responsible parent does not have health coverage for the child, but his or her spouse does, the spouse's plan becomes primary.

d. If a court awards joint custody without stating that one parent has primary responsibility for providing health care coverage, the birthday rule applies.

If the above rules still don't clearly show which plan should pay first, the plan that has covered the person (for whom the claim is filed) for the longest period of time will pay first. The plan which has covered the person for the next longest period of time will pay second, and so on.

C.O.B. With Sub-Plans

This rule will only apply if the Plan is secondary to another plan with a cost-shifting sub-plan rule.

If this Plan is secondary on a covered person's claim under its order of benefit determination rules, but the person's primary plan has a rule allowing it to pay less than its normal benefits when there is secondary coverage, without regard to whether the lesser benefits are payable under the terms of sub-plan or wrap-around provision, then such person will be deemed covered under this Plan's sub-plan. The maximum payable by this Plan for all claims incurred by a person covered under the sub-plan is $1,000 per calendar year, or, if less, the amount payable after application of this Plan's coordination of benefits rules.

If the primary plan has a no-loss provision, and if the sum of the primary plan's sub-plan benefits, plus this Plan's sub-plan benefits, plus any additional benefits payable by the primary plan's regular benefit plan under its no-loss provision, is less than the sum of the benefits otherwise payable under this Plan's regular benefit plan, then this Plan's regular benefit plan will pay the difference.

If the primary plan lacks a no-loss provision or if the primary plan refuses to apply its no-loss provision after this Plan's secondary sub-plan benefits are paid, and if the sum of the primary plan's sub-plan benefits and this Plan's secondary sub-plan benefits is less than the sum of the benefits otherwise payable under this Plan's regular benefit plan, then this Plan's sub-plan may, if the Trustees in their sole discretion choose to do so and notwithstanding the otherwise applicable benefit limit under this Plan's sub-plan, "advance" an amount not in excess of the difference between the sum of the benefits previously paid under the primary plan's sub-plan and this Plan's sub-plan and the benefits otherwise payable under this Plan's regular benefit plan. In order for such an "advance" to be made the participant or beneficiary must

sign any documents the Trustees in their sole discretion deem necessary, including a subrogation or reimbursement agreement, an assignment of benefits or any other document necessary to effectuate recovery of the amount of the "advance" from the primary plan or any other source of payment, and agree to fully cooperate in obtaining such recovery. Any amount recovered for the claim from the primary plan or any other source of payment shall be forwarded to this Plan and offset against the amount of the "advance."

If the primary plan pays its normal benefits for the person's claim, that is, the benefits it would have paid if the person was not also covered under this Plan, then the person will be deemed covered under this Plan's regular benefit plan, and this Plan will coordinate its regular benefits as the secondary payer to the other plan.

C.O.B. With Medicare

Employees Continuing to Work After Age 65

If you continue to work for a contributing employer who has 20 or more employees after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will be your primary provider of health care benefits unless it is legally permitted to pay second. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

If your dependent spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will usually pay its normal benefits for her before Medicare pays unless it is legally permitted to pay second. If she is covered under her own plan, her plan will pay first, this Plan will usually pay second, and Medicare will pay last.

Retirees (and Their Spouses) Eligible for Medicare

Retirees and their spouses who are eligible for Medicare must be enrolled in Medicare Part A and Part B.

If you are an eligible retiree, and if you and/or your spouse are eligible for Medicare and have enrolled in both Medicare Part A ***and*** Part B, this Plan will coordinate benefits with Medicare on your claims. This means that Medicare will pay first, and this Plan will pay after Medicare pays, based on amounts not paid by Medicare. The Plan will determine its benefits as the secondary payor based on the amount of the charge allowed by Medicare—it will not pay any amount in excess of Medicare's allowable charge.

If you have not enrolled in Medicare Parts A and B, this Plan will calculate its benefits as if you had. This means that this Plan will only pay benefits equal to the benefits it would have paid if you were enrolled in both Parts, unless a different payment is required by law. You will have to pay the amount normally paid by Medicare.

Medicare-eligible retirees (and Medicare-eligible spouses of retirees) have the option of dropping this Plan's prescription drug coverage and switching to a Medicare Part D plan. See page 35 for more information.

Medicare-Eligible Persons Under 65

If any covered person is entitled to Medicare for reasons other than being 65 or older (for example, because of disability or being an End Stage Renal Disease beneficiary), this Plan will usually pay its benefits on that person's claims before Medicare pays its benefits unless it is legally permitted to pay second. This provision doesn't apply to retirees or their dependents.

All Medicare-Eligibles Age 65 or Over

Persons age 65 or older are also entitled to select Medicare as their only coverage. To do so, they must decline all coverage under this Plan. Contact your local Social Security Administration office if you have any questions about Medicare enrollment or eligibility.

C.O.B. With Automobile Insurance Policies

In the event a covered person (you, your spouse and/or your dependent child) is eligible for benefits for allowable expenses under this Plan and one or more group or individual fault or no-fault automobile insurance policies, the benefits under this Plan will be coordinated with those under the automobile insurance policy or policies so that the total benefits be paid under this Plan and all automobile insurance policies will not exceed 100% of the total allowable expenses actually incurred. In all cases where a covered person is eligible for receipt of benefits under a no-fault automobile insurance policy, the automobile insurance carrier will be primary.

CLAIM PROCEDURES

In order for the Plan to pay benefits, a claim must be filed with the Claims Administrator in accordance with the procedures described below. A claim can be filed by you, your eligible dependent or by someone authorized to act on behalf of you or your eligible dependent.

1. A claim is considered to have been filed on the date it is received at the correct claims office, even if the claim is incomplete. Claims are received during regular business hours, Monday through Friday.
2. A "claim" is a request for Plan benefits, normally because the claimant has incurred a healthcare expense. A request for confirmation of Plan coverage is not a claim if you have not yet incurred the expense unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy.

Claims must be filed within twelve months from the date of service.

3. Claims must be filed within twelve months from the date of service.
4. You may designate another person as your authorized representative for purposes of filing a claim. Except in the case of an urgent care claim, such designations must be in writing.

- Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you.
- A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as your authorized representative.
- Designation of a person as an authorized representative does not grant that person the rights of a beneficiary under this Plan.

Claim Processing Time Periods

The amount of time the Plan can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

1. A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested. Most claims are post-service claims.
2. A "disability claim" is a claim for Weekly Disability Benefits.
3. A "pre-service claim" is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining the care.
4. An "urgent care claim" is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function, or that could subject you to severe pain that cannot be adequately managed without the proposed treatment.
5. A "concurrent care claim" is also a type of pre-service claim. A claim is a concurrent care claim if a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved.

If all the information needed to process your claim is provided to the Claims Administrator, your claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are as follows:

- Post-service claims—30 days.
- Disability claims—45 days.
- Pre-service claims—15 days.
- Urgent care claims—24 hours.
- Concurrent care claims—24 hours if the concurrent care is urgent and if the request for the extension is made within 24 hours prior to the end of the already authorized treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

When Additional Information Is Needed (Claimant Extension) - If additional information is needed from you, your doctor or the provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the normal time limits shown

above, except that the additional information needed to decide an urgent care claim will be requested within 24 hours.

It is your responsibility to see that the missing information is provided to the Claims Administrator. The normal processing period will be extended by the time it takes you to provide the information, and the time period will start to run once the Claims Administrator has received a response to its request. If you do not provide the missing information within 45 days (48 hours for an urgent care claim), the Claims Administrator will make a decision on your claim without it, and your claim could be denied as a result.

Plan Extension **-** The time periods above may be extended if the Claims Administrator determines that an extension is necessary due to matters beyond its control (but not including situations where it needs to request additional information from you or the provider). You will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

- Post-service claims—15 days.
- Disability claims—30 days (a second 30-day extension may be needed in special circumstances).
- Pre-service claims—15 days.

Claim Denials

If all or a part of your claim is denied after the Claims Administrator has received all other necessary information from you, you will be sent a written notice giving you the reasons for the denial. The notice will include reference to the Plan provisions on which the denial was based and an explanation of the claim appeal procedure. If applicable, it will give a description of any additional material or information necessary for you to perfect the claim, and the reason such information is necessary. The notice will provide a description of the appeal procedures and the applicable time limits for following the procedures. It will also include a statement concerning your right to bring a civil action under section 502(a) of ERISA. In cases where the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the notice will state that the specific internal rule, guideline, protocol or criterion will be provided to you free of charge upon request. If the decision was based on medical necessity or if the treatment was deemed experimental, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. For urgent claims, a description of the Plan's expedited review process will be provided.

Claim Appeal Procedure

If your claim is denied in whole or in part, you can request a review within 180 days of your receipt of the denial notice by sending a letter, along with any additional information that you think will help a favorable decision to be made on your claim, to:

Board of Trustees
2400 Research Boulevard
Suite 500
Rockville, MD 20850

You may orally request a review of a denied urgent care claim by calling the Benefit Office at 1-877-937-9602 or you may submit your request in writing to the address shown above. You may be notified of the Trustee's decision on an urgent care claim by telephone or facsimile.

You can authorize someone else to file your request for review and otherwise act for you. You and/or your representative can review materials in the Fund's files that are related to your claim. You and/or your representative can submit written issues and comments to support your request for review. You and/or your representative may also make a written request for a personal appearance before the Trustees. If a hearing is granted, your and/or your representative's appearance will be at your own expense.

Permission for you to utilize a representative does not provide the representative (particularly a health care provider) with an independent right to payment of benefits in the representative's name, to file or proceed with a review of a claim for benefits in the representative's name or to obtain any rights as a "participant" or "beneficiary" under the Plan. Any appeal can only be brought in the name of yourself or your dependent who are the only entities permitted to be a "participant" or "beneficiary" under this Plan.

The Trustees will conduct a full and fair review of all the material submitted with your claim, the action taken by the claims office, the additional information you have provided, and the reasons you believe the claim should be paid. The review will:

- Be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, nor the subordinate of such party;
- Not afford deference to the initial adverse benefit determination; and
- Take into account all comments, documents, records and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.

When the Claim Denial Was Issued by MetLife

The Trustees have delegated MetLife to be the final decision-maker with respect to dental claim reviews.

If MetLife denies all or part of your dental claim, you can request a review within 180 days of your receipt of the denial notice by sending a letter, along with any additional information that you think will help a favorable decision to be made on your claim, to:

MetLife Dental Claims
P.O.Box 981282

El Paso, TX 79998-1282

Your letter should refer to group account number 304133.

MetLife will conduct a full and fair review of all the material submitted with your claim, the prior action taken on the claim, the additional information you have provided, and the reasons you believe the claim should be paid. The review will be conducted by someone other than the person who made the initial decision.

Procedures Applicable to All Internal Appeals

The following provisions apply to reviews conducted by the Board of Trustees or MetLife:

1. You have the right, upon request and free of charge, to receive copies of all documents, records and other information relevant to your claim for benefits.

2. Your claim review will be conducted by an individual who is neither the party who made the initial denial, nor the subordinate of such party. It will not afford deference to the initial determination, and will take into account all comments, documents, records and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.

3. With respect to a review of any determination based on a medical judgment, a health care professional with appropriate training and experience in the applicable field of medicine will be consulted. Such health care provider will be "independent," which means the person consulted will be an individual different from, and not subordinate to, any individual who was consulted in connection with the initial decision.

4. If you submit your request for an appeal in a timely manner, and if you provide all the additional information necessary for a review of the original denial, you will be notified of the decision following review within the following time periods:
   - *Urgent care claims* - As soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of your request for review.
   - *Pre-service claims* - No later than 15 days per level of review.
   - *Post-service and disability claims* - No later than 5 calendar days following the date of the Trustees meeting that immediately follows the Plan's receipt of a request for review, unless the request is filed within 30 days preceding the date of such meeting. In such case, a determination may be made by no later than the date of the second meeting. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a determination will be rendered not later than the third meeting of the Trustees. Before the start of the extension, you will be notified in writing of the extension, and

that notice will include a description of the special circumstances and the date as of which the determination will be made.

5. All written appeal decisions will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; and a statement of the claimant's right to bring an action under section 502(a) of ERISA. If applicable, you will also be informed of the specific internal rule, guideline, protocol or similar criterion relied on to make the decision and your right to a copy, free of charge, upon request. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.

6. If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, you may go to court to enforce your rights.

External Review

If the review process described above still results in an adverse benefit determination, you may, in certain cases, request an additional review by an independent review organization (IRO). An independent external review is available for claims denied based on clinical or scientific judgments, such as decisions based on medical necessity. It does not apply to claim denials related to a person's eligibility for coverage.

You must apply for the external review within four months after the date of receipt of the written appeal decision you received from the Fund. To request an external review, call or write the Benefit Office. Benefit Office staff will provide you with the information you need to file your formal request for an external review and provide you with the information you need to complete the process.

You may apply for an expedited external review if the claim involves a medical condition for which the regular timeframe for completion of an appeal would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility. To request an external review, call or write the Benefit Office. Benefit Office staff will provide you with the information you need to complete the process.

TRUSTEE INTERPRETATION, AUTHORITY AND RIGHT

The Board of Trustees has full authority to interpret the Plan, all Plan documents, rules and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. Parties to whom the Trustees have delegated the right of decision-making, such as MetLife, will also have the discretion to interpret the Plan. If a decision of the Trustees, or a party to whom the Trustees have delegated decision-making authority, is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

The Trustees have the authority to amend the Plan, which includes the authority to change eligibility rules and other provisions of the Plan, and to increase, decrease or eliminate benefits. However, no amendment may be adopted which alters the basic principles of the Trust Agreement founding the Fund, is in conflict with collective bargaining agreement provisions applicable to contributions to the Fund, is contrary to laws governing multi-employer ERISA trust funds, or is contrary to agreements entered into by the Trustees. In addition, and as more fully explained in the *Plan Discontinuation or Termination* section, the Trustees may terminate the Trust and this Plan of Benefits at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. The Trustees may adopt such rules as they feel are necessary, desirable or appropriate, and they may change these rules and procedures at any time.

The Trustees specifically have the right and the authority to change the provisions relating to coverage for retirees and their dependents at any time and in their sole discretion, since the Retiree Benefits are not "accrued" or "vested" benefits. Any such change made by the Trustees will be effective even though an employee has already become a covered retiree.

The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participants and beneficiaries.

NON-VESTED BENEFITS

All benefits described in this SPD are non-vested benefits. The Trustees may alter or change the provisions of the Plan at any time, which could result in the elimination of one or more benefits. Any savings that result from the reduction or termination of a benefit will revert to the general Trust Fund.

PLAN DISCONTINUATION OR TERMINATION

The Plan of Benefits and the Trust Agreement under which the Plan was founded may be terminated under certain conditions: if there is no longer a

collective bargaining agreement or participation agreement requiring contributions to the Fund; or, if it is determined that the Fund is inadequate to carry out the purposes for which the Fund was founded. The Plan may be terminated at any time by a vote of the Trustees or by a written mutual agreement of the Unions and the Association to terminate the Trust, if the action is taken in conformity with applicable law. In such a case, benefits for covered expenses incurred before the termination date will be paid on behalf of covered persons as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets; and benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

CIRCUMSTANCES WHICH MAY RESULT IN CLAIM DENIALS OR LOSS OF BENEFITS

The Trustees or their representatives are authorized to deny payment of a claim, and the reasons for denial may include one or more of the following:

1. The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.
2. The claim wasn't filed within the Plan time limits.
3. The expenses that were denied are not covered under the Plan or were not actually incurred.
4. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time.
5. No payment, or a reduced payment, was made because some or all of the expenses for which the claim was filed were applied against a deductible or co-payment.
6. Another party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying the incurred medical expenses and you or your dependent did not comply with the rules governing subrogation.
7. Another plan was primarily responsible for paying benefits for the expenses.
8. The Trustees amended the Plan's eligibility rules or decreased Plan benefits.
9. The Trustees reduced or temporarily suspended future benefit payments to a family member in order to recover an overpayment of benefits previously made on that person's behalf or on behalf of another member of the same family.
10. The Plan of Benefits was terminated.

The preceding list is not an all-inclusive listing of the circumstances which may result in denial or loss of benefits. It is only representative of the types

of circumstances, in addition to failure to meet the regular eligibility requirements, that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Claims Administrator.

ADDITIONAL PLAN PROVISIONS

Overpayments; Duty of Cooperation

Whenever a payment or payments are made in excess of the allowable amount payable under the Plan, the Fund has the right to recover such excess payments from any person(s), service plan or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of the employee or dependent, the Fund, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments, including benefit payments due on behalf of another covered family member, or institute legal action to collect the overpayment.

You and your covered dependents must provide the Fund with any information the Fund deems necessary to determine eligibility, process claims or implement Plan terms. Failure to provide any information requested by the Plan or its agents may result in the rejection of a claim for benefits.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Fund may also obtain reimbursement of interest, professional fees incurred and other damages related to that overpayment.

A claim for benefits will be rejected and the Fund will be entitled to recover money that you, your dependents or a service provider have received if a false statement or omission of a material fact was purposely made by any person in order to receive benefits. The Fund may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

HIPAA Privacy Rights

The Plan has responsibilities under the Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of your protected health information ("PHI"). Your PHI is any information that: 1) identifies you or may reasonably be used to identify you; 2) is created or received by a health care provider, health plan, employer or health care clearinghouse; and 3) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact:

NECA/IBEW Family Medical Care Plan
CompuSys, Inc.
5837 Highway 41 North
Ringgold, GA 30736

Examinations

The Trustees have the right to have a doctor examine a person for whom benefits are being claimed, to ask for an autopsy in the case of a death and to examine any and all hospital or medical records relating to a claim.

Payment of Benefits

Health care benefits are payable individually for you and each of your dependents up to but not to exceed the maximum benefits stated on the Schedule of Benefits according to the following provisions:

1. Blue Card PPO providers and out-of-network providers should send their bills directly to the BCBS affiliate in their state which in turn forwards the claim to Blue Cross Blue Shield of Georgia (BCBSGA). BCBSGA then sends the claims to the Benefit Office (CompuSys) who processes medical claims on the Plan's behalf. The Plan's share of the expenses will be paid directly to the PPO provider or to the out-of-network provider. The provider will bill you for your share of the expenses, which you must pay directly to the provider. (If an out-of-network hospital requires payment from you, see No. 2 below for how benefits are paid.)

2. If an out-of-network provider or other non-doctor or non-hospital provider requires payment, you must pay the bill and file a claim for reimbursement. The Plan will reimburse you the Plan's share of the expenses.

3. In most other cases, benefit payments on claims for yourself and for your dependents will be made to you (employee or retiree) unless you assign benefits. Life Insurance and loss of life benefits under the AD&D Insurance proceeds will be paid to your beneficiary. Benefits are payable only when the required forms and information have been received by the Benefit Office.

4. The Trustees may, from time to time, enter into negotiated fee arrangements with health care providers under the terms of which the Plan will receive discounts on fees charged for such services. In such cases, any amount in excess of the negotiated (discounted) fee will not be considered a covered expense.

5. If the Trustees decide that a person isn't mentally, physically, or otherwise capable of handling his business affairs, the Plan may pay benefits

to his guardian or, if there is no guardian, to the individual who has assumed his care and principal support. If the person dies before all due amounts have been paid, the Trustees may make payment to the executor or administrator of his estate, to his surviving spouse, parent, child or children, or to any individual the Trustees believe is entitled to the benefits.

6. In determining the satisfaction of any deductible amounts and the amount of benefit payments, a charge for any service, treatment, or supply will be considered incurred on the date the service or treatment was rendered or on the date the supply was provided.

Any payments made by the Plan in accordance with these rules will fully discharge the Plan's liability to the extent of its payments.

Non-Assignability of Assets; Representations Regarding Coverage

No assignment of benefits or other agreement entered into by a covered person purporting to assign a right to collection of benefits to an assignee shall provide the assignee with any right to maintain an action in contract, tort, or as an ERISA benefit claim by the assignee against the Fund or as an ERISA claim by the assignee against the Fund or the Trustees for recovery of any amounts from the Plan. Any claim for payment of benefits must be brought in the name of the person upon whom services were performed.

Any oral or written representation made regarding coverage to any person or entity is made solely in the person or entity's capacity as a representative of a person covered under the Plan inquiring on the covered person's behalf concerning projected levels of Plan coverage. Any such representation provides no right to a person or entity independent of the rights of the covered person under the terms of the Plan. It does not provide the person or entity with an independent right to recover from the Plan or its representatives under any state or federal law, including state contract and tort law. Any rights a person or entity might have against the Plan or its representatives are solely those which derive from the rights of a participant or beneficiary under the terms of the Plan. No references to coverage and levels of benefits are binding upon the Plan or its representatives unless they have been provided by the full Board of Trustees following a construction of the governing Plan instruments. Any representation regarding coverage and benefit amounts may not be relied upon by any person or entity if it is any way contrary to the terms of governing written Plan instruments. Entitlements to payment under the Plan may only be obtained through action of the Trustees administering the Plan and these Trustee actions may only be appealed by a person covered under the Plan pursuant to the Plan's appeal procedures and by a benefits claim cause of action brought in a court of competent jurisdiction under ERISA.

Workers' Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any workers' compensation law, occupational diseases law or similar

law. Benefits that would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.

Release of Information

You must provide the Claims Administrator with any required authorization for release of necessary information relating to any claim you have filed.

Breast Cancer Rights

The Plan provides benefits for post-mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Certificates of Coverage

When you or a dependent are no longer eligible for Plan benefits, you will receive a certificate of coverage from the Benefit Office. This certificate provides evidence of your prior health care coverage. You may need to furnish this certificate if you become eligible under another group health plan that excludes coverage for preexisting conditions. You may also need this certificate in order to buy an individual insurance policy with a preexisting condition exclusion or limitation.

If your (or your dependent's) coverage terminates, the Benefit Office will automatically send a certificate of coverage to your (or your dependent's) last known address. If you do not receive a certificate because of a change of address, or because the Benefit Office was not notified that a dependent's coverage has terminated, or if you would like a certificate for any other reason, you have the right to request one—just call or write the Benefit Office at the address and telephone number shown on the inside front cover of this booklet. You may request a certificate of coverage any time within 24 months of when you were last covered under the Plan.

Your Rights Under ERISA

As a participant in the NECA/IBEW Family Medical Care Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- 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 and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the

Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- 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.

Continue Group Health Plan Coverage

In certain cases you can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA coverage rights.

You will be provided a certificate of creditable coverage, free of charge, when you lose coverage under the Plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve months after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants, covered dependents 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 health and welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you believe that Plan fiduciaries misuse the Plan's money, or if you believe you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees.

Assistance With Your Questions

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, or if you need assistance in obtaining documents from the Administrative Manager, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions and a list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

How to Read or Get Plan Material

You can read the material listed in the previous section by making an appointment at the Benefit Office during normal business hours. This same information can be made available for your examination at certain locations other than the Benefit Office. The Benefit Office will inform you of these locations and tell you how to make an appointment to examine this material at these locations. Also, copies of the material will be mailed to you if you send a written request to the Benefit Office. There may be a small charge for copying some of the material. Before requesting material, call the Benefit Office to find out the cost. If a charge is made, your check must be attached to your written request for the material. The Benefit Office address and phone number are shown on the inside front cover.

General Information About Your Plan

Name of Plan/Fund - The name of your Plan is the NECA/IBEW Family Medical Care Plan. The name of the trust fund through which your Plan is provided is the NECA/IBEW Family Medical Care Trust Fund.

Plan Sponsorship and Administration - Your Plan is sponsored by a joint labor-management Board of Trustees. The Board of Trustees is the Plan

Administrator. The Board is divided equally between Trustees appointed by the Union membership and by Trustees appointed by the employer Association. The names and addresses of the individual Trustees are shown on page 113.

A complete list of employers and the Unions sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Board of Trustees, and is available for examination by participants and beneficiaries, as required by DOL regulations 29 CFR §§ 2520.104b-1 and 2520.104b-30. This right includes a "superseded" collective bargaining agreement if such agreement controls any duties, rights or benefits under the Plan.

The Trustees are assisted in the administration of the Plan by an Administrative Manager, who is a third party administrator. The name and address of the Fund's Administrative Manager, which is also the address of the Benefit Office, is shown on the inside front cover of this booklet and on page 114.

Service of Legal Process - Service of legal process may be made on the Board of Trustees or on any individual Trustee. Service may also be made on the Administrative Manager.

Source of Financing/Plan Participation - The Fund receives contributions from employers under the terms of collective bargaining agreements and participation agreements and from the Union. The Fund also receives self-payments from employees, retirees and dependents for the purpose of continuing coverage under the Plan. It may also receive rebates from its prescription benefit manager.

Employees are entitled to participate in this Plan if they work under one of the collective bargaining agreements or participation agreements and if the required contributions are made to the Fund on their behalf. Administrative employees of the Union are also entitled to participate in the Plan.

Type of Plan/Accumulation of Assets/Payment of Benefits - The NECA/IBEW Family Medical Care Plan is classified as a health and welfare benefit plan, providing benefits of the type described in the following paragraph. Employer contributions and self-payments by employees, retirees and dependents are received and held in trust by the Trustees pending the payment of benefits, insurance premiums and administrative expenses.

The Plan provides medical (hospital and physician), prescription drug, disability, dental and vision benefits on a self-insured basis. When benefits are self-insured, the benefits are paid directly from the Fund to the claimant or beneficiary. The self-insured benefits payable by the Plan are limited to the Plan assets available for such purposes. Although, as described earlier in the Summary Plan Description, Blue Cross re-prices claims involving medical, surgical and hospital benefits, MetLife reprices and processes dental claims, and VSP processes vision claims, the services of these companies are in the nature of claims processing and/or limiting the amount the Plan must pay providers. All benefits paid remain self-insured.

This Plan is not an insurance policy and no benefits other than the life insurance and AD&D insurance are provided by or through an insurance company. The Plan provides life insurance and AD&D insurance benefits through Union Labor Life Insurance Company, 1625 Eye Street N.W., Washington, D.C., 20006.

***Plan/Fund Year* -** The Plan's financial records are maintained on a twelve-month fiscal year basis, beginning January 1 of each year and ending December 31 of the same year.

Plan/Fund Identification Numbers - The Employer Identification Number (EIN) assigned to this Plan by the I.R.S. is 75-3198514. The Plan Number (PN) assigned to the Plan of Benefits is 501.

BOARD OF TRUSTEES

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HOW TO CONTACT THE BENEFIT OFFICE OR TRUSTEES

To Contact the Benefit Office

- Call 1-877-937-9602, or
- Write a letter to:

  NECA/IBEW Family Medical Care Plan
  5837 Highway 41 North
  Ringgold, GA 30736

To Write to the Board of Trustees

Address your letter as follows:

Board of Trustees
2400 Research Boulevard
Suite 500
Rockville, MD 20850

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