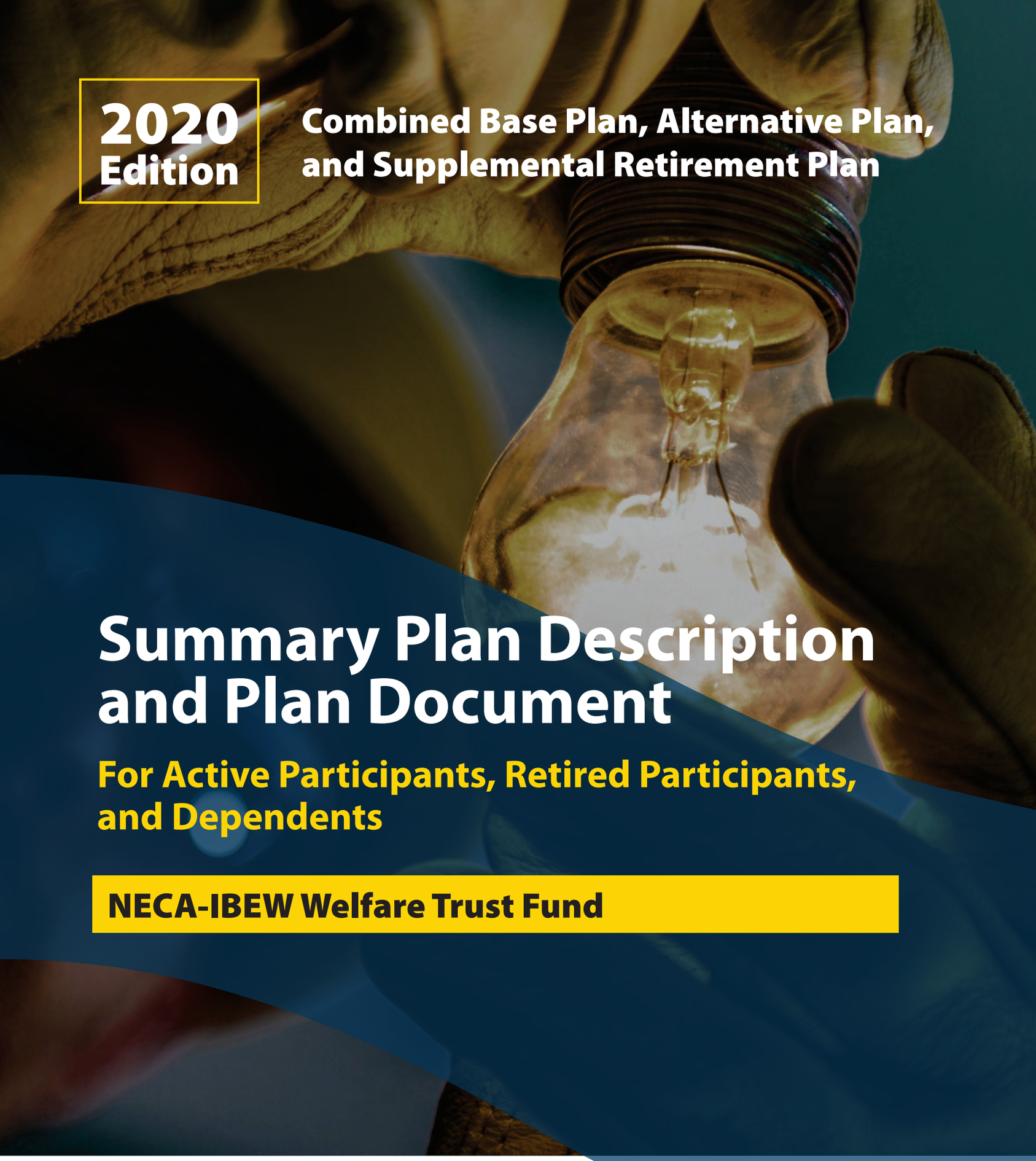

2020 Edition

Combined Base Plan, Alternative Plan, and Supplemental Retirement Plan

Summary Plan Description and Plan Document

For Active Participants, Retired Participants, and Dependents

NECA-IBEW Welfare Trust Fund

NECA
NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS

NECA-IBEW Welfare Trust Fund

2120 Hubbard Avenue
Decatur, IL 62526-2871
800-765-4239
www.neca-ibew.org

Fund Administrator

Kevin Cope

Legal Counsel

Cavanagh & O'Hara, LLP

Fund Auditor

Kerber, Eck & Braeckel, LLP

Fund Consultant

Segal

Agent for Legal Process

Kevin Cope

Statement of Grandfathered Status

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

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

Table of Contents

Introduction

The information in this Summary Plan Description and Plan Document (SPD) explains the Fund's rules and procedures and describes the benefits and coverage offered by the Fund for the Base Plan, Alternative Plan, and Supplemental Retirement Benefit Plan.

This document contains a description of the features of the NECA-IBEW Welfare Trust Fund's various plans for active Employees, retirees, and their Dependents in effect as of July 1, 2020 (unless otherwise specified in this document or the separate "Schedules of Benefits" document). Throughout this SPD, the NECA-IBEW Welfare Trust Fund will be referred to as the "Fund" or the "Welfare Trust Fund." You can also find information in the Fund's newsletters, website, notices, and Trust Agreements, insurance contracts, and Collective Bargaining Agreements that establish the Plan provisions. If there is a discrepancy between the wording in any of those other documents and the wording in this SPD, the language in the SPD will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time. This updated SPD also serves as the Fund's Plan Document and replaces and supersedes any prior Summary Plan Description and/or any prior Plan Document. If this SPD is amended or modified, you will receive written notice of such change.

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

This SPD is adopted by the Trustees of the NECA-IBEW Welfare Trust Fund under the Fund's Trust Agreement to establish the rules and regulations determining the Eligibility of Employees and Dependents for the health and welfare benefits to be provided by the Fund and to prescribe the amount, extent, condition, and method of payment of such benefits.

Automated Information System

The NECA-IBEW Welfare Trust Fund has created an automated information system for you to access certain benefit information. Please use the automated information system to confirm your Eligibility and/or claim status rather than calling the Fund Office. In order to obtain your information from the system, please be prepared to provide your unique ID number (which is located on your BlueCross BlueShield card (after the "NEC"), your CVS Caremark card, and/or your NECA-IBEW Welfare Trust Fund Medicare Retiree Card), the date of birth of the patient, and/or the date of service of the claim you are inquiring about. The system is very efficient. To use the system:

- Call 800-765-4239.
- When your call is answered, listen to the instructions and follow the system's prompts to direct your call.

You can also find instructions for using the phone system on our website.

NECA-IBEW Website

The NECA-IBEW Welfare Trust Fund has also created a website for you to access certain benefit information. The website, www.neca-ibew.org, is designed to be a resource for NECA-IBEW members, their families, and others requiring information about our organization or the benefits administration of the Welfare Trust Fund and Pension Trust Fund.

The Board of Trustees of the Fund is dedicated to making the information easily accessible to Participants and beneficiaries. Please contact us with questions, for additional information, or if you have suggestions for other website features that might be helpful to you.

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

- Access the Member Benefits Portal, which includes electronic copies of Explanation of Benefits (EOB) statements, or "EOBs";
- Access the Wellness Power Portal;
- Access an electronic version of this SPD;
- Access current and past issues of the Fund's newsletters;
- Access information about your Health Reimbursement Account (HRA), including a list of Eligible expenses, reimbursement forms, and a link to the HRA Participant Portal to view your HRA balance, contributions, and claim information;
- Access claim forms and other forms;
- Check on claims and Eligibility status for you and your family;
- Find out more about your medical and prescription drug coverage; and
- Contact the Fund Office.

Online Member Benefits Portal

The Welfare Trust Fund launched the Member Benefits Portal to help you have access to information 24 hours a day, seven days a week. You can access the portal from the Fund's website. Here are some of the things you can do when you visit the Member Benefits Portal:

- Check your future benefits Eligibility. You can still call the Fund's automated phone system, but you can also check your Eligibility online.
- See information about your Dependents who are under the age of 18 when you log in. You do not need to create separate logins for your Dependents who are under 18.
- Check your progress toward meeting your Deductible.
- Check claims status and search for claims by provider, dollar amount, date, Dependent name, etc.
- View your work history to ensure it was reported correctly.
- Verify demographic information.
- View Explanation of Benefits statements.

- View Disability payments made to the Participant (if applicable).
- View beneficiary information. Remember to keep your beneficiary information up to date!

If you have not already set up a Member Benefits Portal Account, you should do it as soon as possible. You will need to create an account in order to access your information. Go to the Welfare Trust Fund's website, www.neca-ibew.org, for instructions on how to set up an account and to find a link to the portal.

The Member Benefits Portal is designed to keep your information safe, private, and secure.

Points to Remember

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

Plan Definitions

Here some definitions to help you understand the benefits in this SPD:

Administrator or Plan Administrator: The term "Administrator" or "Plan Administrator" will mean the Board of Trustees. The Board of Trustees has delegated authority to the Fund Office to administer the Plan on a day-to-day basis.

Allowable Charge:

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

Ambulatory Medical-Surgical Facility: The term "Ambulatory Medical-Surgical Facility" will mean a surgical or medical center licensed by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located that is operating within the scope of its license or operating as part of a Hospital, solely engaged in providing surgical or medical care on an outpatient basis.

Association: "Association" will mean Associations of Electrical Contractors and/or the Chapters of the National Electrical Contractors Association, Inc., who become parties to or bound by the Trust Agreement.

Behavioral Health Disorder: Any Illness that is defined in the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol, psychiatric drugs, or medications, regardless of any underlying organic cause.

This includes, among other things, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods.

Substance abuse means a psychological and/or physiological dependence or addiction to alcohol, drugs, or medications, regardless of any underlying physical or organic cause and/or other drug

dependency as defined by the current edition of the ICD manual or identified in the current edition of the DSM.

Calendar Year: The term "Calendar Year" means the 12-month period from January 1 of each year through December 31 of the same year. The Calendar Year is the Plan's benefit year, which is the period by which the Plan calculates benefit limits, Deductibles, and Out-of-Pocket Maximums, as well as other benefits and benefit limitations.

Coinsurance: When the Plan pays a percentage of Covered Expenses and you pay the rest, this is called Coinsurance.

Copayment: A Copayment is the flat dollar amount that you are responsible to pay before the Plan begins to pay certain Covered Expenses.

Cosmetic or Reconstructive Surgery: The term "Cosmetic or Reconstructive Surgery" will mean any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat Sickness or disease. However, a Cosmetic or Reconstructive Surgery can also include procedures to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an accident or trauma, or disfiguring disease.

Covered Medical Expenses or Covered Expenses: The Allowable Charges incurred for Medically Necessary covered medical services and supplies required for treatment. These must be recommended and approved by the attending Physician and must be consistent with the symptoms or diagnosis of the condition.

Custodial Care: The term "Custodial Care" will mean care that is provided to help an individual with daily living activities such as walking, bathing, dressing, grooming, assisting in and out of bed, eating, preparing foods, and laundry. The term "Custodial Care" will also mean any service that could be performed by a person without any medical or paramedic training.

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

Dependent: Your Eligible Dependents include your:

- Spouse, provided you are not divorced or legally separated; and
- Children, provided they are:
  - Under 26 years of age;
  - Over age 26, permanently and Totally Disabled and incapable of any gainful activity and/or self-sustaining employment due to a medically determinable physical or mental impairment that began before the child attained age 26 and is expected to result in death or last for a continuous period of 12 months or more. However, if your Disabled child loses Eligibility for coverage because he or she becomes employed and self-sustaining, the child may again be considered a Dependent if he or she once again becomes permanently and Totally Disabled and incapable of any gainful activity and/or self-sustaining employment due to a medically determinable physical or mental impairment; and

- Named under a Qualified Medical Child Support Order (QMCSO). A QMCSO is a medical child support order that:
  - Is made pursuant to a state domestic relations law (including a community property law) or certain other state laws relating to medical child support; and
  - Provides for child support or health benefit coverage for a child of a Participant under a group health plan and relates to benefits under the plan.

In addition to children named under a Qualified Medical Child Support Order (QMCSO), children may include your:

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

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

- You are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or have lived apart from the child's other parent at all times during the last six months of the Calendar Year;
- You and/or the child's other parent provide more than 50% of the child's support and maintenance during the Calendar Year; and
- The child is in your custody or the custody of the child's other parent for more than one-half of the Calendar Year.

Your Dependents' Eligibility for coverage ends on the earliest of the:

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

- With respect to a divorce, last day of the month the divorce decree is entered by the court and finalized; or
- With respect to Dependents of retirees, the last day of the month in which the Dependent fails to make a self-contribution in accordance with the terms of the Plan. If this happens, coverage will not be reinstated.

Electrician: The term "Electrician" will mean any Employee engaged in doing work of the character falling within the jurisdiction of the Local Unions affiliated with the International Brotherhood of Electrical Workers.

Eligible or Eligibility: The terms "Eligible" or "Eligibility" will mean being entitled to the benefits payable under the provisions of the Plan by virtue of having fulfilled the Eligibility requirements stated in this Plan.

Employee: The term "Employee" will mean:

- With respect to bargaining unit Employees, all construction and non-construction Employees employed by a Participating Employer on whose behalf a Union acts as a bargaining agent and who are covered by a Collective Bargaining Agreement requiring contributions to the Trust Fund by a Participating Employer; or
- With respect to non-bargaining Employees, all Employees employed by a Participating Employer who are covered by terms of one of the Fund's participation agreements.

Employed in the Industry: The term "Employed in the Industry" will mean employment by a Participating Employer that is engaged in electrical construction or in fields directly related to electrical construction and that is obligated under a Collective Bargaining Agreement to make contributions to the Fund on behalf of its Employees.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as "Experimental and/or Investigational." If your procedure is Experimental or Investigational, it may not be covered. If you are not sure if your procedure is Experimental or Investigational or if it is covered, you should call the Fund Office before you have the procedure to make sure that it will be covered.

A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Pre-certification under the Plan, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;

3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental, or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental, or scientific experts: classify the service or supply as Experimental and/or Investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;

4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is:

    a. Approved by the FDA as an "investigational new drug for treatment use"; or

    b. Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or

    c. Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

5. The prescribed service or supply is available to the Covered Person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, the National Institutes of Health, or a pharmaceutical or biotechnology manufacturer.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for Pre-certification under the Plan:

1. Medical or dental records of the Covered Person;

2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;

3. Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply;

4. Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the Covered Person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information" and "American Hospital Formulary Service";

5. The published opinions of the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program," etc.; or specialty organizations recognized by the AMA; or the

National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the published screening criteria of national insurance companies such as Aetna and Cigna, or the American Dental Association (ADA), with respect to dental services or supplies;

6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply; and

7. The latest edition of "The Medicare Coverage Issues Manual."

Gene and Cellular Therapy Products: Certain Gene and Cellular Therapy Products are products included on the Select Drugs and Products List, as defined by the Office of Tissues and Advanced Therapies (OTAT) of the U.S. Food and Drug Administration, under either the Medical Benefits or the Prescription Drug Benefits.

Home Health Care:

- The term "Home Health Care" will mean the services and supplies defined under "Home Health Care Plan" as defined below. Home Health Care must replace a needed Hospital stay, must be for the care or treatment of sick or injured Persons, and must be furnished by a Home Health Care Agency, in accordance with the Home Health Care Plan.
- "Home Health Care Agency" will mean a:
  - Hospital;
  - Visiting nurse association licensed by the state; or
  - Non-profit or public Home Health Care Agency or organization licensed as such by the jurisdiction in which it is located.
- "Home Health Care Plan" consists of these services and supplies:
  - Part-time nursing care provided by a registered nurse, a licensed public health nurse, or licensed vocational nurse supervised by a registered nurse, not to exceed:
    - Two hours of nursing service in a 24-hour period; and
    - 60 visits per occurrence;
  - Part-time or intermittent home health aide services;
  - Physical, occupational, or speech therapy provided in the Eligible Person's home;
  - Physical, occupational, or speech therapy or the use of medical equipment provided on an outpatient basis by either a Home Health Care Agency, Hospital, or other facility, if arranged with the Home Health Care Agency; or
  - Medical supplies, drugs, and medications prescribed by a Physician or Surgeon, and related pharmacy and laboratory services, but only to the extent that they would have been covered in a Hospital.
- Each visit from a Home Health Care Agency team of four hours or less is considered a single visit. The Eligible Person must be homebound to qualify for benefits under this definition, except if the patient is a minor child being cared for at home or in a daycare facility. If, under these latter circumstances involving a minor child, there is no practicable or economically feasible way, in light of the Eligible Person's particular circumstances, to transport the child to an outpatient facility to receive speech therapy (and proof of such circumstances will be the burden of the Eligible Person to establish), the Fund will pay for the therapy to be

provided in the home or daycare facility, but only up to the amount the Fund would have paid had the service been rendered at the outpatient facility.

Hospice:

- The term "Hospice" will mean an agency or organization (including a facility within a Hospital) that administers a coordinated plan of home and/or inpatient care, which treats the terminally ill patient and family as a unit. The Plan provides palliative and supportive health care services to meet the special needs of a Family Unit during the final stages of a terminal Illness and during bereavement. Care is provided by a team made up of trained medical Hospice administration to help the Family Unit cope with physical, psychological, spiritual, social, and economic stresses. The Hospice administration must be approved as meeting established standards, including any legal licensing requirements of the jurisdiction in which it operates.
- "Hospice Benefit Period" means a period prior to the terminally ill patient's death and a period of bereavement after the patient's death as follows:
  - Benefit Period: This period begins on the date the attending Doctor certifies that an Eligible Person of the Family Unit is a terminally ill patient. It ends six months after it began, or on the death of the patient, if sooner. If the patient is living at the end of the benefit period, a new benefit period may begin if the attending Doctor certifies that the patient is still terminally ill.
  - Period of Bereavement: This period begins on the death of the terminally ill patient; it ends 12 months after it began.
- "Home Health Care Services" for purposes of Hospice care will mean:
  - Part-time nursing care rendered in the Family Unit's home by:
    - A registered nurse (RN);
    - A licensed practical nurse (LPN);
    - A licensed public health nurse; or
    - Nurses' aides when registered nurses are not available;
  - Physical therapy rendered in the Family Unit's home;
  - The use of medical equipment; and
  - The rental of wheelchairs and Hospital-type beds.
- "Bereavement Services" for purposes of Hospice care will mean those supportive services provided in the counseling sessions with the Family Unit to assist them in coping with the death of the terminally ill patient.
- "Attending Doctor" for purposes of Hospice care will mean a Doctor who is:
  - Charged with the overall care of the terminally ill patient, and
  - Responsible for directing the treatment program.
- "Family Unit" for purposes of Hospice care will mean the Employee and the Employee's Eligible Dependents, if any.
- "Terminally Ill Patient" for the purposes of Hospice care will mean an Employee or a member of the Employee's Family Unit with a life expectancy of six months or less, as certified by the attending Doctor.

Hospital:

- The term "Hospital" will mean any non-government-sponsored Hospital (except VA Hospitals) accredited by The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations), licensed by the state, and approved by Medicare as a Hospital that provides inpatient medical care and treatment for sick and injured Persons.
- Services provided by a Hospital must also include:
  - Diagnosis of Injury and Sickness;
  - Full-time supervision by at least one Physician;
  - 24-hour services provided by Physicians and by graduate registered nurses;
  - Surgery or formal arrangements for available surgical facilities; and
  - Therapeutic care of patients who are convalescing from Injury or Sickness.
- The surgery requirement will be waived if treatment for services is provided for:
  - Behavioral Health Disorders;
  - Rehabilitation from a Sickness; or
  - If the institution would otherwise qualify as a "Hospital."
- "Hospital" also includes:
  - Any institution accredited by The Joint Commission, licensed by the state, and recognized by Medicare that is used primarily for the treatment of Behavioral Health Disorders.
  - For the purposes of maternity only, an "Alternative Birthing Center," which will mean:
    - A birthing center operating as a part of a Hospital; or
    - A freestanding facility engaged in providing an alternative to conventional obstetrics that:
      - Is licensed as such and operating within the scope of the license recognized by the jurisdiction in which it is operating;
      - Is directed by a Physician specializing in obstetrics or gynecology;
      - Has a Physician or certified nurse-midwife present at all births and during the immediate postpartum period; and
      - Is equipped and has trained staff or has a written agreement with a Hospital to handle emergencies including the transfer of a patient or child.

Hour Bank: All hours worked in excess of 420 hours worked during the initial Eligibility period or in excess of 140 hours each month after meeting the Plan's initial Eligibility requirements will be credited to an individual Hour Bank. Accumulated hours in your Hour Bank allow you to continue Eligibility during periods of unemployment and underemployment. The maximum balance permitted to accumulate in your Hour Bank is 840 hours (equivalent to six months of Eligibility). An Hour Bank is not established in your name until you have met the Plan's initial Eligibility requirements. Your Hour Bank may be forfeited if you engage in Prohibited Employment as described below.

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

Legend Drug: The term "Legend Drug" will mean any drug or medicine that is required to bear the legend "CAUTION: Federal Law Prohibits Dispensing Without a Prescription," or similar warning.

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

- Provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide and prescribe it;
- Necessary in terms of generally accepted American medical standards;
- Consistent with the symptoms or diagnosis and treatment of a Sickness or Injury;
- Not provided solely for the convenience of the patient, Physician, Hospital, health care provider, or facility;
- Appropriate, as defined by the Plan, given the patient's circumstances and conditions;
  - According to the Plan's definition, a medical service or supply will be considered appropriate if:
    - The diagnostic procedure is called for by the health status of the patient and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the Sickness or Injury involved and the patient's overall health condition.
    - The care or treatment is as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the Sickness or Injury involved and the patient's overall health condition;
- Cost-efficient, as defined by the Plan, for the supply or level of service that can be safely provided to the patient;
  - According to the Plan's definition, a medical service or supply will be considered cost-effective if it is no more costly than any alternative "appropriate" service or supply when considered in relation to all health care expenses incurred in connection with the service or supply;
- Safe and effective for the Sickness or Injury for which it is used.

The fact that a Physician may provide, order, recommend, or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan. The Plan reserves the right to decline coverage for new experimental and/or technological innovative medical procedures that have not been historically covered, notwithstanding the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid Services (CMS) approval of such treatment.

A Hospitalization or confinement to a facility will not be considered to be Medically Necessary if the patient's Sickness or Injury could safely and appropriately be diagnosed or treated while not confined.

A medical service or supply that can safely and appropriately be furnished in a Physician's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital, facility, or other more costly facility.

The non-availability of a bed in another facility, or the non-availability of a Physician to provide medical services will not result in a determination that continued confinement in a Hospital or other facility is Medically Necessary.

A medical service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Physician or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Physician, Hospital, or facility.

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

Non-Contributing Employer: The term "Non-Contributing Employer" will include any employer that performs work in the electrical construction industry that is covered by an area-wide construction industry Collective Bargaining Agreement that does not remit contributions to this Plan. Non-Contributing Employer will not include any public employer.

Organ Transplant: The term "Organ Transplant" will include any covered transfer of body organ(s) from the donor to the recipient. The donor will mean the individual who undergoes a surgical operation for the purpose of donating body organ(s) for Organ Transplant surgery. The recipient will include any Person Eligible for benefits under the terms of the Plan who undergoes a surgical operation to receive an Organ Transplant.

Out-of-Pocket Maximum: The portion of Covered Medical Expenses that you must pay, after you meet any applicable Deductibles, before Covered Medical Expenses are paid at 100%. The Out-of-Pocket Maximum does not include medications obtained through the Select Drugs and Products Program. Please refer to the applicable schedule in the "Schedules of Benefits" document for more information about the Out-of-Pocket Maximum.

Participant: The term "Participant" will mean any individual on whose behalf contributions are made to the Trust Fund pursuant to the provisions of a Collective Bargaining Agreement, Participation Agreement, the Trust Agreement, and this Plan of Benefits. A Participant may become Eligible to receive benefits for the Participant and the Participant's Dependents only upon meeting the Eligibility requirements of the Plan.

Participating Employer: The term "Participating Employer" will mean:

- Any person, partnership, firm, or corporation employing Electricians that has become a party to or bound by the Agreement and Declaration of Trust and has agreed by a Collective Bargaining Agreement with the Union to make remittances, or contribute, to the Trustees, as a part of this Trust Fund such sums as the employer may be obligated to contribute or remit in accordance with said Collective Bargaining Agreement for each hour worked for such employer by an Eligible Employee;
- The Association, the Union, any Building Trades Council with which any Union is affiliated, the National Electrical Health and Welfare Fund, and Apprenticeship Committees or Apprenticeship Trusts and Receiving Trusts that were created by agreement between the Association and the Union in their capacity as employers, as to those of its Employees on whose behalf contributions had previously been made to this Trust Fund;

- The current Administrator of the Fund for the purpose of making contributions solely for those of its full-time Employees in the Decatur, Illinois office of such Administrator;
- Such other persons or entities as are not covered by a Collective Bargaining Agreement, but should, in the sole discretion of the Trustees, be covered, so long as a signed written Participation Agreement in a form acceptable to the Trustees is submitted evidencing such agreement; or
- Any local, regional, state, national, or international labor organization of which the Union is an affiliate may make contributions on behalf of those of its Employees on whose behalf contributions had been made to the Trust Fund while they were employed as Electricians. Contributions on behalf of such individuals will be made at the rate per hour and for the number of hours per month as may be established in a Participation Agreement between such labor organization and the Trustees.

Person: The term "Person" will mean active or retired Employees or their Dependent(s).

Physician, Doctor, or Surgeon: The term "Physician," "Doctor," or "Surgeon" will mean a person who is licensed to practice medicine and surgery as a Doctor of medicine or as a Doctor of osteopathy. While acting within the scope of the person's practice to the extent that benefits are provided, Physician, Doctor, or Surgeon will also include a person legally licensed to practice as a dentist, podiatrist, chiropractor, optometrist, or psychologist referred by, or working under, the direction of a Doctor of medicine. Physician will not include the Participant or the Participant's Dependents or any other person who is the spouse, parent, child, brother, or sister of an Employee or the Employee's Dependents.

Plan, Benefit Plan, or Plan of Benefits: The term "Plan," "Benefit Plan," or "Plan of Benefits" will mean the Health and Welfare Plan described in this SPD and as it may be amended from time to time by the Trustees.

Plan Year or Fiscal Year: "Plan Year" or "Fiscal Year" means the 12-month period from July 1 to June 30. The Plan Year or Fiscal Year is the period used by the Plan for financial reporting and disclosure requirements for all Plan benefits, including the Health Reimbursement Account (HRA). All records of the Fund are kept consistent with the Plan Year/Fiscal Year. The Plan Year/Fiscal Year is different from the 12-month benefit administrative period, which is the Calendar Year.

Pre-authorization/Prior Authorization/Prior Approval/Pre-certification: A decision by the Fund that a health care service, treatment plan, prescription drug, or durable medical equipment is Medically Necessary. Sometimes called Prior Authorization, Prior Approval, or Pre-certification, the Fund requires Pre-authorization for the following four services: bariatric surgery, solid organ/blood and marrow/stem cell transplants (including meniscal allograft transplant for Eligible Persons under age 55), surgical services and/or hormone therapy related to gender dysphoria, and drugs and medications listed on the Plan Select Drugs and Products List. The Fund does not *require* Prior Authorization/Pre-certification unless is it one of these services. However, we strongly recommend a pre-service/pre-determination review by MCM, our Utilization Review vendor, as the Fund does not cover anything considered not Medically Necessary or appropriate, Experimental/Investigational, off-label, or in any phase of a current clinical trial. If we receive a claim that triggers a "second look" in our system, the Fund will request medical records for a retrospective review. If the service or procedure is deemed NOT

Medically Necessary or appropriate upon completion of the retrospective review, the claim(s) for that service or procedure will be denied.

Prohibited Employment: The term "Prohibited Employment" will include work regularly and historically performed by electrical workers. Any employment which requires contributions to this Plan will not be considered Prohibited Employment.

Residential Treatment Program/Facility/Care: The term "Residential Treatment Program/Facility/Care" means a non-acute Hospital, intermediate inpatient setting with 24-hour level of care that operates seven days a week, for individuals with Behavioral Health Disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by the Plan, a facility must be licensed as a Residential Treatment Facility (licensure requirements for this residential level of care may vary by state).

Room and Board Charges: The term "Room and Board Charges" will mean all charges for room, board, general duty nursing, and any other charges by whatever name called that are regularly made by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services or personal convenience items.

Select Drugs and Products List: This is a list of Specialty medications or Gene and Cellular Therapy Products that are subject to step therapy, Prior Authorization, and administrative review and must be acquired after enrollment in the Plan's Specialty medication Program for coverage limits to apply.

Select Drugs and Products Program: This term means a program for which the Plan requires Participants to enroll in the program to receive coverage for medications or biologics listed on the Plan's Select Drugs and Products List. All Plan Participants seeking coverage for such products are required to meet Prior Authorization criteria, which includes enrollment in the Select Drugs and Products Program. Plan Participants choosing not to enroll in the Select Drugs and Products Program may be charged 100% of the billed charges, subject to the automatic claim review process and charges required to be covered by applicable law.

Sickness or Illness: A "Sickness" or "Illness" includes:

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

Skilled Nursing Care: The term "Skilled Nursing Care" means services performed by a licensed nurse (RN, LVN, or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on a less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to, the initiation of intravenous therapy and the initial management of medical gases, such as oxygen.

Skilled Nursing Facility:

- The term "Skilled Nursing Facility" means a Subacute Care Facility, licensed by the state and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, Disabled, or sick people, and that meets all of the following requirements:
  - It is accredited by JCAHO and/or certified by Medicare as a Skilled Nursing Facility; and
  - It is regularly engaged in providing room and board and continuously provides 24-hour-a-day Skilled Nursing Care of sick and injured Persons at the patient's expense during the convalescent stage of an Injury or Sickness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
  - It provides services under the supervision of Physicians; and
  - It provides nursing services by or under the supervision of a licensed registered nurse (RN), with one licensed registered nurse on duty at all times; and
  - It maintains a daily medical record of each patient who is under the care of a licensed Physician;
- A Skilled Nursing Facility (SNF) unit and/or "swing bed" that is part of a Hospital, as defined by this Document, will be considered a Skilled Nursing Facility for the purpose of this Plan.
- The term "LTACH" or "Specialty Hospital" means a freestanding acute care facility, licensed by the state and operated according to law, that primarily provides acute care Hospital services for patients who require ongoing acute care medical treatment that is projected to extend past 25 days due to complex wound care, ventilator dependence, and/or complex medical care, and that meet the following requirements:
  - It is accredited by JCAHO as a Subacute Care Facility and is certified by Medicare as a Subacute Care Facility; and
  - It maintains on its premises all facilities necessary for medical care and treatment; and
  - It provides services under the supervision of Physicians; and
  - It provides nursing services by or under the supervision of a licensed registered nurse.

Subacute Care Facility:

- The term "Subacute Care Facility" means a public or private facility, either freestanding, Hospital-based, or based in a Skilled Nursing Facility or as a stand-alone facility, licensed and operated according to law, and authorized to provide Subacute Care (sometimes called specialty care or post-acute care, comprehensive inpatient care for an individual who has had an acute Illness, Injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets all of the following requirements:
  - It is accredited by The Joint Commission as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
  - It maintains on its premises all facilities necessary for medical care and treatment; and
  - It provides services under the supervision of Physicians; and

  - It provides nursing services by or under the supervision of a licensed registered nurse; and
  - It is not (other than incidentally) a place for rest, domiciliary (non-skilled/Custodial Care) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
  - It is not a hotel or motel.
- A Subacute Care Facility is sometimes referred to as a specialty Hospital or long-term care (LTC) facility.

Total Disability, Disability, Totally Disabled, or Disabled: In the case of an Eligible Employee, a "Total Disability" is said to be present if the Employee is completely unable to perform the duties pertaining to the Employee's occupation within the Electrical Industry/or usual occupation and ineligible for compensation continuation from an electrical employer.

Trust Agreement: The terms "Agreement and Declaration of Trust" and "Trust Agreement," as used in this SPD, will mean the instrument, including any amendments hereto, which establishes the NECA-IBEW Welfare Trust Fund.

Trust Fund: The terms "Trust," "Fund," "Trust Fund," "Welfare Fund," and "Welfare Trust Fund," as used in this SPD, will mean the NECA-IBEW Welfare Trust Fund, the Trust Fund created pursuant to the Trust Agreement.

Union or Participating Local Union: The terms "Union" or "Participating Local Union" will mean the Local Unions affiliated with the International Brotherhood of Electrical Workers who have or will become signatory to the Trust Agreement.

Utilization Review: This term means any organization selected by the Trustees that contracts with the Fund to review the prescribed care suggested by the attending Physician or other professional providers and to provide large case management. For purposes of Utilization Review, the Fund will only refer cases for review to the organization(s) selected by the Trustees and will in no way be involved in the decision-making process of the Utilization Review organization(s).

The Utilization Review process determines whether certain services, treatments, and/or supplies are Medically Necessary. Currently, Medical Cost Management (MCM) provides Utilization Review and case management services for medical and behavioral health care on behalf of the Fund.

Virtual Care: A health care service through the use of online technology (computer, tablet, or smartphone), telephonic, or secure messaging transmission of member-initiated care from a remote location (for example, home); with a provider that is diagnostic- and treatment-focused; and the member is NOT located at a health care site.

Summary of Eligibility Rules

Construction Bargaining Group Employees (Based on Hourly Contribution Rate)

If you work under a Collective Bargaining Agreement requiring that your employer contribute an hourly contribution to the Fund on your behalf and your bargaining unit joins the Plan on or after January 1, 2008, you are Eligible for benefits after you meet the Plan's Eligibility rules. Continuing Eligibility is based on an Hour Bank system, as described on page 21.

Initial Eligibility

Initial Eligibility begins on the first day of the second calendar month after you have 420 employer contribution hours made on your behalf in a six-consecutive-month period. Self-pay hours do not count toward earning initial Eligibility.

You may accumulate the required 420 hours in less than six months. If this is the case, your Eligibility begins on the first day of the second calendar month after working 420 hours. (Note there is a lag month between when Eligibility is met and when coverage begins.) These hours provide you with Eligibility for your first month of coverage. The following is an example of how you may become initially Eligible for benefits:

Month Worked	Monthly Hours Worked	Cumulative Hours Worked	Eligibility
January	140	140	Not yet Eligible.
February	140	280	Not yet Eligible.
March	140	420	Initial Eligibility met; coverage not yet effective.
April	140	560	Initial Eligibility met. Lag month; coverage not yet effective.
May	140	700	Coverage begins first of month (i.e., May 1) based on hours worked in January through March.

Please note that all hours worked in excess of 420 hours during the initial Eligibility period are credited to your Hour Bank (see page 21).

Accelerated Eligibility

The initial 420-hour requirement will be waived for Employees of newly organized employer groups, newly indentured first-year apprentices, and newly organized Employees who have never before been Eligible under the Plan. Eligibility will begin on the first day of the second calendar month in which at least 140 hours are contributed on their behalf. To continue Eligibility, at least 140 hours must be contributed each month or monthly COBRA Continuation Coverage premiums must be paid.

When contribution hours are less than 140 hours in a month, the Participant will have to maintain Eligibility by making a COBRA Continuation Coverage premium payment. No accumulated Hour Bank hours in excess of 140 can be used to continue Eligibility or for adjusted COBRA Continuation Coverage premium payments until at least a total of 420 contribution hours have been credited to the new Employee under these accelerated Eligibility provisions. The hours reported will be credited toward the 420 hours that were initially waived. In the event the Participant does not maintain Eligibility or does not have employer contributions for six consecutive months, the Participant will lose his or her accelerated Eligibility status and will be required to gain Eligibility by meeting the initial Eligibility requirements as explained above.

An Hour Bank is not established for new Employees until they have met the initial Eligibility requirements. Thereafter, new Employees may use their Hour Bank to continue Eligibility. For example, if a new apprentice works 160 hours in January, he or she will become Eligible in March; the additional 20 hours will NOT be credited to an Hour Bank. He or she must continue to have at least 140 hours for Eligibility each month to maintain Eligibility. Once he or she meets the initial 420-hour requirement, if he or she works over 140 hours in a month, those excess hours will begin to accumulate in his or her Hour Bank and he or she may use that Hour Bank to continue Eligibility in the future if he or she should work fewer than 140 hours in a month.

Continuing Eligibility

Eligibility continues on a month-to-month basis as long as:

- You work 140 hours a month;
- The total in your Hour Bank is at least 140 hours; or
- The hours you work in a month combined with the hours in your Hour Bank total 140.

NOTE: There is a lag month between the month you work and the month those same work hours are counted for Eligibility and coverage. For example, 140 hours worked in July (or a 140 Hour Bank balance alone or when combined with the hours worked in July) provide you with coverage for September. The following is a sample of a bargaining group Employee’s use of the continuing Eligibility and Hour Bank rules:

Work Month	Hours Worked	Hours Credited to or Drawn from Hour Bank	Hour Bank Balance	Benefit Month
Starting Base			**480**	**February**
January	**160**	**+20**	**500**	**March**
February	**140**	**0**	**500**	**April**
March[1]	**100**	**-40**	**460**	**May**
April	**0**	**-140**	**320**	**June**
May	**0**	**-140**	**180**	**July**
June	**140**	**0**	**180**	**August**
July	**160**	**+20**	**200**	**September**
August	**90**	**-50**	**150**	**October**
September	**0**	**-140**	**10*[2]**	**November**
October[3]	**0**	**COBRA/Hours**	**0**	**December**
November	**0**	**COBRA**	**0**	**January**

Extended Eligibility for Active Member Organ Donors

The Fund will freeze their Hour Bank and grant 21 months of Eligibility due to Disability to all active Participants who donate an organ either to a family member or to another Participant covered under the Fund. (Family members include a spouse, child, sibling, parent, grandchild, or grandparent.)

Single Coverage Tier

The Trustees have authorized a Single Coverage Tier under the Alternative Plan that provides coverage for single Participants and their Eligible Dependent children. Spouses will not be Eligible for coverage under this coverage tier. Participants in this coverage tier will be Eligible for retiree health coverage when they retire but will have to pay the full cost of their retiree coverage at the monthly rate in effect at the time of their retirement. Only certain bargaining unit groups will be Eligible to enroll in this coverage tier.

Hour Bank

All hours worked in excess of 420 hours worked during the initial Eligibility period or in excess of 140 hours each month after meeting the Plan's initial Eligibility requirements will be credited to an individual Hour Bank. Accumulated hours in your Hour Bank allow you to continue Eligibility during periods of unemployment and underemployment. The maximum balance

[1] Because the Participant only worked 100 hours in March, the hours shortage (40 hours) is deducted from the Hour Bank to maintain Eligibility. This provided the Participant with the 140 hours required to maintain Eligibility.

[2] Bargaining Employees may offset their COBRA Continuation Coverage premiums with their accumulated bank hours. The adjusted COBRA Continuation Coverage premium will not extend the maximum period of coverage a bargaining Employee may continue COBRA Continuation Coverage.

[3] If the Participant does not work in October, Eligibility will end on November 30. An adjusted COBRA Continuation Coverage premium will be due for December. Any remaining Hour Bank balance is applied to the Participant's first COBRA payment.

permitted to accumulate in your Hour Bank is 840 hours (equivalent to six months of Eligibility). An Hour Bank is not established in your name until you have met the Plan's initial Eligibility requirements. Your Hour Bank may be forfeited if you engage in Prohibited Employment as described below.

Work in Other Jurisdictions Covered by the Fund

The Fund has administrative practices related to how contributions are credited and how Participants are Eligible for participation in the Base Plan and/or Alternative Plan if the Participant works outside of his or her home Local Union in the jurisdiction of a Local Union that also participates in this Fund but which contributes a different contribution rate and/or participates in a different plan. As an example, these administrative practices apply to circumstances where a Participant's home Local Union participates in the Alternative Plan, but the Participant works in the jurisdiction of a Local Union that participates in the Base Plan. Please contact the Fund Office for more information regarding how contributions are credited and/or how Eligibility for participation is addressed.

Prohibited Employment

Participants who engage in Prohibited Employment and work for a Non-Contributing Employer or are self-employed will forfeit the hours in their Hour Bank and will lose their Eligibility for Fund coverage. If you lose your Eligibility for coverage as a result of engaging in Prohibited Employment and later return to work for a contributing employer, you will have to start over and meet the Fund's initial Eligibility requirements.

A Non-Contributing Employer is defined as any employer that performs work in the electrical construction industry that is covered by an area-wide construction industry Collective Bargaining Agreement but does not make contributions to this Plan. Public employers are not considered Non-Contributing Employers.

Prohibited Employment is defined as work that regularly and historically is performed by electrical workers, but is not being performed through a contributing employer. Any employment that requires contributions to this Plan is not considered Prohibited Employment.

Termination of Eligibility

In general, your Eligibility ends on the last day of the month in which you have less than 140 hours in your Hour Bank. However, your Eligibility may also end as of:

- The 31st day following the date that your Union, representing you for collective bargaining, withdraws from participation in the Trust Fund;
- The first day of the month following the month in which the Collective Bargaining Agreement under which you are working no longer provides for the rate of contribution established by the Trustees for participation in the Trust Fund, unless the Trustees decide to allow Eligible Employees to make a self-contribution of the rate differential in a timely manner in accordance with the rules established by the Trustees;
- The last day of coverage available to you from the use of Hour Bank reserves or COBRA Continuation Coverage following the date you enter the armed forces of the United States; or

- The 31st day following the date that the Participating Employer that had been making contributions on your behalf withdraws from participation in the Trust Fund.

You will also be given an opportunity to continue coverage on a self-pay basis if you choose to elect COBRA Continuation Coverage. See below for further details.

Reinstatement of Eligibility

If your Eligibility ends, it may be reinstated on the first day of the second calendar month following the month in which you have 140 contribution hours credited on your behalf within 12 months of your termination of Eligibility. For example, if your Eligibility ends on March 31 and you are credited with 140 hours to your Hour Bank in June, your Eligibility will be reinstated on August 1.

If, after 12 consecutive months, your Hour Bank has less than 140 hours and there have been no hours credited by Participating Employer contributions, your Hour Bank balance will be reduced to zero and you must meet the Plan's initial Eligibility requirements to again be Eligible. This 12-consecutive-month requirement is waived for an Employee who has been on COBRA for more than 12 months.

Non-Bargaining Construction Employees and Non-Construction Group Employees (Based on Monthly Contribution Rate)

The Fund also covers two other categories of full-time Employees (working more than 20 hours a week), whose employer is obligated by a written agreement to contribute a monthly contribution to the Fund and who join the Plan on or after January 1, 2008, as follows:

- Non-bargaining construction Employees whose employer has signed a participation agreement to pay a monthly contribution based on 160 hours per month.
- Non-construction Employees whose employer is obligated to pay a monthly contribution based on 160 hours per month.

Initial Eligibility

You become Eligible on the first day of the second calendar month following the month in which employer contributions are made on your behalf. For example, if you start work in January, you become Eligible for benefits March 1 based on your employer's contribution (160 hours) paid in February for the work you performed in January.

Continuing Eligibility

Once Eligible, your Eligibility continues on a month-to-month basis as long as a monthly employer contribution is received for you on time by the Fund Office. Each month that you have the sufficient contributions made on your behalf enables you to be Eligible during the second calendar month after the month the contribution was made. Sufficient contributions means that you have at least 140 contribution hours credited on your behalf.

Termination of Eligibility

In general, Eligibility ends on the last day of the month following the month for which a monthly contribution is last paid by your employer on your behalf. For example, if your employer last pays a contribution for your work in April, your Eligibility will end on June 30, but you may continue Eligibility through COBRA as explained in this SPD. However, your Eligibility may also end as of:

- The last day of the second calendar month in which you do not meet the requirements for continued Eligibility;
- The 31st day following the date on which your Collective Bargaining or Participation Agreement is terminated or fails to provide for the required monthly contribution;
- With respect to your Eligibility by payment in accordance with COBRA Continuation Coverage, the first day of the month following the month your premium was not received;
- The last day of coverage available to you from the use of Hour Bank reserves, the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) continuation coverage, or COBRA Continuation Coverage following the date you enter the armed forces of the United States; or
- The 31st day following the date that the employer that had been making contributions on your behalf withdraws from participation in the Trust Fund.

You will also be given an opportunity to continue coverage on a self-pay basis if you choose to elect COBRA Continuation Coverage. See below for further details.

Hour Bank Eligibility (Non-Bargaining Construction Employees Only)

Non-bargaining construction Employees will have 20 hours credited to an individual Hour Bank account for each monthly employer contribution received on their behalf. The accumulated hours in their individual Hour Bank account can then be used for future Eligibility the same way as the Hour Bank system works for bargaining unit construction Employees (see page 21).

This Hour Bank Eligibility system does not apply to non-construction bargaining or non-construction, non-bargaining group Employees.

All other Eligibility rules and conditions of coverage, including continuation of coverage during FMLA or military leave, apply. If you have any questions, please call the Fund Office at 800-765-4239.

Retiree Eligibility

Initial Retiree Eligibility

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

- If you elect COBRA Continuation Coverage under the Active Plan at the time of your retirement, you will lose any future right to receive Supplemental Retirement Benefits. COBRA Continuation Coverage is described in this SPD.
- If you elect Supplemental Retirement Benefits, you will lose any future right to elect COBRA Continuation Coverage. However, your Dependents may be Eligible to elect COBRA Continuation Coverage from the Supplemental Retirement Benefit Plan if they experience a qualifying event while they are covered by the Supplemental Retirement Benefit Plan. See the COBRA Continuation Coverage section starting on page 40.

You may be Eligible for retiree benefits under the Supplemental Retirement Benefit Plan if you meet all of the following criteria:

- Submit a written application to the Fund Office within 90 days of:
  - The last day you work;
  - The date of the award letter, as it appears on the award letter;
  - The date of your Social Security Disability Award; or
  - The expiration of your accumulated Hour Bank.
- Are at least age 55 or Totally Disabled as defined by the Plan.
- Submit proof of retirement acceptable to the Trustees. Proof of retirement means that you are Eligible or have been awarded a retirement or Disability pension from:
  - The National Electrical Benefit Fund;
  - Any other defined benefit pension fund in which Union Trustees are selected by one or more Local Unions affiliated with the IBEW; or
  - The Social Security Administration. Entitlement to a Social Security Disability Award is considered a form of retirement and your Social Security entitlement date will be considered your retirement date. If you work past your Social Security full retirement age and are receiving Social Security benefits, you may provide other proof of retirement other than Social Security benefits.

  In the event you have not been awarded a retirement under any of the above entities, a "Certification of Retirement" may be executed by two trustees in the wage area which is common to your historical work and/or IBEW membership. This "Certification of Retirement" will also qualify as proof of retirement acceptable to the Trustees.
- Are Eligible for active benefits under the NECA-IBEW Welfare Trust Fund during the month in which you retire or the month immediately before you retire.
- Have been Eligible for benefits under the NECA-IBEW Welfare Trust Fund (or working toward Eligibility reinstatement at the rate of at least 80 hours per month) for at least 45 of the last 60 months immediately before:
  - The Fund Office receives your retirement application; or
  - Your entitlement to a Social Security Disability Award (a closed Social Security Disability Award with a specific starting and ending date does not qualify as a Disability pension for these purposes) if you are retiring because of a Total Disability.

Proof of retirement requires proof that a Participant retired from a defined benefit pension plan and/or is receiving Social Security benefits. Retirement from a defined contribution retirement plan (such as an annuity fund, 401(k) plan, profit sharing plan, money purchase plan, etc.) is not acceptable proof of retirement.

For bargaining unit Employees, the 60-month period noted above may be extended by up to 30 months (to a maximum of 90 months). This period may be extended by one month for every month that no hours were reported on your behalf, but during which you were seeking employment with a Participating Local Union. Your Participating Local Union must verify, in writing, that you were seeking employment. This may help you meet the 45-month Eligibility rule.

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

If you are an Employee who comes from a fund that merged with this Fund, and there was not sufficient time for you to accumulate the required 45 of the last 60 months of Eligibility under the NECA-IBEW Welfare Trust Fund, you may be Eligible for the Supplemental Retirement Benefit Plan if:

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

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

If you elect coverage under the Supplemental Retirement Benefit Plan, your Eligibility and self-contribution payment obligation for Supplemental Retirement Benefits will commence as of the later of (i) the date of your first retirement award or entitlement to Social Security benefits; or (ii) exhaustion of active coverage Hour Bank.

If a Medicare-Eligible retired Employee or the Medicare-Eligible Dependent of a retired Employee elects Medicare Prescription Drug Coverage (Medicare Part D), the individual will not be entitled to Prescription Drug Benefits under the Fund. Additionally, your monthly premium for coverage under the Welfare Trust Fund will not be reduced as a result of not receiving Prescription Drug Benefits under the Fund. If you enroll for Medicare Prescription Drug Coverage and your Prescription Drug Benefits end, you will have one opportunity to re-enroll for Prescription Drug Benefits if you subsequently drop Medicare Prescription Drug Coverage.

Retiree Opt-In/Opt-Out Option

New retirees who become Eligible for the Supplemental Retirement Benefit Plan can opt out at the time of retirement and then opt back in at a later date, after providing proof of continuous coverage from their Dependent spouse's employer's plan. Only the retired Employee may opt in or opt out of coverage under the Opt-In/Opt-Out Program. However, a Dependent surviving spouse may opt back in to retiree coverage only as explained on page 32.

Retirees cannot opt out of Supplemental Retirement Benefit Plan coverage at the time of retirement for *ANY* other coverage.

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

- Be a retiree who is Eligible for coverage under the NECA-IBEW Welfare Trust Fund; and
- Be covered under your Dependent spouse's employer's plan (and provide proof of this other coverage); and
- Complete and file a form electing to postpone or suspend coverage.

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

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

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

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

In the event that you die during a period of postponement or suspension of coverage, your surviving spouse may not exercise your option to resume coverage under the Plan.

Continuing Retiree Eligibility

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

Before you and/or your Dependents become Eligible for Medicare, the Fund Office will send you an enrollment package. Once you enroll, you will receive detailed information about your coverage. The Plan will be responsible for answering questions, paying claims, and handling any appeals relating to its coverage for Medicare-Eligible Participants.

Termination of Retiree Eligibility/Return to Active Work

Coverage will terminate on the last day of the second month after the month in which the retired Employee's bank account from which the required self-contributions are paid does not have sufficient funds to make the required withdrawal. Once such coverage terminates, it will not be reinstated. For example, if you do not have sufficient funds in the designated bank account in the month of May, then your coverage will end on July 31.

If a retired Employee returns to active work, the Employee must meet the initial Eligibility rules to become Eligible for the benefits provided as an active Employee. Withdrawals for retiree self-contribution amounts will continue, and refunds will be provided, for any months the Employee has active Employee Eligibility.

Retiree Self-Contribution Amounts

Base Plan Coverage

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

- **Before January 1, 2002, the monthly self-contribution rate for single or family coverage is equal to:**
  - 100% of the active Employee contribution rate minus $0.20 multiplied by 160 hours for:
    - Retirees or surviving spouses who are younger than age 62; and
    - Surviving spouses of early retirees who are not yet Eligible for Medicare.
  - 75% of the active Employee contribution rate minus $0.20 multiplied by 160 hours for:
    - Disabled retirees who are younger than age 65 and not yet Eligible for Medicare; and
    - Surviving spouses of deceased Medicare-Eligible retirees who are not yet Eligible for Medicare.
  - 50% of the active Employee contribution rate minus $0.20 multiplied by 160 hours for:
    - Retirees or surviving spouses who are Eligible for Medicare; and
    - Early retirees who are between ages 62 and 65.
- **On or after January 1, 2002, the monthly self-contribution rate is:**

- 100% of the active Employee contribution rate minus $0.20 multiplied by 160 hours for:
  - Retirees between ages 55 and 61; and
  - Surviving spouses of early retirees who are younger than age 62 and not yet Eligible for Medicare.
- 75% of the active Employee contribution rate minus $0.20 multiplied by 160 hours for:
  - Retirees between ages 62 and 64;
  - Surviving spouses of retirees who are between ages 62 and 64 and not yet Eligible for Medicare;
  - Surviving spouses of deceased Medicare-Eligible retirees who are not yet Eligible for Medicare; and
  - Disabled retirees who are younger than age 65 and not yet Eligible for Medicare.
- 65% of the active Employee contribution rate minus $0.20 multiplied by 160 hours for:
  - Retirees age 65 and over;
  - Surviving spouses who are Eligible for Medicare;
  - Disabled retirees who are under age 65 and Eligible for Medicare; and
  - Disabled surviving spouses who are under age 65 and Eligible for Medicare.

Alternative Plan Coverage

You may elect coverage under the Alternative Plan when you are initially Eligible for retiree coverage. Retirees who are Eligible for coverage may also, at any time, elect to change coverage from the Base Plan to the Alternative Plan. The Alternative Plan provides a lower level of coverage at a reduced cost to retirees.

If you were last covered under the Alternative Plan as an active Participant, you cannot elect Base Plan coverage when you retire.

If you elect coverage under the Alternative Plan, your monthly self-contribution rate is determined by the Trustees. The rate is based on the same formula as that used for the Base Plan but is adjusted to be based on the full Alternative Plan contribution rate (without the $0.20 reduction). Retirees who select the Alternative Plan will not have the option of re-enrolling in the higher level of coverage (i.e., the Base Plan).

Monthly Payments

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

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

If you are a Disabled Employee and you are Eligible for Supplemental Retirement Benefit Plan coverage, you must retire at the time you receive your Social Security Disability award, and you

may not run out the balance of your 21-month Disability period before beginning your self-payments for retiree benefits. Your coverage will begin on the effective date of your retirement, which is based on the Disability date established in the Social Security Disability award letter.

Special Enrollment Rights

Special enrollment is allowed for active Employees or their Dependents who originally declined coverage if they:

- Had other coverage and either later had a loss of Eligibility for that coverage or employer contributions toward the other coverage were terminated; or
- Were on COBRA Continuation Coverage under another plan, but their Eligibility expired.

If an Employee gets married, has a natural child, has children placed for adoption, or adopts a child, the Employee is entitled to special enrollment, along with the spouse, birth child, children placed for adoption, or adopted child, if enrollment is requested within 30 days of the marriage, birth, or adoption.

If you are Eligible for special enrollment, you will become an Eligible Participant on the first day of the month following receipt of the properly completed application form, subject to administrative approval. A Dependent Eligible for special enrollment, including a spouse, birth child, children placed for adoption, or adopted child, will become Eligible for coverage on the date the Dependent is acquired.

You must request enrollment within 30 days after the other coverage ended if that other health coverage was employer-provided health coverage, COBRA Continuation Coverage that had expired, or other coverage that expired because you reached the lifetime maximum benefit.

Special enrollment is permitted for you and your Eligible Dependents if you request special enrollment within 60 days immediately following the date you or your Dependent:

- Loses Eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP) coverage; or
- Becomes Eligible to participate in a premium assistance program under Medicaid or SCHIP.

Dependent Eligibility

Your Dependents are Eligible for coverage when you become Eligible for coverage, provided that you complete the Fund's appropriate forms and submit the applicable documentation within the applicable time periods. Your Eligible Dependents include your:

- Spouse, provided you are not divorced or legally separated; and
- Children, provided they are:
  - Under 26 years of age;
  - Over age 26, permanently and Totally Disabled, and incapable of any gainful activity and/or self-sustaining employment due to a medically determinable physical or mental impairment that began before the child attained age 26 and is expected to result in death or last for a continuous period of 12 months or more. However, if your Disabled child loses

Eligibility for coverage because he or she becomes employed and self-sustaining, the child may again be considered a Dependent if he or she once again becomes permanently and Totally Disabled and incapable of any gainful activity and/or self-sustaining employment due to a medically determinable physical or mental impairment; and

- Named under a Qualified Medical Child Support Order (QMCSO). A QMCSO is a medical child support order that:
  - Is made pursuant to a state domestic relations law (including a community property law) or certain other state laws relating to medical child support; and
  - Provides for child support or health benefit coverage for a child of a Participant under a group health plan and relates to benefits under the Plan.

In addition to children named under a Qualified Medical Child Support Order (QMCSO), children may include your:

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

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

- You are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or have lived apart from the child's other parent at all times during the last six months of the Calendar Year;
- You and/or the child's other parent provide more than 50% of the child's support and maintenance during the Calendar Year; and
- The child is in your custody or the custody of the child's other parent for more than one-half of the Calendar Year.

Your Dependents' Eligibility for coverage ends on the earliest of the:

- Date the Plan ends;
- Date you are no longer Eligible;
- Last day of the month your Dependent no longer meets the Plan's definition of Dependent (for example, coverage for your enrolled Eligible children will end on the last day of the month in which they turn age 26);
- Date coverage would end in accordance with other Plan provisions;

- With respect to a legal separation, last day of the month that an order or decision of the court is entered or, in the event that there is no court order or decision, last day of the month the parties reach agreement on the terms of the separation;
- With respect to a divorce, last day of the month the divorce decree is entered by the court and finalized; or
- With respect to Dependents of retirees, the last day of the month in which the Dependent fails to make a self-contribution in accordance with the terms of the Plan. If this happens, coverage will not be reinstated.

If your spouse is Eligible for other health care coverage through an employer plan, regardless of the cost to your spouse, he or she must take that coverage or he or she will not be covered under the Plan.

Extension of Coverage for Dependents of Deceased Eligible Employees

If you die while Eligible for coverage, health benefits for your surviving Dependent spouse and/or child(ren) will be continued until the earlier of the following:

- The last day of the month in which any remaining banked hours are used to maintain Eligibility; or
- The day your surviving spouse remarries.

If you are considered Disabled (as defined by the Plan) and you die while Eligible for coverage, your surviving Dependent spouse and/or child(ren) may continue health benefits until the earlier of the following, provided the 21-month maximum described on page 34 is not exceeded:

- The last day of the month in which any remaining banked hours are used to maintain Eligibility; or
- The day your surviving spouse remarries.

Upon termination of coverage, your surviving Dependent spouse and/or child(ren) may elect to make payments to remain Eligible for coverage through COBRA Continuation Coverage for a maximum of 36 months. See page 40 for more information about COBRA Continuation Coverage.

Extension of Coverage for Retiree's Surviving Children

The covered Dependent children of a retiree may remain covered by the Plan after the retiree's death, as long as they continue to meet the other Eligibility requirements for Dependents.

Retiree's Surviving Spouse Can Opt Back In

The surviving spouse of a retiree has the option to opt back in for coverage under the Supplemental Retirement Benefit Plan. If the retiree dies after opting out of coverage under the Supplemental Retirement Benefit Plan, but before the retiree opts back in to the Plan, the retiree's surviving spouse has 60 days from the date of the retiree's death to opt in for Plan coverage. To be Eligible to opt in for Supplemental Retirement Benefit Plan coverage, the surviving spouse must be at least age 55 at the time of the retiree's death and the appropriate self-payments are made for retiree coverage.

Active Employee's Surviving Spouse Can Opt Back In

The surviving spouse of an active Employee who died after age 60 may apply for retiree benefits under the Supplemental Retirement Benefit Plan if the active Employee was covered under the Fund:

- During the month the Employee died or in the month immediately prior to the Employee's death; and
- For at least 45 of the last 60 months immediately prior to the Employee's death.

If Your Spouse Has Other Coverage Available

If your spouse is Eligible for other health care coverage through an employer plan, regardless of the cost to your spouse, he or she must take that coverage or he or she will not be covered under the Plan. If your spouse is employed, then his or her employer needs to complete the Spousal and Dependent Insurance Form. It is your responsibility to make sure the form is completed and submitted to the Fund. Failure to complete and submit the Spousal and Dependent Insurance Form will result in the Fund denying claims.

If your spouse is employed, there may be instances where your spouse may prefer to purchase a private insurance policy rather than elect his or her employer's coverage. In these instances, your spouse may elect to purchase private insurance, provided it is comprehensive coverage that is comparable to your spouse's employer's coverage. The Fund will then consider this private insurance policy as your spouse's other coverage and your spouse will continue to be covered under the Plan.

If your spouse has other coverage, either through an employer plan or a private insurance policy, the Fund will pay benefits second, after the other coverage. This provision helps manage the Fund's health care costs. While this provision is beneficial in helping the Fund reduce expenses, it is also beneficial for your spouse because your spouse will have coverage through more than one plan.

It is your responsibility to notify the Fund if your spouse has other coverage through an employer or private policy. If the Fund learns that your spouse has other coverage and does not notify the Fund or refuses to take the available coverage, your spouse will no longer be covered under the Fund's Plan.

If your spouse is employed, his or her employer will be required to complete the Fund's Spousal and Dependent Insurance Form and submit it to the Fund Office. If your spouse's employer does not offer health care coverage or if your spouse is not Eligible for the coverage offered, the employer will indicate this on the form.

If your spouse is Eligible for other coverage and does not enroll for that coverage when Eligible, your spouse's coverage under this Plan will generally end as of the date your spouse is Eligible for such other coverage. In addition, benefits will be backdated to the date your spouse could have enrolled in the other coverage. The Fund may rescind or retroactively terminate coverage as permitted by applicable law and as stated in this SPD based on fraud or a misrepresentation of a material fact.

Eligibility During Disabilities

In the event you become Disabled (as defined below), the Fund will freeze your Hour Bank and grant coverage, which may continue for up to a maximum of 21 months from the date of the Injury or Sickness.

For purposes of this section, "Disabled" means you are unable to engage in gainful pursuit within the electrical industry or usual occupation. An Employee who performs light-duty work will not be considered to be Disabled.

Disability months are counted from the first day of the month following the month in which the Disability begins. If, at the end of the 21-month period, you have not recovered from your Disability, you may continue your Eligibility using hours remaining in your Hour Bank. Bank hours will be drawn down at a rate of 140 hours per month. Once your Hour Bank is reduced to zero, you may continue Eligibility by electing COBRA Continuation Coverage for up to a maximum of 36 months. Thereafter, you must have at least three consecutive months of Eligibility, based on employer contributions, to requalify for the 21-month extension of Eligibility due to Disability.

Please note that the 21-month extension of Eligibility due to Disability is not available:

- During any period that you are working for compensation or profit, drawing a salary, performing light-duty work, or drawing unemployment benefits;
- For any condition that does not meet the Plan's definition of Disability and that cannot be verified per Plan provisions;
- For any Disability for which you willfully fail to follow the treatment plan prescribed by the Physician who certified you as Disabled; or
- For any circumstances that are described in the "General Limitations and Exclusions" section on page 118.

NOTE: Disabled Employees Eligible for coverage as stated above may not begin self-paying for Supplemental Retirement Benefits following the completion of the 21-month Disability period. Coverage under the Supplemental Retirement Benefit Plan must begin on the effective date of the Disabled Employee's first retirement. See page 24 for more information about retiree Eligibility rules.

Continuation of Coverage During Family and Medical Leave

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption, or placement with you for foster care or adoption of a child;
- The care of a seriously ill spouse, parent, or child;
- Your serious Illness; or
- A qualifying urgent need for leave because your spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26 weeks of unpaid leave during a 12-month period to care for a service member. The service member must be:

- Your spouse, son, daughter, parent, or next of kin;
- Undergoing medical treatment, recuperation, or therapy for a serious Illness or Injury incurred in the line of duty while in military service; and
- An outpatient or on the temporary Disability retired list of the armed services.

During your leave, you will maintain all the coverage offered through the Fund. You will remain Eligible until the end of the leave, provided your Participating Employer properly grants the leave under the federal law and your employer makes the required notification to the Fund. Contact your employer or the Fund Office to learn if this leave is available to you.

If you and your employer have a dispute regarding your Eligibility and coverage under the FMLA, the Fund will not have any direct role in resolving the dispute, and your benefits may be suspended while the dispute is being resolved.

Continuation of Coverage During Military Leave

Your health care coverage will continue if you serve in the uniformed services of the United States (active duty or inactive duty training) for up to 31 days. If you continue in military service for more than 31 days, you may continue your coverage at your own expense for up to 24 months under USERRA. However, the Plan allows you to continue your coverage, at your own expense, under these circumstances for up to 36 months.

If you continue your coverage at your own expense, it will stop at the earliest of the following:

- The date you or your Dependents do not make the required payments within 30 days of the due date;
- The date the Fund no longer provides any group health benefits;
- The date you reinstate your Eligibility for coverage under the Plan;
- The end of the period during which you are Eligible to apply for reemployment in accordance with USERRA; or
- The last day of the month after 36 consecutive months.

To continue coverage under USERRA, you must elect USERRA continuation coverage within 60 days after the date Eligibility for coverage ends due to your service in the uniformed services. You may elect USERRA continuation coverage for yourself and/or your Dependents; your Dependents do not have a separate right to elect this USERRA continuation coverage and are not entitled to this coverage unless you elect it on their behalf.

A monthly premium is required for this coverage. Continuation coverage under USERRA will be administered in the same manner as COBRA Continuation Coverage, and the monthly payment will be the same as the payment under COBRA, unless service in the uniformed service is for fewer than 31 days, in which case the employer must pay the Employee's share, if any, of the premium. The Plan Administrator will inform an Employee or the Employee's Dependent of procedures to pay premiums.

If you are a member of a construction collective bargaining unit, your hours worked and Hour Bank balance as of the last day of Eligibility will be "frozen" unless you notify the Fund Office, in writing, that you want to use your Hour Bank balance during the period you are serving.

Military Leave Definitions

- **"Health Coverage"** means Comprehensive Major Medical, Medical, Prescription Drug, Dental, and Vision Benefits provided under the Plan. Health Coverage is subject to change as a result of Plan modifications. Health Coverage does not include Death, Accidental Death and Dismemberment, or Weekly Income Benefits.
- **"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).
- **"Service in the uniformed services"** means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a Person is absent from a position of employment for the purpose of an examination to determine the fitness of the Person to perform any such duty.
- **"Uniformed services"** means the United States armed forces, the Army National Guard, and the Air National Guard when engaged in inactive duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

End of USERRA Continuation Coverage

An election of USERRA continuation coverage under the provisions of this section may terminate before the expiration of the maximum period described above in this section for any other reason set forth in the same manner as COBRA Continuation Coverage or if the Employee loses the right to USERRA coverage, such as for a dishonorable discharge. However, in the event of a conflict between the provisions of USERRA and those related to the Plan provisions related to COBRA Continuation Coverage, a Person Eligible for continuation coverage rights under the provisions of USERRA and under the Plan provisions related to COBRA Continuation Coverage will be entitled to the more generous coverage provisions of USERRA or COBRA Continuation Coverage, during these periods in which the Person is Eligible under both provisions.

Other USERRA Continuation Coverage Provisions

In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which the premium is paid in whole or in part by an employer, then the premium an Employee is required to pay may increase for the remainder of the period provided above.

Following your discharge from service, you may be Eligible to apply for reemployment with your former employer under USERRA. Such reemployment includes your right to elect

reinstatement in any existing health care coverage provided by the Fund through your employer. For more information about paying for your own coverage under USERRA, contact the Fund Office.

In the event of a conflict between these Plan provisions and USERRA, the USERRA's provisions will apply.

Termination Due to Withdrawal of Local Union

If a Participating Local Union or Employer ends participation in the Plan or a Participating Local Union no longer provides in its Collective Bargaining Agreement for the required employer contributions, the Eligibility and benefit rights of those Local Union members, retirees, and Dependents become subject to special rules and limits including the following:

- Eligibility ends as of the 31st day following the date contributions are no longer required regardless of any Hour Bank accumulation.
- All remaining hours accumulated in individual Hour Banks are forfeited/canceled and no one has any rights to any of the Plan assets.
- After Eligibility ends, all rights to qualify in the future for 21 months of continued Eligibility due to Total Disability, retiree benefits, and reciprocity end. To be Eligible again, you must meet the Plan's reinstatement Eligibility rules, as stated on page 23.
- Retiree Eligibility, Eligibility due to Disability, and Eligibility due to COBRA Continuation Coverage ends as of the 31st day following the date contributions are no longer required because of the Participating Local Union's termination.

Rescission of Coverage

The Fund may rescind your and/or your Dependents' coverage for fraud, or if you make an intentional misrepresentation of a material fact, after the Fund Office provides you with 30 days' advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud or an intentional misrepresentation of a material fact. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, meaning that it will be effective back to the time that you and/or your Dependents should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Fund to give you and/or your Dependents 30 days' advance written notice:

- The Fund terminates your and/or your Dependents' coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your and/or your Dependents' loss of employment and notification to the Fund of your termination of employment.
- The Fund retroactively terminates your and/or your Dependents' coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Fund retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and/or your Dependents were covered by the Plan when you or they should not have been covered, the Fund will cancel your and/or your Dependents' coverage prospectively—for the future—once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Fund to give you and/or your Dependents 30 days' advance written notice.

A rescission or prospective cancellation or discontinuation of coverage is an adverse benefit determination that may be appealed under the Fund's claims and appeals procedures.

Keep Your Fund Records Up to Date

If you move, be sure to notify the Fund Office. The Fund Office must have your current address on file to ensure that you receive information about your benefits.

It is a good idea to periodically review your beneficiary designation information (see page 48 for more information about designating a beneficiary). If you need to update this information, contact the Fund Office.

You must notify the Fund Office when your spouse has a change in employment status and/or a change in Benefit Plans. If your spouse is Eligible for other health care coverage through an employer plan, regardless of the cost to your spouse, your spouse must take that coverage or your spouse will not be covered under this Plan. If your spouse is employed, his or her employer will be required to complete the Fund's Spousal and Dependent Insurance Form and submit it to the Fund Office. If your spouse's employer does not offer health care coverage or if your spouse is not Eligible for the coverage offered, the employer will indicate this on the form.

The Fund must also be made aware of any change in Dependent health insurance coverage.

If you fail to notify the Fund Office of changes, you may be liable for benefits paid in error due to misinformation or lack of information supplied by you. The Fund has the right to recover any overpayment or mistaken payment made to you or to a third party. The Fund may recover those monies by reducing benefit payments, through legal action, or any other methods the Trustees, in their discretion, deem appropriate.

Data Cards

You must complete and submit a Data Card once a year—or anytime your information changes, including moving, family status changes (getting married or divorced, adding a Dependent, a death in the family), or if your spouse has a change in employment status and/or a change in benefit plans or health insurance offered by his or her employer. If you do not send in a completed Data Card, the Fund Office will not process your claims. Make sure to submit your updated Data Card to the Fund Office by January 1 of each year or your claims will be denied until the updated Data Card is received.

The Fund Office sends out emails once a year reminding Participants to update your Data Cards if the Fund has your email on file. You may choose to complete and sign your Data Card online as an alternative.

When properly completed, the Online Data Card will automatically be sent to the Fund Office. The Participant will receive a confirmation email at the address indicated on the Online Data Card after the Online Data Card is successfully submitted.

Extension of Medical Benefits (For Active Employees and Their Dependents Only)

If you or your Dependent no longer meets the Plan's Eligibility requirements, your medical coverage will end. However, if you or your Dependent is Totally Disabled (as defined by the Plan) when your Eligibility ends, Comprehensive Major Medical Benefits may be continued for up to 12 months for expenses incurred for treatment of the Disability that exists on your Eligibility termination date. Benefits payable during the 12-month extension period are subject to a new Deductible and a new Out-of-Pocket Maximum at the beginning of each Calendar Year. Only those charges related to treatment of the Disability that existed on your termination date are Eligible for Plan payment.

Note that extended coverage will end sooner if you either recover from the Disability or become covered under another welfare fund or any other group plan. Coverage will end on that date or on the date you would become Eligible under such other welfare or group plan but for the operation of the extension of benefits provisions of this Plan.

COBRA Continuation Coverage Self-Pay Rules

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

If you or your Dependent experiences a "qualifying event," you will be considered a "qualified beneficiary" and you will have the right to continue coverage on a self-pay basis as required under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You and each of your Dependents have an independent right to elect COBRA Continuation Coverage. You must self-pay for COBRA Continuation Coverage. For COBRA Continuation Coverage information, contact:

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

Qualifying Events

If you are an Employee, you become a "qualified beneficiary" if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your employment is terminated for any reason other than your gross misconduct;
- You have a reduction in hours of work or not having sufficient hours in your Hour Bank;
- You become entitled to Medicare benefits (under Part A, Part B, or both).

If you are the spouse of an Employee, you become a "qualified beneficiary" if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both). Your spouse's becoming entitled to Medicare means that your spouse:
  - Was Eligible for Medicare benefits; and
  - Enrolled in Medicare and the entitlement date is the date of enrollment; or
- You become divorced or legally separated from your spouse.

Your Dependent children become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;

- The parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both). The parent-Employee becoming entitled to Medicare means that the parent-Employee:
  - Was Eligible for Medicare benefits; and
  - Enrolled in Medicare and the entitlement date is the date of enrollment; or
- The parents become divorced or legally separated; or
- The child stops being Eligible for coverage under the Fund as a Dependent child.

Employer Must Give Notice of Certain Qualifying Events

The Fund will offer COBRA Continuation Coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. The employer must notify the Fund of the qualifying event within 30 days from the date coverage ends when the qualifying event is the end of employment or reduction of hours of employment, or death of the Employee.

You Must Give Notice of Certain Qualifying Events

For other qualifying events (divorce or legal separation of the employed, Eligibility for Medicare, and a spouse or a Dependent child's losing Dependent child status), you must notify the Fund Office within 60 days of the date you would lose coverage due to the qualifying event.

Additional COBRA Qualified Beneficiaries

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

Type of Coverage

If you elect COBRA Continuation Coverage, you will be entitled to the same type of coverage (Comprehensive Major Medical, including Behavioral Health, Prescription Drug, Dental, and Vision, as well as Weekly Income, Death, and Accidental Death and Dismemberment Benefits) that you had before the event that triggered COBRA, but you must pay for it. If there is a change in the Health Coverage provided under the Plan to similarly situated active members and their families, that same change will be made in your COBRA Continuation Coverage.

Health Insurance Marketplace Alternative

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

NOTE: If you opt out of Fund coverage and purchase your own coverage through a state or federal Health Insurance Marketplace, the Affordable Care Act prohibits you from participating in an HRA account.

Cost of COBRA Coverage

Every 12 months, the Trustees establish the monthly COBRA premium self-payment amount. A Person who has a qualifying event, makes a timely election, and regularly pays the required monthly premium may self-pay for up to 36 months of COBRA Continuation Coverage. Bargaining Employees only may offset their COBRA premium with contributions made on their behalf by employers and/or accumulated Hour Bank. However, all contributions for the period of COBRA Continuation Coverage preceding the election and for the first two months after the election must be received by the Fund Office within 45 days after the date of the election. All contributions for succeeding months must be received by the Fund Office within 30 days of the beginning of the month. This adjusted COBRA premium will not extend the time the Employee may continue COBRA Continuation Coverage. After 36 months, the Employee will lose coverage unless he or she meets the Fund's initial Eligibility requirements, as explained on page 19.

Notice and Election Period

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

If a child loses Dependent status or you and your spouse divorce or get legally separated, it is the responsibility of that individual to notify the Fund Office that a qualifying event has occurred within 60 days from the date of the qualifying event. The Fund Office will advise that individual of his or her COBRA Continuation Coverage rights by letter. The Fund Office will also provide written notification to individuals that are not entitled to COBRA Continuation Coverage. Such notice will explain why COBRA Continuation Coverage is not available.

Length of COBRA Continuation Coverage

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's entitlement to Medicare benefits, divorce or legal separation, or a Dependent child's losing Eligibility as a Dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to (qualified for and enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. However, the covered Employee's maximum coverage period will be 18 months. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment ends, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA Continuation Coverage generally lasts for up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended, as explained in the next two sections.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Fund is determined by the Social Security Administration to be Disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month continuation period. You must notify the Fund Office of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA Continuation Coverage. This notice should be sent to the Fund Office.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

If your family experiences another qualifying event while receiving COBRA Continuation Coverage, your spouse and Dependent children in your family can receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Fund. This extension is available to the spouse and any Dependent children receiving COBRA Continuation Coverage if:

- The Employee or former Employee dies;

- The Employee or former Employee becomes entitled to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both);
- The Employee or former Employee gets divorced or legally separated; or
- The Dependent child stops being Eligible under the Plan as a Dependent child.

The extension is available only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure to notify the Fund Office after the second qualifying event occurs.

Termination of COBRA Coverage

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

- He or she does not make a timely notice of his or her election for COBRA Continuation Coverage.
- He or she makes a timely election but does not pay the required premium (or the Fund Office does not receive the payment within the prescribed time limits).
- He or she enrolls in Medicare after electing COBRA Continuation Coverage.
- He or she becomes covered as an Employee or Dependent under any group health plan.
- The Plan is terminated by the Trustees.

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

Making Payments for COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment for COBRA Continuation Coverage with the election form. However, you must make your first payment for COBRA Continuation Coverage within 45 days after the date your election form is returned to the Fund Office. (This is the date the election form is postmarked, if mailed.) If you do not make your first payment for COBRA Continuation Coverage within those 45 days, you will lose all COBRA Continuation Coverage rights under the Fund.

Your first payment must cover the cost of COBRA Continuation Coverage from the time your coverage under the Fund would have otherwise ended, up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Fund Office to confirm the correct amount of your first payment.

After you make your first payment for COBRA Continuation Coverage, you will be required to pay for COBRA Continuation Coverage for each subsequent month of coverage. Under the Fund, these periodic payments for COBRA Continuation Coverage are due on the first day of the month for which payment is made. If you make a periodic payment on or before its due date, your

coverage under the Plan will continue for that coverage period without any break. The Fund will not send periodic notices of payments due for these coverage periods. A COBRA payment will be considered on time if it is received within 30 days of the due date. A COBRA payment is considered made when it is mailed (postmarked) or personally delivered.

Grace Periods for COBRA Payments

Although COBRA payments are due on the dates previously noted, you will be given a grace period of 31 days to make each COBRA payment. You should note that the grace period does not apply to the first COBRA payment, which is due within 45 days of election of COBRA Continuation Coverage, as previously described. Your COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage and you submit a claim within that period, you may receive an explanation of benefits that a benefit determination cannot be made due to a pending COBRA payment.

If you fail to make a COBRA payment before the end of the grace period for that payment, you will lose all rights to COBRA Continuation Coverage under the Plan.

Reciprocity

The NECA-IBEW Welfare Trust Fund is a party to the IBEW/NECA Electronic Reciprocal Transfer System (ERTS).

In the electrical industry, many Employees are at times employed by employers under contract to contribute to one welfare fund and at other times employed by an employer under contract to contribute to another fund. You are able to maintain Eligibility for benefits from this Fund if you work for an employer who contributes to another fund. You must register in person with ERTS at the Local Union hall. You will be issued a User ID and Password. If an Employer contributes to a different fund on your behalf, the money will be electronically transferred to this Fund. You will be able to change your registration or stop transfers at any time. This system will allow you to continue your welfare benefits with minimal interruption.

Earning and maintaining Eligibility with the NECA-IBEW Welfare Trust Fund is based on the Fund receiving the required amount of hours reported on your behalf at the Fund's established contribution rate for the specific plan type in which you are participating (for example, the "Base Plan," "Alternative Plan," or the "Alternative Plan for the Employee and Dependent Children Only" coverage tier). Please be aware that the NECA-IBEW Welfare Trust Fund credits contributions received on your behalf through reciprocity on a pro rata basis based on the NECA-IBEW Welfare Trust Fund's contribution rate for the specific plan type in which you are participating (as explained above) in effect when reciprocal contributions are received. As a result, if you work in an area where the welfare contribution rate is lower than the NECA-IBEW Welfare Trust Fund's contribution rate for the specific plan type in which you are participating (as explained above), it will take you more hours of work to maintain your Eligibility. You do not receive "hour for hour" credit for the hours that are transferred to the Fund through reciprocity.

Overview of Retiree Benefits

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

- A self-insured benefits program for retirees and their Eligible Dependents who are not yet Eligible for Medicare; and
- A self-insured benefits program for Medicare-Eligible retirees over age 65 and/or their Medicare-Eligible Dependents over age 65.

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

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

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

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

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

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

If you and/or your Eligible Dependents are age 65 or over and Eligible for Medicare Parts A and B, you will receive your Medical Benefits through a separate, self-insured plan administered by the Fund. In addition to Medical Benefits, you will receive coverage for Organ Transplants and prescription drugs through the Fund's self-insured benefits program.

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

If you or your Eligible Dependents are enrolled in Medicare Parts A and B due to Disability, your claims will be coordinated with Medicare, in accordance with the Plan's and Medicare's coordination of benefits provisions. Benefits will be coordinated with Medicare based on a supplemental approach, whether or not you or your Eligible Dependents are actually enrolled in Medicare Parts A and B.

Death Benefits—Employees/Retirees Only

The Death Benefit, as shown in the in the applicable schedule in the “Schedules of Benefits” document, is paid to your beneficiary if you die from any cause while Eligible for benefits. Payment will be made in one lump sum to your beneficiary or beneficiaries, or in installments if requested by you or your beneficiary.

Benefits Payable

Benefits are payable to each beneficiary listed on, and in accordance with, the most current information on file at the Fund Office. If no beneficiary is named, the Death Benefit will be paid to your surviving spouse. If you do not have a surviving spouse, the Death Benefit will be paid to your estate. Also, if you name a beneficiary, but he or she and any contingent beneficiary dies before you, the Death Benefit will be paid to your estate.

If you die within 31 days of the termination of your Eligibility, the Death Benefit is still payable.

Designated Beneficiary

Your designated beneficiary or beneficiaries for any Death Benefit will be the Person or Persons whom you designate in the last written notice on file in the Fund Office prior to your death. It will be your responsibility to notify the Fund Office, in writing and on such form as the Trustees prescribe, of the choice of beneficiary or beneficiaries and/or any change in beneficiary or beneficiaries. You may change your beneficiary or beneficiaries by filing a written notice on such form as the Trustees prescribe with the Fund Office. Any change in the beneficiary or beneficiaries will not become effective unless such change is received in the Fund Office prior to your death. If you fail to designate a beneficiary or beneficiaries, then any Death Benefit will be distributed as set forth above.

Effect of Divorce

In the event that your marriage is legally terminated by divorce, any prior beneficiary designation naming your former spouse as beneficiary (but not any other beneficiary designations) will be null and void. If you desire to retain your former spouse as beneficiary, you must complete a new beneficiary form after your marriage is legally terminated by divorce, listing such former spouse as beneficiary.

Accidental Death and Dismemberment Benefits—Active Employees Only

If you die or suffer accidental Injuries that result in any of the losses described below, as a result of bodily Injuries sustained solely through purely accidental means, directly and independently of all other causes within 90 days following the date of such Injuries, benefits will be paid as explained in this SPD.

The full benefit amount shown in the applicable schedule in the "Schedules of Benefits" document is paid for the loss of:

- Life;
- Two hands or feet or the sight of two eyes; or
- Any combination of one foot, one hand, or the sight of one eye.

One-half of the full benefit amount shown in the applicable schedule in the "Schedules of Benefits" document is paid for the loss of:

- One hand;
- One foot; or
- The sight of one eye.

Loss of hands or feet means severance at or above the wrist or ankle joint, respectively, and loss of sight means total and irrecoverable loss of sight.

If you suffer more than one of these losses because of any one accident, the Plan pays only for the loss for which the largest benefit is provided.

No payment will be made for any loss incurred wholly or partly, directly or indirectly, by:

- Disease, ptomaine, or bacterial infections, except pyogenic infection of a visible cut or wound accidentally sustained.
- Insurrection, participation in a riot, or war or any act of war, declared or undeclared.
- Military service for any country or organization.
- The claimant during the commission of an assault or felony.
- Medical or surgical treatment, except payment will be made for a death that is caused by negligence of an attending Physician.

If benefits are payable for loss of life, the Fund will have the right and opportunity to have an autopsy performed where it is not forbidden by law.

Accidental Death and Dismemberment Exclusions

No payment will be made for any loss incurred wholly or partly, directly or indirectly, by:

- Disease, ptomaine, or bacterial infections, except pyogenic infection of a visible cut or wound accidentally sustained.

- Insurrection, participation in a riot, or war or any act of war, declared or undeclared.
- Military service for any country or organization.
- The Participant during the commission of an assault or felony.
- Medical or surgical treatment, except payment will be made for a death that is caused by negligence of an attending Physician.

Retirees

Only active Employees are Eligible for Accidental Death and Dismemberment Benefits. Retirees are not Eligible for Accidental Death and Dismemberment Benefits.

Weekly Income Benefits—Active Employees with Base Plan Coverage Only

If you become Totally Disabled while Eligible under the Plan, a Weekly Income Benefit is payable for up to a maximum of 26 weeks per period of Disability. Totally Disabled or Total Disability means you are unable to engage in gainful pursuit within the electrical industry or usual occupation and are not Eligible for any salary continuation from an electrical Employer. Disabilities lasting 13 weeks or longer are subject to Utilization Review. The amount of your weekly benefit depends on how long you are Totally Disabled, as shown in the applicable schedule in the "Schedules of Benefits" document. If you are Disabled for part of a week, you will receive one-seventh of your weekly benefit for each day of Disability.

If you become Disabled while employed, or within 30 days of the date you were last Employed in the Industry, benefits will begin on the first day of Disability if the Disability is the result of an accidental Injury or on the eighth day of Disability if the Disability is due to a Sickness. If a Disability due to a Sickness lasts eight weeks, the Plan will retroactively pay benefits from, and including, the first week. If you become Disabled more than 30 days after you were last Employed in the Industry, your Disability will be considered to start on the first day of Hospital confinement. (This applies if your Eligibility has been extended due to your Hour Bank.)

You are not considered to be working in the electrical industry if you are making self-payments to the Fund, unless you provide written verification of employment on the date of the Disability from a Participating Employer. Upon receipt of written verification from the employer, you will be considered to be Employed in the Industry. Verification of employment will be confirmed by reviewing the employer's Monthly Payroll Reporting (MPR) for the period in question.

Successive periods of Disability are considered one period of Disability unless:

- You return to active full-time work and earn Eligibility for at least three consecutive months based on employer contributions.
- You are a non-bargaining member who works (as opposed to merely having hours reported on your behalf) 40 hours per week for three consecutive months.
- The Disabilities are due to unrelated causes and you return to active full-time work for at least one day between Disabilities.
- You return to work for at least 90 days if the successive periods of Disability are due to accidental Injuries.

Limitations

Weekly Income Benefits are not paid:

- If you are a Disabled Employee and are not under the care of a Physician.
- If treatment resulting from an Injury did not occur within 14 days of the date of the Injury.
- For any Disability due to work or pursuit of compensation or profit.

- For any Disability for which benefits are payable under any workers' compensation, occupational disease, or similar law.
- For any Disability for which you perform light-duty work.
- For any condition that does not meet the Plan's definition of Total Disability and cannot be verified by an examination by a Physician designated by the Trustees.
- For any period you are drawing a salary or unemployment benefits.

Termination of Benefits

Benefit payments will end after 26 weeks or upon recovery from Total Disability, if earlier.

Taxation of Weekly Income Benefits

As required by the Internal Revenue Service, Weekly Income Benefits are subject to withholding for federal income tax purposes.

Comprehensive Major Medical Benefit—Employees and Retirees Not Eligible for Medicare, and Their Dependents

How the Plan Works

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

- **Deductible:** You are responsible for meeting your Calendar Year Deductible (between January 1 and December 31) before the Plan begins to pay for Covered Medical Expenses. That means you and your Dependents must pay up to the amount of the Deductible (as shown in the applicable schedule in the "Schedules of Benefits" document) of Covered Medical Expenses before the Plan pays benefits. Once payments toward the individual Deductible for each of your family members reach the family maximum, individual Deductibles for all family members will be met for the year. The amounts you pay toward the annual Deductible do not apply toward meeting the Plan's annual Out-of-Pocket Maximum.
- **Emergency Room Deductible:** If you or your Dependents visit a Hospital emergency room for treatment of a Sickness or Injury not due to an accident, you are required to pay an additional Deductible (as shown in the applicable schedule in the "Schedules of Benefits" document) for each visit after the first two visits in a Calendar Year. This Deductible is in addition to the Calendar Year Deductible and any other Coinsurance or Copayment amounts you are responsible for paying. In addition, this emergency room Deductible does not apply toward meeting your Calendar Year Deductible or Out-of-Pocket Maximum, and you must pay this Deductible even after you have met your Out-of-Pocket Maximum.
- **Office Visit Copayment:** When you or a family member goes to a Physician's office, you pay a separate Copayment (as shown in the applicable schedule in the "Schedules of Benefits" document) for each office visit. This office visit Copayment is in addition to the Calendar Year Deductible and any other Coinsurance amounts you are responsible for paying. In addition, this office visit Copayment does not apply toward meeting your Calendar Year Deductible or Out-of-Pocket Maximum, and you must pay this amount even after you have met your Out-of-Pocket Maximum.
- **Specialist Visit Copayment:** When you or a family member goes to a specialist's office, you pay a separate Copayment (as shown in the applicable schedule in the "Schedules of Benefits" document) for each office visit. This office visit Copayment is in addition to the Calendar Year Deductible and any other Coinsurance amounts you are responsible for paying. In addition, this office visit Copayment does not apply toward meeting your Calendar Year Deductible or Out-of-Pocket Maximum, and you must pay this amount even after you have met your Out-of-Pocket Maximum.

You do not pay your office visit Copayment directly to your Physician or specialist. Once a claim is submitted, the Fund Office will deduct the Copayment from the amount that the Fund reimburses you. Please also remember that if you have a Health Reimbursement Account (HRA), you can use the funds in your account to pay for your office visit Copayment. See page 97 for more information about how your HRA works.

- **Coinsurance:** Once you or your Dependents meet the Deductible, the Plan pays a percentage of Covered Medical Expenses and you pay the rest. Benefits are paid based on Allowable Charges for the duration of an Injury or Sickness. The Coinsurance percentage the Plan pays varies depending on whether you use a PPO or non-PPO provider. If you or your Dependent uses a:
  - **PPO provider,** the Plan pays a higher percentage of Allowable Charges, which requires you to pay the remaining percentage of Covered Medical Expenses, up to the Out-of-Pocket Maximum (as shown in the applicable schedule in the "Schedules of Benefits" document); or
  - **Non-PPO provider,** the Plan pays a lower percentage of Allowable Charges, which requires you to pay the remaining percentage of Covered Medical Expenses, up to the Out-of-Pocket Maximum (as shown in the applicable schedule in the "Schedules of Benefits" document).

  The Coinsurance percentages apply unless specifically noted otherwise.
- **Out-of-Pocket Maximum:** After you or your Dependent has met the Deductible, then when Coinsurance and Copayment amounts you pay for Covered Medical Expenses reach the Calendar Year Out-of-Pocket Maximum, the Plan pays 100% of Allowable Charges for most Covered Medical Expenses incurred for the remainder of that Calendar Year (January 1 – December 31). The Calendar Year Out-of-Pocket Maximum is set per Person, up to a family maximum (as shown in the applicable schedule in the "Schedules of Benefits" document). Generally, you will not pay more than your Out-of-Pocket Maximum plus your Deductible in a Calendar Year (as shown in the applicable schedule in the "Schedules of Benefits" document).

  Please note that certain expenses are not subject to the Out-of-Pocket Maximum. This means amounts you pay for these expenses do not count toward meeting your Out-of-Pocket Maximum and you will continue to pay your Copayment or Coinsurance percentage toward these expenses even after you reach your Out-of-Pocket Maximum. Expenses that are not subject to the Out-of-Pocket Maximum include:
  - Deductible for emergency room services;
  - Copayments for office visits;
  - Chiropractic treatment;
  - Organ Transplant surgery performed at a non-Centers of Excellence Facility; and
  - Medications obtained through the Specialty medications and Products Program.

Note that some benefits and expenses may be covered differently or be subject to benefit maximums. See the applicable schedule in the "Schedules of Benefits" document and specific benefit descriptions for more information.

Virtual Visits

Effective April 1, 2020, the Fund began covering Virtual Visits through MDLIVE. Both phone and video visits with a Doctor or therapist are available by a mobile app or web-based browser portal.

The following is a summary of the MDLIVE Virtual Visits benefit:

- The service is available for both General Medical and Mental/Behavioral Health visits.
- The MDLIVE Virtual Visits benefit is covered 100% by the Fund. There are no Copayments, Deductibles, or Coinsurance that will be owed by you.[4] Eligibility and coverage under the Fund are required to use the service.
- There is no minimum age for a Participant to use the General Medical service. The minimum age to use the Mental/Behavioral Health service is 12. Participants under age 18 may proceed with an MDLIVE Virtual Visit only with a parent/guardian present.
- The MDLIVE Virtual Visits benefit is only available to active Employees, retirees not Eligible for Medicare, and their spouses and Dependents. The service will not be available for Medicare-Eligible retirees.[5]

Preferred Provider Organization

The Fund has entered into a contract with BlueCross BlueShield for the provision of its Preferred Provider Organization (PPO) network. The PPO network is comprised of Physicians and Hospitals, known as "PPO providers," that have agreed to provide discounts to Plan members. To find a PPO provider, call BlueCross BlueShield of Illinois at 800-571-1043 or use its website (www.bcbsil.com).

Excluded Providers

Services provided by Excluded Providers are not covered. The list of Excluded Providers is shown in the "Schedules of Benefits" document.

Infusion Medication Coverage—Site of Service Program

The Fund partners with Magellan Rx Management to help Covered Persons who have complex health conditions that require infusion therapy (excluding cancer treatments). This program is called "Site of Service." Registered nurses who are experienced in infusion therapies will review your current health condition treatment plan and identify the most cost-effective site of service for the administration of your medication. These nurse care managers are an educational resource to help you with your health condition, benefits, medicine therapy, treatment plan, and options. If

[4] Prescription drug charges resulting from medications prescribed through the MDLIVE Virtual Visits benefit are covered under the Fund's Prescription Drug Benefit. Services received by providers outside of the MDLIVE Virtual Visits benefit will be covered under the Fund's standard Medical Benefit. Copayments, Deductibles, and Coinsurance will apply for these such drugs and services outside of the MDLIVE Virtual Visits benefit.

[5] For Medicare-Eligible Participants, Medicare covers certain virtual visits or telemedicine. On behalf of Medicare-Eligible Participants, the Fund will process claims for those virtual visits or telemedicine that are covered by Medicare under the Fund's Medicare Supplement Plan.

you have a health condition that involves treatment covered by this program, a nurse from Magellan Rx Management will contact you. The Magellan Rx Management Site of Service program recommendations will be required for coverage of these medical drugs to be provided under the Plan. Effective October 14, 2020, this program will no longer be in place.

Covered Medical Expenses

The Plan covers the following Medically Necessary expenses/services:

1. Hospital expenses, including pre-admission testing for diagnostic purposes, room and board up to the semi-private room rate, and intensive care. Federal law requires that the Plan pay Hospital expenses for any Hospital length of stay in connection with childbirth for a mother and/or the newborn child for at least 48 hours (following a vaginal delivery) or at least 96 hours (following a cesarean section). However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours, if applicable) following delivery.

2. Miscellaneous Hospital charges, including services in an operating room, services of an anesthesiologist, pathologist, or radiologist, and emergency outpatient medical care (including surgical procedures and emergency first-aid treatment) if due to bodily Injury or Sickness.

3. Outpatient surgery for procedures performed in the outpatient department of a Hospital, Ambulatory Medical-Surgical Facility, or other facility approved by the Trustees.

4. Charges made by an emergency professional ambulance service for transportation to the nearest Hospital or Physician's office equipped to provide the required treatment for a life-threatening Injury or Sickness. In the case of a terminal Illness, routine ground ambulance service to and from a Physician's office will also be covered. Any other transportation services are not covered.

5. Surgical expenses, including Physician, Surgeon, and assistant Surgeon fees, within limits, when performed in a Physician's office or on an outpatient basis (at a Hospital, Hospital-approved Ambulatory Medical-Surgical Facility, or other facility approved by the Trustees).

    a. Charges made by a Physician, Surgeon, or Assistant Surgeon for professional services including Hospital visits while the Eligible Person is an inpatient. If two or more operations are performed through the same incision or body orifice, the benefit payable for the least costly operation will be one-half of the normal allowance for that procedure.

    b. Charges made by a co-Surgeon are limited to not more than 50% of the Allowable Charge, or 20% of the Allowable Charge for an Assistant Surgeon, for the operation performed. Charges incurred for a standby "Surgeon," even if the Hospital rendering care requires the services of a standby Surgeon, will not be paid under this Plan of benefits.

6. Surgical expenses for reconstructive breast surgery and breast prosthesis following a mastectomy, including:

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

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

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

7. Doctor's services in the office or Hospital.

8. Initial Doctor's exam for newborn, well-baby care in the Hospital.

9. Services of physiotherapists, physicians assistants, speech therapists, registered nurses, nurse practitioners, legally licensed social workers, respiratory therapists (within guidelines), licensed practical nurses, and nurse aides (when trained nurses are not available), when those services are specifically recommended by a referring medical Physician or such treatment or consultation is under the direct supervision of a medical Physician, provided the services are not rendered by an Eligible Person's relative by blood or marriage or by someone who ordinarily resides in the Eligible Person's home. Providers must possess a master's or higher degree.

10. Routine physical exams, including X-ray and laboratory testing (including Pap smears).

11. Radiology (X-ray), nuclear medicines, and radiation therapy.

12. Legend Drugs and medicines requiring a prescription that are received or administered as part of a Covered Expense and prescribed by the attending Physician. Compliance with the Fund's Site of Service program, which is outlined on page 55, is required for coverage of certain infusion medications and treatments. In addition, certain drugs and medications listed on the Plan Select Drugs and Products List require Pre-certification for Medical Necessity.

13. Blood or blood plasma and its administration and storage related to surgery.

14. Casts, splints, trusses, crutches, bandages, surgical dressings, oxygen, and rental of equipment for its administration.

15. Durable medical equipment (DME), which is Medically Necessary for the treatment of a Sickness or Injury. Rental coverage for certain items of DME is required prior to outright purchase coverage. The Trustees, in their sole discretion, determine when rental, purchase, or conditions for repair or replacement are appropriate.

    a. Only one item of the same or similar DME will be covered during each Eligible Person's lifetime, unless the Trustees, in their sole discretion, approve the replacement of such DME. The Allowable Charge for DME does not include the cost of supplemental features; however, the Plan will still pay up to the industry standard on basic and standard DME, provided the Eligible Person pays the difference.

    b. Covered DME includes but is not limited to: orthotic devices, which are covered once every three years; CPAPs/BiPAPs, which are covered once every five years; and hearing aids, which are limited to $1,250 per ear once every five years for Participants and Dependents age 18 and over; there is no limit for hearing aid

coverage for Dependents under age 18. Deductible, patient Coinsurance, and application toward out-of-pocket limits do not apply to hearing aid coverage; however, Allowable Charges do apply.

c. The following items are covered as DME under the Plan:

1) Airway Clearing Devices
2) Alternating Pressure Point Pumps/Supplies
3) Apnea Monitor
4) Automatic Blood Pressure Monitor
5) Bone Growth Stimulator
6) Braces and Splints
7) Breast Pumps, limited to one per pregnancy, at 100% for in-network services/equipment (effective January 1, 2021)
8) Canes
9) Cervical Collars
10) Continuous Glucose Monitoring Device
11) CPAP/BiPAP (one every five years)
12) Crutches
13) Flotation Pads
14) Glucometer
15) Hearing Aids (maximum $1,250 per ear every five years; this dollar limit is for adults age 18 and older; benefits for patients under age 18 are unlimited)
16) Hospital Beds
17) Humidifier (in connection with a CPAP machine)
18) Insulin Pumps
19) Intermittent Compression Unit (only devices used during inpatient treatment or following outpatient total joint replacements, when Medically Necessary)
20) Intrathecal Pain Pump
21) Lymphatic Pump and Sleeves
22) Medication Delivery Pumps
23) Muscle Stimulators (used during therapy)
24) Nerve Stimulator
25) Orthotic Devices (one every three Calendar Years)
26) Oxygen and Supplies
27) Pacemaker/External (Life Vest) and IED Implantable Device
28) Palatal Plastic Device
29) Penile Implants
30) Pressure Injector
31) Prosthetics
32) Small Volume Nebulizer (SVN)

33) Stoma Unit and Supplies
34) Suction Machine
35) Sun Lamps/Ultraviolet Equipment
36) Surgical Bra (mastectomy included)
37) Traction Equipment
38) Ventilator
39) Voice (TE) Prosthesis
40) Volumetric Infusion Pumps
41) Walker
42) Wheelchair
43) Wound Vac

d. The following items are not covered as DME under the Plan:
1) Basic Exercise Bicycle for Cardiac Rehabilitation Program
2) Bathroom Equipment
3) Batteries (unless needed to operate equipment)
4) Biofeedback Equipment
5) Blood Pressure Cuff
6) Chairs
7) Colonic Irrigation Units
8) Environmental Equipment, including:
a) Air Cleaner
a) Air Filter
b) Humidifier (except in connection with a nasal CPAP machine)
c) Air Conditioner
d) Dehumidifier
e) Precipitator
9) Exercise Equipment
10) Food Blenders
11) Gravetonic Traction Device
12) Handrails
13) Hearing Masker
14) Heating Pads
15) Hot Tubs
16) Hydraulic Lifts
17) Lifts
18) Massage Devices
19) Nocturnal Enuresis Devices
20) Sauna Baths

21) Sitz Baths
22) Sleep Warm Electric Comfort Units
23) Swimming Pools
24) Water Piks
25) Whirlpool Equipment
26) Wigs

e. The covered and non-covered items lists above may be updated periodically by the Trustees. Please contact the Welfare Fund Administrative Office for a current list.

16. Cardiac rehabilitation.

17. Home Health Care, as defined on page 10.

18. Hospice care in a freestanding facility or an approved method of treatment for a terminally ill patient, including services of a Physician, home health care services, emotional support services, homemaker services, bereavement services, and medications.

19. Well-child care for routine office exams, inoculations, school physicals, athletic physicals, gynecological exams, and other kinds of well-child care, as defined by the Plan.

20. Charges for vasectomies or sterilization procedures performed on a Participant or a Participant's Dependent spouse when performed in a Physician's office. Inpatient vasectomies or sterilization procedures or outpatient procedures performed in an Ambulatory Medical-Surgical Facility, outpatient Hospital setting, or similar setting are covered only when the attending Physician certifies that the patient's health would be endangered if the procedure were performed in a Physician's office. Expenses incurred for reversals of such vasectomies or sterilization procedures are not covered.

21. Bone mass (bone density) measurement screening and repeat bone mass measurements when such tests are prescribed by the attending Physician as Medically Necessary. Testing is covered once every two years, unless more frequent screening is Medically Necessary. Bone mass measurements by dual photon absorptiometry (DPA) are not covered.

22. Colorectal cancer screening when recommended by a Physician for an Eligible Person over age 50 once every 10 years, unless more frequent screening is Medically Necessary. Colorectal cancer screenings using molecular genetic techniques are not covered.

23. Testosterone replacement therapy, up to $2,500 per Calendar Year. However, to be considered a Covered Expense under the Plan, verification must be provided of the therapy's Medical Necessity from the attending Physician, including lab results showing a testosterone deficiency. Testosterone replacement therapy must be FDA-approved for the diagnosis.

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

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

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

27. Pediatrician or neonatologist professional services.

28. Genetic counseling, including charges for chorionic villi sampling (CVS), when prescribed by the attending Physician as Medically Necessary.

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

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

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

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

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

34. Charges for the following additional services and supplies:

    a. Anesthesia and its administration.

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

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

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

for the treatment to be covered by the Plan, the Dependent must still be Eligible under the rules of the Plan when the treatment begins.

e. Oral surgery services, including extractions and other types of oral surgery, performed by a Physician or dentist. For Base Plan Participants, such coverage will be coordinated with the Dental Benefit whereby the Medical Benefit will be applied first, then any outstanding patient liability will be applied toward the Covered Person's Dental Benefit.

35. Charges for routine foot care.

36. Acupuncture, subject to a 48-visit limit (combined visit limit with physical therapy and massage therapy) for each Illness, Injury, or disease. Bariatric surgery after Utilization Review by the case manager if the Participant meets industry standards for such surgery.

37. Private duty nursing, but only when the Participant is in Hospice care.

38. Treatment for sleep apnea when Medically Necessary and prescribed by a medical Doctor. Charges for oral appliances and home sleep studies that are prescribed by a dentist to treat mild to moderate sleep apnea are not covered.

39. Treatment of gender dysphoria for Medically Necessary services, subject to the following conditions, limitations, and any exclusions set forth in this SPD. All regular Plan rules apply, such as Copayments, Deductibles, Coinsurance, and out-of-pocket limits.

    In order to be a Covered Expense, the Participant has undergone evaluation by a qualified mental health professional (QMHP) who is experienced in the evaluation and treatment of patients with a variety of mental health issues and has the requisite skill and experience in evaluation of patients with gender dysphoria and all relevant comorbid mental health conditions, including familiarity in the application of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) or the then current version of the DSM. A practitioner will be considered a QMHP if they are a board-certified psychiatrist or psychologist, or an in-network master's-level provider with a degree in a clinical behavioral science field from a nationally accredited credentialing board and appropriately licensed in the jurisdiction in which they practice and are qualified to evaluate and treat Participants as noted above. For the treatment of gender dysphoria to be considered a Covered Expense, the Participant must meet all criteria in the current version of the DSM and have no confounding comorbid mental health conditions, which would be contraindications to treatment, and treatment must have been recommended by a qualified practitioner with appropriate training and credentials. The approval of the practitioner is to be administered so it does not constitute a prohibited non-quantitative treatment limitation (NQTL) under the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Plan imposes corresponding approval requirements for medical/surgical benefits.

    Covered Expenses may include supportive mental health counseling and treatment of any additional comorbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy, and hysterectomy, or genital reconstructive surgery where those interventions and treatments comply with all other provisions of the Plan. Any limitations on mental health counseling will be consistent with corresponding limitations on medical/surgical benefits under the MHPAEA.

Related surgical expenses are covered, subject to the following conditions:

- Well documented and persistent gender dysphoria;
- Two referral letters from QMHPs as described above, one of which must be the Participant's treating mental health professional and the second from an additional qualified mental health professional who has performed an appropriate evaluation of the Participant;
- Documented control of any comorbid medical or mental health conditions that would render the Participant incapable of making a fully informed decision or interfere with the diagnosis of gender dysphoria and substantially diminish the likelihood of a reasonable treatment outcome;
- In the absence of a medical contraindication, complete 12 months of continuous hormone therapy appropriate to the Covered Person's gender goals, and complete 12 months of living in a congruent gender role;
- Obtain treatment from a practitioner and facility with appropriate experience in the provision of the requested services;
- Obtain Pre-certification prior to surgical procedure;
- Hormone therapy is covered under the Comprehensive Major Medical Benefit and the Prescription Drug Benefit under the following conditions: Completion of evaluations as outlined and have a diagnosis of gender dysphoria with no contraindications to treatment;
- Treatment must be ordered and supervised by a practitioner experienced in the treatment of individuals with gender dysphoria;
- Obtain Pre-certification or Prior Authorization prior to beginning therapy; and
- Age 18 or over.

40. Virtual Care for Medically Necessary Behavioral Health services, subject to the following conditions, limitations, and any exclusions set forth in this SPD. All regular Plan rules apply, such as Copayments, Deductibles, Coinsurance, and out-of-pocket limits. Benefits are payable as shown for Behavioral Health expenses in the applicable schedule in the "Schedules of Benefits" document when **all** of the following criteria are met:
    a. Services are initiated by the member seeking care from a remote location, for example, home or work; a non-clinical location.
    b. The service replaces the need for the member to travel to a provider's office or clinic.
    c. The service takes place via online technology (including video), telephonic, or secure messaging.
    d. Claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.
41. Continuous glucose monitoring systems, when Medically Necessary.

42. Contraceptive methods for female Fund Participants and Dependents. Regular Copayments, Deductibles, and Coinsurance apply. Some contraceptives are covered under the Plan's Prescription Drug Benefits and others under the Fund's Comprehensive Major Medical Benefits.

43. Growth hormones, when Medically Necessary.

44. Applied behavior analysis (ABA) therapy for autism spectrum disorder, when Medically Necessary (effective October 1, 2020).

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

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

Temporomandibular Joint Dysfunction (TMJ) Treatment: The Plan covers Medically Necessary diagnostic and surgical treatment charges for TMJ (temporomandibular joint dysfunction). These charges will be processed under the applicable Comprehensive Major Medical Schedule of Benefits. There is a lifetime maximum of $3,500 for appliances, manipulation, and other non-surgical, non-diagnostic charges. There is no lifetime maximum for Dependents under age 18.

Skilled Nursing Care/Skilled Nursing Facility or Subacute Care Facility: The Plan covers expenses for Skilled Nursing Care or for expenses incurred in a Skilled Nursing Facility or a Subacute Care Facility up to the limits stated in the applicable schedule in the "Schedules of Benefits" document, if applicable.

Physical Therapy/Massage Therapy/Acupuncture: The Plan covers up to 48 combined visits for physical therapy/massage therapy/acupuncture for patients age six or older for each Illness, Injury, or disease. The Plan will cover unlimited physical therapy visits for a patient under age six if the patient continues to make ongoing progress.

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

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

Outpatient Psychological Counseling: Family counseling is covered if it is Medically Necessary.

Hearing Benefit Program: The Fund, in partnership with EPIC Hearing Service Plan, assists active Participants and retirees in locating hearing care professionals and, in most cases, reducing out-of-pocket expenses for hearing exams and hearing aid devices. Fund Participants can save approximately 25%–50% on major brand hearing instruments. In addition, EPIC has a discount program for hearing aid batteries. As a Participant, you can have batteries shipped directly to

your home at a savings of over 40% from standard retail store pricing. To learn more, contact EPIC toll-free at 866-956-5400. Be sure to identify yourself or a family member as a Participant in the NECA-IBEW Welfare Trust Fund.

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

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

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

1. You are under the age of 55;
2. Pre-operative studies (MRI or previous arthroscopy) reveal the absence or near-absence of the meniscus;
3. Degenerative changes in the surrounding articular cartilage must be absent or minimal; and
4. Normal knee alignment and stability (i.e., intact or reconstructed ACL) or stability will be achieved concurrently with meniscal transplant.

Behavioral Health Benefits: The Plan provides Behavioral Health Benefits, which include treatment and services for mental health disorders and substance abuse (including alcoholism, chemical dependency, and drug addiction) recommended by the attending Physician or a behavioral health practitioner, up to the limits shown in the applicable schedule in the "Schedules of Benefits" document. Covered Expenses must be Medically Necessary and include the services of a Physician, behavioral health practitioner, Hospital, Residential Treatment Program/Facility/Care, or other accredited treatment facility or recognized outpatient treatment program as determined by the Trustees. Hospital expenses include Room and Board Charges, medications, X-rays, lab/Physician charges, and detoxification. Two days of partial Hospitalization counts as one day of inpatient treatment.

Employee Assistance Program (EAP): The Plan provides Participants and their covered Dependents with access to an Employee Assistance Program (EAP). The EAP offers counseling and resources for when you need them most—whether you are going through a rough patch at home, stressed over work or finances, or looking to improve your work/life balance. Programs offer in-person or over-the-phone assistance, as well as referrals for childcare, elder care, legal services, and other services.

Through the EAP, you and your covered Dependents have access to up to three counseling sessions per year, which will be covered 100% by the Plan.

The Fund's EAP is offered through LifeWorks. You can find information about the program on the Fund's website (www.neca-ibew.org/lifeworks), or you can call LifeWorks toll-free at 888-456-1324, 888-732-9020 (en español), or 800-999-3004 (TTY), or visit www.lifeworks.com.

The EAP is 100% confidential. No one from your Union, the Fund, or your Employer will know that you contacted the program.

Organ Transplants: The Plan covers Organ Transplants. Pre-certification is required for Medical Necessity. Contact the Fund Office Utilization Review Department immediately regarding Organ Transplants. Benefits are provided according to the applicable schedule in the "Schedules of Benefits" document. Covered Organ Transplant surgeries are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated, including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants.

Organ procurement benefits are limited to a $20,000 maximum (payable at 100%, not subject to the Plan's Deductible) at non-Centers of Excellence facilities. There is no organ procurement benefit maximum at Centers of Excellence facilities (effective October 1, 2020). If you use a Centers of Excellence (COE) facility, the Plan's Coinsurance and Out-of-Pocket Maximums apply. However, if a COE facility is not used, the Plan only pays 50% of the Allowable Charge, and there is no Out-of-Pocket Maximum on the amount of expenses you are required to pay.

The following services are included:

- The use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s);
- Multiple Organ Transplant(s) during one operative session;
- Replacement(s) or subsequent Organ Transplant(s);
- Work-up and follow-up expenses; and
- Transportation and lodging expenses (effective October 1, 2020), limited to the Plan's per-transplant benefit period maximum shown in the applicable schedule in the "Schedules of Benefits" document, which include:
    - Transportation to and from the site of the covered Organ Transplant procedure for the Eligible individual and one other individual, or in the event the Eligible individual or the donor is a minor, two other individuals. Transportation expenses include airfare, toll/parking fees, and tax and gas mileage at the standard IRS rate; and
    - Reasonable and necessary lodging expenses, including apartment or hotel rental.

Donor expenses will include:

- Testing to identify suitable donor(s);
- The expense for the procurement of organ(s) from a donor;
- The expense of life support of a donor pending the removal of usable organ(s); and
- Transportation of organ(s) or a donor on life supports.

Expenses incurred by a non-Eligible donor to an Eligible Person will be paid under this Plan, provided such charges are not payable under another plan.

Extended Eligibility for Organ Donors: The Fund will freeze their Hour Bank and grant 21 months of Eligibility due to Disability to Eligible Participants who donate an organ either to a family member or to another Participant covered under the Fund. Family members include a spouse, child, sibling, parent, grandchild, or grandparent.

Immunosuppressive Medications: Immunosuppressive medications are covered by the Plan under the Prescription Drug Benefit, subject to the Plan's specialty medications coverage provisions.

Prescription Drugs: The Plan covers most prescription drugs under separate Prescription Drug Benefits, as described beginning on page 73.

Utilization Review

Transplant surgery, bariatric surgery, surgical services, and/or hormone therapy related to gender dysphoria, and drugs and medications listed on the Plan Select Drugs and Products List are required to be pre-certified for Medical Necessity for benefits to be payable under the Fund. There is no requirement for Covered Persons to obtain Pre-certification for Hospital admissions or certain other services including, but not limited to, spinal (back/neck) surgeries, orthopedic surgeries, joint replacement surgeries, sinus surgeries, podiatric surgeries, certain injection procedures, infusion treatments, durable medical equipment (DME), physical therapy, occupational therapy, speech therapy, vision therapy, substance abuse treatments, ABA therapy, genetic testing, and cancer treatments. However, all services, treatments, and supplies are subject to review for Medical Necessity and must be Medically Necessary (see the definitions of "Pre-authorization," "Medically Necessary or Medical Necessity," and "Experimental and/or Investigational" in the "Plan Definitions" section starting on page 5 for more information) for benefits to be payable under the Plan, unless specified otherwise in this SPD.

The Fund Office Utilization Review Department, through MCM, will perform coverage pre-determinations for the services outlined above in this definition. Covered Persons or their providers should contact the Fund Office or the "Medical Management" phone number on their Participant identification card (e.g., BlueCross BlueShield card) to begin the Pre-certification or pre-determination process.

The Fund only requires Prior Authorization/Pre-certification for transplant surgery, bariatric surgery, surgical services, and/or hormone therapy related to gender dysphoria, and drugs and medications listed on the Plan Select Drugs and Products List. However, we strongly recommend a pre-service/pre-determination review by MCM, our Utilization Review vendor, as the Fund does not cover anything considered not Medically Necessary or appropriate, Experimental/Investigational, off-label, or in any phase of a current clinical trial. Participants or your providers are encouraged to contact the Fund Office to verify that any procedures you are considering are covered. The Fund Office Utilization Review Department, through MCM, will perform coverage pre-determinations for you. We find that contacting the Fund for a pre-determination review can avoid issues for services like Hospital admissions, spinal (back/neck) surgeries, orthopedic surgeries, joint replacement surgeries, durable medical equipment, substance abuse treatments, or cancer treatments.

Medical Exclusions and Limitations

Comprehensive Major Medical Benefits under this section do not cover:

1. Dental work except as specifically provided otherwise by the Plan.
2. Eye refraction (for fitting of glasses only) or eyeglasses and charges for the fitting of eyeglasses and related eye exams.
3. Dental prosthetic appliances and charges for the fittings of such appliances.
4. Any expenses incurred for pre-natal testing, including amniocentesis, when done to determine the sex of a child or without medical diagnosis.
5. Equipment that does not significantly enhance the medical management of patient care.
6. Equipment that is used solely as a patient comfort item.
7. Supplies or equipment for personal hygiene, comfort, or convenience, such as telephones, televisions, cosmetics, guest trays, magazines, or beds or cots for family members or other guests.
8. Charges for a second surgical opinion from a Physician affiliated with the Physician rendering the first opinion.
9. Expenses incurred for physical exams not performed by a Doctor, as defined by the Plan, or for a pre-marital or pre-employment exam.
10. Expenses incurred for standby Surgeons.
11. Expenses incurred relating to Organ Transplants, except as specifically provided otherwise by the Plan:
    a. Unless there is medical documentation that conventional treatment could be unsatisfactory, unavailable, and/or more hazardous than a transplant;

b. For any animal organ or mechanical equipment, device, or organ(s) except as otherwise specified by the Plan;

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

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

12. Expenses incurred for a Hospital confinement when the Eligible Person leaves the facility against the medical advice of the attending Physician.

13. Any of the circumstances described in the Plan's general exclusions and limitations (see page 118).

14. Expenses related to sperm washing.

15. Weight loss programs.

16. Private duty nursing, except when the patient is in Hospice care.

17. Any services provided by Excluded Providers. Charges for services rendered by any of the Excluded Providers identified and listed on the applicable schedule in the "Schedules of Benefits" document are not covered.

18. Drugs and medications that are listed on the Plan Select Drugs and Products List that have not been pre-certified by the Plan as meeting the Medical Necessity criteria of the Plan.

19. Any services, expenses, or charges that are not Covered Medical Expenses.

Comprehensive Major Medical Benefit—Retirees Eligible for Medicare, and Their Medicare-Eligible Dependents

Medicare Supplement Plan

Coverage for Medicare-Eligible retirees who are age 65 or over and/or their Medicare-Eligible Dependents age 65 or over is self-insured. “Medicare-Eligible retiree” means an individual who is age 65 or older, or who is under age 65 and Medicare-Eligible due to Disability, and who is enrolled in Medicare Parts A and B. Coverage for retirees Eligible for Medicare and Medicare-Eligible Dependents is described in the applicable schedule in the “Schedules of Benefits” document.

If you are Medicare-Eligible, you must be enrolled in Medicare Parts A and B in order to be covered under the Fund’s Supplemental Retirement Benefit Plan. Prescription drugs are covered under the Plan’s “Prescription Drug Benefit for Participants Eligible for Medicare,” as described beginning on page 80. Before you and/or your Dependent reach age 65 and become Eligible for Medicare, the Fund Office will send you an enrollment package. This package will include information on how to become covered, as well as how to elect your prescription drug coverage.

The Medicare Supplement Plan for Medicare-Eligible retirees and Dependents provides a Skilled Nursing Facility Benefit for care received at Skilled Nursing Facilities for Eligible retirees. The Plan pays in addition to Medicare, so a portion of your expenses will be covered from days one to 365.

The Plan will be responsible for answering benefit questions, paying claims, and handling any appeals relating to Medicare-Eligible Participants. If you have questions about your retiree medical coverage, submitting a claim or the status of a claim, or your premiums, contact the Fund Office at 800-765-4239.

It is possible that you and your spouse or other Dependents will be covered under different schedules of benefits. Only retirees and/or their Dependents Eligible for Medicare will be insured through this Plan option. All other benefits will be provided by the Fund on a self-funded basis.

Coordination of Benefits with Medicare

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

The claims of retirees and their Eligible Dependents who are enrolled in Medicare Parts A and B due to age or Disability will be coordinated with Medicare, in accordance with the Plan’s and Medicare’s coordination of benefits provisions. Benefits will be coordinated with Medicare based on a supplemental approach whether or not the retiree or Eligible Dependent actually enrolls in Medicare Parts A and B, or Medicare+ Choice (Part C). This is how your benefits will work:

- If you are under age 65, you must meet the Plan Deductible.
- The Plan covers the Deductible and Copayments not covered by Medicare Part A.
- The Plan covers 20% of your Medicare-Eligible expenses after the Medicare Part B Calendar Year Deductible is met. Medicare-Eligible expenses are health care expenses covered by Medicare to the extent recognized by Medicare. Charges not recognized as Medicare-Eligible are not covered by the Plan.
- Each Calendar Year, the Plan covers the first three pints of blood that you require.
- The Plan covers transplant expenses approved by Medicare but that exceed Medicare's limit for reimbursement. Such transplant expenses will be covered as shown in the applicable schedule in the "Schedules of Benefits" document.

Please refer to the applicable schedule in the "Schedules of Benefits" document for a complete breakdown of coverage and benefit levels.

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

Prescription Drug Benefits

If you and/or your Eligible Dependents are Eligible for Medicare and are covered under the Plan, you do not need to enroll in Medicare Part D for prescription drug coverage. By electing retiree coverage with the Fund, you will be automatically enrolled in Medicare Part D through the NECA-IBEW-sponsored prescription drug plan (PDP). As long as you and/or your Dependents remain Eligible for Plan coverage, you will be covered under the Fund's Supplemental Retirement Benefit Plan, which includes Prescription Drug Benefits. The Plan's Prescription Drug Benefits for Medicare-Eligible retirees and their Medicare-Eligible Dependents are described beginning on page 80.

If you or your Eligible Dependents enroll for Medicare Part D prescription drug coverage outside of the Fund's Supplemental Retirement Benefit Plan, you will no longer be Eligible for Prescription Drug Benefits through the Fund. This will not affect your Eligibility for Medical Benefits; however, your monthly premiums for coverage through the Supplemental Retirement Benefit Plan will not be reduced even though you are not receiving Prescription Drug Benefits through the Fund. This means you will be paying the same monthly premium to the Fund but without prescription drug coverage.

If you enroll for Medicare Part D prescription drug coverage, you will have one opportunity to re-enroll for Prescription Drug Benefits through the Fund's Supplemental Retirement Benefit Plan if you subsequently drop Medicare's prescription drug coverage. Otherwise, your retiree prescription drug coverage may not be reinstated unless you return to work and meet the Eligibility requirements for active coverage.

If you drop or lose your coverage under the Plan and you go 63 days or longer without prescription drug coverage that is at least as good as Medicare Part D prescription drug coverage, your monthly premium for Medicare Part D prescription drug coverage may increase. The increase would not exceed 1% per month for every month that you were Eligible but did not

have coverage. In these circumstances, the higher premium may apply as long as you have Medicare Part D prescription drug coverage. In addition, you may have to wait until the next open enrollment period (October 15 through December 7 each year) to enroll.

Retirees and Eligible Dependents who are age 65 or over and Eligible for Medicare Parts A and B have a choice when electing Prescription Drug Benefits to go along with Medical Benefits. You can choose either Base Plan or Alternative Plan coverage. The Alternative Plan provides a lower level of coverage at a reduced cost to retirees. The Alternative Plan's Prescription Drug Benefit requires a larger Copayment per prescription but does not have a Deductible. If you elect to receive benefits under the Alternative Plan, you will not have the option, at any time, to re-enroll in the Base Plan and receive the higher level of coverage.

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

Prescription Drug Benefit for Participants Not Eligible for Medicare

NOTE: For information about prescription drug coverage for Eligible retirees and their Eligible Dependents who are Eligible for Medicare, please see the "Prescription Drug Benefit for Participants Eligible for Medicare" section on page 80.

Prescription Drug Benefits are available to all Eligible Persons. The Plan's Prescription Drug Benefit is administered through CVS Caremark. The Prescription Drug Benefit includes coverage for medications purchased at retail pharmacies or through the CVS Caremark Mail Service Pharmacy, subject to the prescription drug Deductible and any applicable Copayment or Coinsurance as outlined below and in the applicable schedule in the "Schedules of Benefits" document. The Fund's Prescription Drug Benefit also includes a Specialty Medication Program.

The retail pharmacy component provides access to a national network of participating retail pharmacies, which have agreed to provide medications at a discounted price for Eligible Participants. For a free listing of participating pharmacies, mail-order forms, and information regarding coverage for specific medications, contact CVS Caremark at the telephone number stated on your CVS Caremark prescription drug card or through its website, www.caremark.com. For information about the Specialty Medication Program, visit www.caremark.com.

Prescription Drug Calendar Year Deductible

The prescription drug Deductible for each Calendar Year with respect to each Eligible Person is shown on the applicable schedule in the "Schedules of Benefits" document.

Formulary

The prescription drug plan utilizes a four-tier formulary. A formulary is a list of prescribed medications, including generic, brand name (preferred and non-preferred), and specialty medications, that have proven to be both clinically effective and cost effective. Prescription drugs on the formulary are categorized into four tiers, and these tiers determine your cost for a particular medication. There are preferred products in every therapeutic class in the formulary. Some medications are "excluded" from the formulary, and these medications are not covered under the prescription drug plan. **If you choose to fill a prescription for a medication that is not on the Plan's list of Covered Medications, you will pay 100% of the cost.** The formulary may change from time to time throughout the Calendar Year. Refer to www.caremark.com for the current formulary.

Drug Tier	**Definition**
Generic	A drug that is equivalent to a brand name prescription. By law, a generic must contain the same active ingredients as brand name drugs. Therefore, taking a generic drug should treat the condition the same as the brand, but the prescription can be obtained at a lower cost.
Preferred Brand	Brand name medications that are on the formulary.

Non-Preferred Brand Specialty	Brand name medications that are placed at a higher cost share tier; this includes certain pharmaceuticals, biotech, or biological drugs that are used in the management of chronic or genetic disease, including, but not limited to, injectable, infused, or oral medications, or products that otherwise require special handling.

Retail Pharmacy Program

In addition to the prescription drug Deductible outlined above, you pay a Copayment or Coinsurance for each prescription filled under the Retail Pharmacy Program. When you have your prescription filled at a participating retail pharmacy, you will be charged the applicable Copayment set forth in the applicable schedule in the "Schedules of Benefits" document. If you choose a non-preferred brand name medication when a generic substitute is available, you are required to pay the applicable Copayment as shown in the applicable schedule in the "Schedules of Benefits" document plus the difference in cost between the non-preferred brand name and the generic equivalent. You may obtain up to a 34-day supply at a retail pharmacy.

Maintenance medications are those medications that are taken for an extended period to treat a chronic condition, such as diabetes, high blood pressure, arthritis, or heart disease. The Retail Pharmacy Program will honor your initial maintenance medication prescription and the first two refills. The third maintenance medication refill and all subsequent refills must be filled through the Mail-Order Program or CVS Caremark Maintenance Choice Program (described below) in order to be covered under the Plan.

Non-Participating Network Pharmacy

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

Maintenance Choice Programs

In addition to the prescription drug Deductible outlined above, you pay a Copayment for each prescription filled under the Mail-Order Program or CVS Caremark Maintenance Choice Program. When you have your prescription filled through these programs, you will be charged the applicable Copayment or Coinsurance set forth in the applicable schedule in the "Schedules of Benefits" document.

If you choose a non-preferred brand name drug when a generic drug substitute is available, you are required to pay the applicable Copayment as shown in the applicable schedule in the "Schedules of Benefits" document plus the difference in cost between the non-preferred brand name and the generic equivalent.

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

CVS Caremark Maintenance Choice Program. Maintenance Choice® offers you choice when it comes to filling long-term prescriptions. You must choose to receive 90-day supplies of your long-term medications either by mail through the CVS Caremark Mail Service Pharmacy or to pick them up at a CVS Pharmacy near you. Either way, your Copayment remains the same for both services, and you will receive a 90-day supply.

You must have the third maintenance medication refill and all subsequent maintenance medication refills filled through the Mail-Order Program or CVS Caremark Maintenance Choice Program.

Prior Authorization (PA)

In order for some prescription medications to be covered as a part of your benefit, a Prior Authorization (PA) evaluation will be conducted to determine if the medications' prescribed use meets defined clinical criteria. Through this process, your Doctor and CVS Caremark pharmacists will work together to ensure that the drug you are prescribed is the most appropriate for your condition. The CVS Caremark Prior Authorization number is 800-294-5979. Please visit www.caremark.com to determine which drugs have a PA.

You may attempt to fill a prescription for a non-formulary medication which is excluded from coverage. If this happens, there may be a preferred alternative drug recommended by CVS Caremark. If you and your Doctor do not believe the recommended alternative(s) is appropriate for you, your Doctor can request a Prior Authorization by contacting CVS Caremark.

If a PA request is subsequently denied, both you and your Doctor will receive written communication from CVS Caremark, which will outline the process of initiating an appeal. If the appeal is approved, the Plan will then cover the non-formulary medication, subject to the prescription drug Deductible and Copayment or Coinsurance shown in the applicable schedule in the "Schedules of Benefits" document.

If the appeal is denied, you may then choose to file a Second Level appeal as described later in this section. You will receive information on how to file a Second Level appeal through a written communication from CVS Caremark.

Quantity Limits

Quantity limits are defined as the maximum number of tablets or units (i.e., injections or nasal spray bottles) covered by the Plan per Copayment or Coinsurance amount. These limits are generally set around safety and efficacy established by the drug manufacturer. Please visit www.caremark.com to determine which drugs have quantity limits.

Specialty Medication Program

The Plan provides a separate specialty medication cost share tier for its pharmacy benefit program. Prior Authorization may apply. Immunosuppressive specialty medications (drugs used for transplants) are included in the specialty medications Copayments as outlined in the applicable schedule in the "Schedules of Benefits" document. Specialty medication prescriptions will be limited to a 30-day supply. Persons who were receiving specialty medications prior to

January 1, 2013 will continue to receive those medications at the retail and mail-order Copayments shown in the applicable schedule in the "Schedules of Benefits" document. Visit www.caremark.com for more information.

Effective July 1, 2020, Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.

Utilization Management Program

A Utilization Management Program, including step therapy, Prior Authorization, and quantity limits, applies to certain prescription medications. Under the Utilization Management Program, certain drugs and products may also be completely excluded from coverage under the Plan's Prescription Drug Benefit. You can contact CVS Caremark to find out if a prescribed medication or supply is subject to Utilization Management.

Important Coverage Reminder: Products not approved by the U.S. Food and Drug Administration (FDA) as a prescription drug are not covered under the Fund's Prescription Drug Benefit.

Opioid Management Program

The Fund's Opioid Management Program requires step therapy, first prescription fills limited to a seven-day supply (can be greater if prior authorized), and a quantity limit of up to 90 MME (morphine milligram equivalents) per day (based on a 30-day supply) for opioid medications. The Opioid Management Program also includes limiting Covered Persons age 19 and younger who are new to therapy to a three-day supply.

Vaccination Program

Certain vaccines are covered under the Prescription Drug Benefit when they are administered at a CVS Pharmacy. This includes vaccines for influenza (flu), pneumococcal, shingles, and TDAP vaccinations. Such vaccines are subject to a $20 Copayment under the Prescription Drug Benefit. Effective January 1, 2020, vaccines are covered 100% under the Prescription Drug Benefit when administered at a CVS Pharmacy.

NOTE: The 100% vaccine coverage described in this section is **only** available at a CVS Pharmacy and NOT at a CVS MinuteClinic® or through any other medical provider. See the applicable schedule in the "Schedules of Benefits" document for vaccine coverage provided under the Fund's Comprehensive Major Medical Benefit.

Prescription Drug Appeals

First Level Appeals

When an initial coverage review has been denied, a request for clinical review may be submitted by the Eligible Person, their authorized representative, or their provider within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical review requests:

- Name of patient
- Person's Plan ID
- Phone number
- The drug name for which benefit coverage has been denied
- A brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills, or any other documents

Send the information to:

CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 888-443-1172

Standard pre-service appeals are completed no later than 15 days from receipt. Post-service appeals are completed no later than 30 days from submission. Urgent appeals are completed within 72 hours. Covered Persons receiving specialty medications included on the Select Drugs and Products List and enrolled in the Select Drugs and Products Program may, at the discretion of the Plan, have their standard pre-service appeal adjudicated by the Plan or an administrative delegate of the Plan.

Second Level Appeals

When a First Level appeal has been denied a request for a Second Level appeal may be submitted by the Eligible Person, their authorized representative, or their provider within 90 days from receipt of the notice of the First Level appeal adverse benefit determination. To initiate a Second Level appeal, the information listed above for a First Level appeal must be included and sent to the same address.

Third Level Appeals

When a Second Level appeal has been denied, an appeal to the NECA-IBEW Welfare Trust Fund may be submitted by the Eligible Person or authorized representative within 180 days from the receipt of the notice of the Second Level appeal adverse benefit determination. To initiate this appeal, please submit appeal forms and all relevant information to:

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

For Third Level prescription drug appeals, you may obtain appeal forms at www.neca-ibew.org/documents-and-forms or by contacting the Fund Office at 800-765-4239.

Covered Medications

The following medications are covered when prescribed by a Physician or Dentist and obtained by an Eligible Person, subject to all the provisions outlined in this "Prescription Drug Benefit" section and the applicable schedule in the "Schedules of Benefits" document:

- Legend medications on the CVS Caremark formulary
- Insulin syringes and needles
- Compound medications containing at least one federal legend ingredient
- Prescription oral and intrauterine contraceptives
- Diabetic diagnostics
- Chantix and other oral smoking cessation medications
- Erectile dysfunction medications (e.g., Viagra, Cialis), limited to 10 tablets per month
- Insulin pumps
- Continuous glucose monitoring systems

Prescription Drug Benefit Exclusions

Benefits are not payable for:

- Devices of any type, including those approved by the FDA with 510K clearance, even though such devices require a Physician's order, such as, but not limited to, therapeutic devices and artificial appliances; such devices do not include devices that are specifically covered under this section.
- The medication carbinoxamine.
- Any charges for the administration or injection of any drug.
- Any prescription for which an Eligible Person is entitled to receive reimbursement under any workers' compensation law or is entitled to receive reimbursement of such prescription Legend Drug without charge from a municipality, state, or federal program, including Title XVIII of the Social Security Act.

- Any prescription filled in excess of the number specified by the Physician or any refill after one year from the order of the Physician.
- Drugs dispensed by a Hospital, Skilled Nursing Facility, or long-term acute care Hospital where the Eligible Person is confined.
- Any drug labeled "Caution: Limited by Federal Law to Investigational Use" or any Experimental drug.
- Any drug, the use of which is related to the restoration of fertility or the promotion of conception.
- Any drug that has not secured full FDA approval for safety and efficacy.
- Hair loss products (e.g., topical minoxidil, Rogaine).
- Drugs used for cosmetic purposes.
- Over-the-counter medications, including smoking deterrents (such as Nicorette) and vitamins (whether the vitamins are prescribed or not).
- Anabolic steroids, unless approved through the Prior Authorization process.
- Any of the circumstances described in the Plan's "General Exclusions and Limitations" section (see page 118).
- Any drugs or medications that are not Covered Medications.

Prescription Drug Benefit for Participants Eligible for Medicare

If an Eligible Person incurs expenses for prescription drug Covered Medications, benefits will be payable, subject to the provisions explained in this section and in accordance with the limitations set forth in the applicable schedule in the "Schedules of Benefits" document.

The prescription drug plan for retirees and their covered spouses or Dependents who are age 65 or older or otherwise Eligible for Medicare is SilverScript Employer Prescription Drug Plan (PDP) sponsored by NECA-IBEW ("SilverScript"). The plan is administered by SilverScript® Insurance Company, which is affiliated with CVS Caremark®, the Fund's pharmacy benefit manager for Participants and their Dependents who are not Eligible for Medicare. For any questions regarding your Prescription Drug Benefit, please contact SilverScript Customer Care at 866-235-5660.

SilverScript combines a standard Medicare Part D prescription drug plan with additional coverage provided by the Fund to close the gaps between the standard Part D plan and the Plan for Persons who are not Eligible for Medicare.

SilverScript provides you with the *Evidence of Coverage* that explains your rights and the rules you need to follow to get covered services and prescription drugs covered by the Medicare Part D portion of your coverage.

NOTE: Active Employees and their Eligible Dependents are covered under the Prescription Drug Benefit administered by CVS Caremark, even if they are Eligible for Medicare. See the "Prescription Drug Benefit for Participants Not Eligible for Medicare" section.

Spouses and Dependents of Medicare-Eligible retirees, who themselves are not yet Eligible for Medicare, will continue to be covered under the Prescription Drug Benefit administered by CVS Caremark (see the previous section) until such time they become Eligible for Medicare.

Prescription Drug Deductible

The prescription drug Deductible for each Calendar Year with respect to each Eligible retiree or Eligible Dependent is in the applicable schedule in the "Schedules of Benefits" document. There is no prescription drug Deductible for the Alternative Plan.

Prescription Drug Benefits Payable

Benefits are payable for prescription drug Covered Expenses dispensed through the Retail Pharmacy Program and the Mail-Order Program, subject to the prescription drug Deductible described above and as shown on the applicable schedule in the "Schedules of Benefits" document.

Formulary

The prescription drug plan uses a four-tier formulary. A formulary is a list of prescribed medications, including generic, brand name (preferred and non-preferred), and high cost or specialty medications, that have proven to be both clinically effective and cost effective. Medications on the formulary are categorized into four tiers, and these tiers determine your cost for a particular medication. There are preferred products in every therapeutic class in the formulary. Some medications are "excluded" from the formulary, and these medications are not covered under the prescription drug plan. The formulary may change every calendar quarter. Log in to www.caremark.com and use the drug search tool to find your drug, or call SilverScript Customer Care at 866-235-5660.

Drug Tier	Definition
Tier 1 - Generic	A drug that is equivalent to a brand name prescription. By law, a generic must contain the same active ingredients as brand name drugs. Therefore, taking a generic drug should treat the condition the same as the brand, but the prescription can be obtained at a lower cost.
Tier 2 - Preferred Brand	Brand name medications that do not have a generic equivalent and are included on a preferred drug list.
Tier 3 - Non-Preferred Brand	Brand name medications that are not on a preferred drug list and are a high cost.
Tier 4 - High Cost or Specialty	High cost drugs as defined by Medicare, as well as biotech and other unique drugs; includes both brand and generic drugs.

Retail Pharmacy Program

Once a Covered Person has met the prescription drug Deductible, he or she will pay the applicable Copayment and/or Coinsurance under the Retail Pharmacy Program for each prescription as shown on the applicable schedule in the "Schedules of Benefits" document.

Under Medicare guidelines, a Covered Person can receive either a one-month (34-day) supply of the prescription drug or a long-term supply of up to a 90-day supply under the Retail Pharmacy Program. The amount the Person pays depends on the tier, days' supply of the prescription filled, and, if a 90-day supply, whether it is filled at a preferred or non-preferred pharmacy. If the actual cost of a drug is less than the normal Copayment or Coinsurance for that drug, the Person will pay the actual cost, not the higher Copayment or Coinsurance.

Non-Participating Pharmacy

Eligible Persons must use a network pharmacy to have their Copayment or Coinsurance count toward their Medicare Part D out-of-pocket costs and Medicare total drug costs, unless it is an emergency or non-routine circumstance. Eligible Persons who fill a prescription at a non-participating pharmacy may have to pay the full cost of the drug at the pharmacy. In this case, a paper claim must be completed and sent to the Fund Office to request reimbursement. The non-participating pharmacy claim will be reimbursed at 50%.

Mail-Order Program

Once the Covered Person has met the prescription drug Deductible, he or she will have to pay the applicable Copayment or Coinsurance under the Mail-Order Program through the CVS Caremark Mail Service Pharmacy for each prescription as shown in the applicable schedule in the "Schedules of Benefits" document.

Preferred Network Retail Pharmacies

SilverScript has preferred network retail pharmacies where Eligible Persons can get up to a 90-day supply of their maintenance medications for the same Copayment or Coinsurance as mail order, similar to the Maintenance Choice® program available through CVS Caremark for Participants who are not Eligible for Medicare. A maintenance medication is taken regularly for chronic conditions or long-term therapy, such as asthma, diabetes, high blood pressure, arthritis, or cardiovascular disease.

Prior Authorization (PA)

In order for some prescription medications to be covered as a part of your benefit, a Prior Authorization (PA) evaluation will be conducted to determine if the medications' prescribed use meets defined clinical criteria. Through this process, your Doctor and SilverScript pharmacists will work together to ensure that the drug you are prescribed is the most appropriate for your condition. The SilverScript Prior Authorization number is 844-449-4729. Please visit www.caremark.com to determine which drugs have a PA.

You may attempt to fill a prescription for a non-formulary medication which is excluded from coverage. If this happens, there may be a preferred alternative drug recommended by SilverScript. If you and your Doctor do not believe the recommended alternative(s) is appropriate for you, your Doctor can request a Prior Authorization by contacting SilverScript.

If a PA request is subsequently denied, both you and your Doctor will receive written communication from SilverScript which will outline the process of initiating an appeal. If the appeal is approved, the Plan will then cover the non-formulary medication, subject to the prescription drug Deductible and Copayment or Coinsurance shown in the applicable schedule in the "Schedules of Benefits" document.

If the appeal is denied, you may then choose to file a Second Level appeal as described later in this section. You will receive information on how to file additional levels of appeals through a written communication from SilverScript.

Quantity Limits

For certain prescription drugs, SilverScript limits the amount of the prescription drug that you can get each time you fill your prescription. Quantity limits are defined as the maximum number of tablets or units (i.e., injections or nasal spray bottles) covered by the Plan. For example, if it is normally considered safe to take only one pill per day for a certain drug, SilverScript may limit coverage for your prescription to no more than one pill per day. These drugs have a "QL" next to

them in your formulary, or visit www.caremark.com and use the drug search tool to determine which drugs have quantity limits.

Specialty Medication Program

The Plan provides a separate specialty medication cost share tier for its pharmacy benefit program. Prior Authorization may apply. Immunosuppressive specialty medications (drugs used for transplants) are included in the specialty medications Copayments as outlined in the applicable schedule in the "Schedules of Benefits" document. Specialty medication prescriptions will be limited to a 30-day supply. Persons who were receiving specialty medications prior to January 1, 2013 will continue to receive those medications at the retail and mail-order Copayments shown in the applicable schedule in the "Schedules of Benefits" document. Visit www.caremark.com for more information.

Utilization Management Program

A Utilization Management Program, including Prior Authorization (PA), step therapy (ST), and quantity limits (QL), applies to certain prescription medications. These drugs have a "PA," "ST," or "QL" next to them in your formulary, or visit www.caremark.com and use the drug search tool to determine which drugs fall under this program.

Certain drugs and products may also be completely excluded from coverage under the Fund's Prescription Drug Benefit.

Important Coverage Reminder: Products not approved by the U.S. Food and Drug Administration (FDA) as a prescription drug are not covered under the Fund's Prescription Drug Benefit.

Opioid Management Program

The Opioid Management Program requires step therapy, first prescription fills limited to a seven-day supply (can be greater if prior authorized), and quantity limits based on 90 MME (morphine milligram equivalents) per day for opioid medications.

The Opioid Management Program also includes limiting Covered Persons age 19 and younger who are new to therapy to a three-day supply.

Vaccination Program

Effective January 1, 2020, certain vaccines are covered 100% under the prescription drug plan when they are administered at a network Pharmacy. This includes vaccines for influenza (flu) and pneumococcal. See Chapter 4, Section 8 of the *Evidence of Coverage* from SilverScript for more information about vaccinations. Certain other vaccinations, such as vaccines for shingles and TDAP are only covered by your medical plan. You should contact SilverScript Customer Care before you get a vaccination to find out if your vaccination is covered by the prescription drug plan or your medical plan.

NOTE: You could be assessed all or a portion of your prescription drug Deductible at the pharmacy when obtaining one of these vaccinations. If this happens, please contact the Fund Office to ensure you are reimbursed for such charges.

Prescription Drug Appeals

For drugs covered by the Medicare Part D portion of the Plan, refer to Chapter 7 of the *Evidence of Coverage* from SilverScript.

For drugs covered solely through the additional coverage provided by the Fund:

First Level Appeals

When an initial coverage review has been denied, a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- A brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills, or any other documents

Send the information to:

SilverScript Insurance Company
Prescription Drug Plans
Medicare Part D Paper Claim
P.O. Box 52066
Phoenix, AZ 85072-2066

Standard pre-service appeals are completed no later than 15 days from receipt. Post-service appeals are completed no later than 30 days from submission. Urgent appeals are completed within 72 hours.

Second Level Appeals

When a First Level appeal has been denied, a request for a Second Level appeal may be submitted by the member or authorized representative within 90 days from receipt of the notice of the First Level appeal adverse benefit determination. To initiate a Second Level appeal, the information listed above for a First Level appeal must be included and sent to:

SilverScript Insurance Company
Prescription Drug Plans
Medicare Part D Paper Claim
P.O. Box 52066
Phoenix, AZ 85072-2066.

Third Level Appeals

When a Second Level appeal has been denied, an appeal to the Fund may be submitted by the member or authorized representative within 180 days from the receipt of the notice of the Second Level appeal adverse benefit determination. To initiate this appeal, please submit information to:

SilverScript Insurance Company
Prescription Drug Plans
Medicare Part D Paper Claim
P.O. Box 52066
Phoenix, AZ 85072-2066

Covered Medications

The drugs included on the SilverScript formulary are covered by the Plan, but restrictions or limitations may apply.

Through the additional coverage provided by the Fund, you are covered for certain drugs not covered on the SilverScript formulary. You may also have coverage for certain drugs that Medicare will not cover, such as:

1. Prescription drugs when used for anorexia, weight loss, or weight gain.
2. Prescription drugs when used for the symptomatic relief of cough or cold.
3. Prescription drugs when used for the treatment of sexual or erectile dysfunction.
4. Prescription drugs when used for tobacco cessation.
5. Certain diabetic supplies not covered by Medicare Part D.
6. Part B products, such as oral chemotherapy agents.

These drugs are not subject to the SilverScript appeals and exceptions process, and your Copayments or Coinsurance for these drugs will not count toward your Medicare out-of-pocket costs or Medicare total drug costs.

Items excluded from coverage are listed on the next page.

Prescription Drug Benefit Exclusions

Benefits are not payable for:

1. Devices of any type, including those approved by the FDA with 510(k) clearance, even though such devices require a Physician’s order such as, but not limited to, therapeutic

devices and artificial appliances; such devices do not include devices that may be covered under the SilverScript Employer PDP or through the additional coverage provided by the Fund.

2. The medication carbinoxamine.
3. Any charges for the administration or injection of any drug.
4. Any prescription for which an Eligible Person is entitled to receive reimbursement under any workers' compensation law or is entitled to receive reimbursement of such prescription Legend Drug without charge from a municipality, state, or federal program, including Title XVIII of the Social Security Act.
5. Any prescription filled in excess of the number specified by the Physician or any refill after one year from the order of the Physician.
6. Drugs dispensed by a Hospital, Skilled Nursing Facility, or Subacute Rehabilitation Facility where the Eligible Person is confined.
7. Any drug labeled "Caution: Limited by Federal Law to Investigational Use" or any Experimental drug.
8. Any drug, the use of which is related to the restoration of fertility or the promotion of conception.
9. Any drug that has not secured full FDA approval for safety and efficacy.
10. Hair loss products (e.g., topical minoxidil, Rogaine).
11. Drugs used for cosmetic purposes.
12. Over-the-counter medications, including smoking deterrents (such as Nicorette) and vitamins (prescribed vitamins are also not covered).
13. Anabolic steroids, unless approved through the Prior Authorization process.
14. Any of the circumstances described in the "General Plan Exclusions" section.
15. Bulk ingredients when used for compounding (e.g., bulk powders).
16. Any drugs or medications that are not Covered Medications.
17. Additional items excluded from coverage are listed starting on page 118.

Dental Benefits

The Fund has entered into an agreement with a Preferred Provider Dental Organization (PPDO). You and your Dependents may choose dental treatment provided by network providers or non-network providers. Network providers have negotiated an agreement with the PPDO to discount prices.

Eligibility for Dental Benefits

Participants and Dependents in the Base Plan are Eligible for Dental Benefits described herein. Effective January 1, 2020, retirees who elect coverage and benefits under the Base Plan under the Supplemental Retirement Plan are Eligible for Dental Benefits. Prior to January 1, 2020, retirees were not Eligible for Dental Benefits.

Participants and Dependents in the Alternative Plan, including retirees who elect the Alternative Plan coverage and benefits under the Supplemental Retirement Plan, are not Eligible for Dental Benefits described herein.

How to Opt Out of Dental Coverage

If you wish, you may elect to cease coverage for dental benefits under the Plan for yourself or your Dependents at any time by providing written notice to the Fund Office of your intention to cease dental coverage. Cessation of dental coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you.

If you previously elected to cease coverage for dental benefits under the Plan, you may reinstate coverage by providing written notice to the Fund Office. Reinstatement of dental coverage will be effective as of the first day of the month immediately following the date the Fund Office receives such written notice from you.

Covered Dental Expenses

The Plan pays a percentage of Covered Dental Expenses up to the Calendar Year maximum for Participants and Dependents over age 19 (there is no dollar maximum for Dependents under age 19) as shown in the applicable schedule in the “Schedules of Benefits” document. Covered Dental Expenses include:

- Type I Dental Services:
  - Routine oral examinations and topical fluoride applications up to twice each Calendar Year;
  - Dental prophylaxis, including cleaning, scaling, and polishing, up to twice each Calendar Year;
  - Space maintainers for replacement of deciduous prematurely lost teeth for Dependent children under age 19; and
  - Emergency palliative treatment.

- Type II Dental Services:
  - Full-mouth X-rays once in any period of 36 consecutive months;
  - Supplementary bitewing X-rays up to twice each Calendar Year;
  - Dental X-rays required in connection with the diagnosis of a specified condition requiring treatment;
  - Extractions and other oral surgery;
  - Restorative services using amalgam, synthetic porcelain, and plastic filling material;
  - General anesthetics when Medically Necessary and administered in connection with oral or dental surgery;
  - Periodontics for the treatment of gum diseases;
  - Endodontics, including pulpal therapy and root canal filling;
  - Injection of antibiotic drugs by the attending dentist;
  - Repair or cementing of crowns, inlays, onlays, bridgework, or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any 36-consecutive-month period; and
  - Onlays or crown restorations to restore diseased or 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.
- Type III Dental Services:
  - Initial installation of fixed bridgework, including inlays and crowns as abutments;
  - Initial installation of partial or full removable dentures, including precision attachments and any adjustments during the six-month period following installation;
  - Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework or the addition of teeth to an existing partial, removable denture or to bridgework, but only if satisfactory evidence is presented that the:
    - Replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;
    - Existing denture or bridgework cannot be made serviceable and if at least five years have elapsed before its replacement and absent of unusual circumstances as determined by the Trustees in their sole discretion; or
    - Existing denture is an immediate temporary denture that cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.
  - Charges for bridgework where only bridgework can adequately replace dentures;
  - Charges for implantology; and
  - Expenses incurred for an alternate method of treating a dental condition will be paid at the Allowable Charge for the service that is:
    - Most commonly used nationwide in the treatment of that condition; and

    - › Recognized by the dental profession to be appropriate in accordance with accepted nationwide standards of dental practice.
- Type IV Dental Services: Orthodontia, 50% of the initial payment up to the lifetime maximum shown in the applicable schedule in the "Schedules of Benefits" document.
    - **Example 1:** You make a $5,400 initial payment for orthodontia services. The Fund would pay the maximum benefit of $2,000. Half (50%) of $5,400 is $2,700, which exceeds the $2,000 maximum benefit.
    - **Example 2:** You make an initial payment of $3,000 for orthodontia services, but the total cost is $5,400. The Fund would pay $1,500 (50% of $3,000). The remaining $2,400 would be divided by the number of months in the treatment plan. If the treatment plan is 24 months, you would be charged $100 per visit. The Fund would pay $50 for each visit until the remaining $500 of your $2,000 maximum orthodontia benefit is exhausted. You must be Eligible at the time of your initial visit to the orthodontist and in the following months in which services are rendered to receive payment for those services.

Benefits are limited to the amount specified above. You are responsible for paying the difference in cost between the alternate method selected and the amount reimbursed.

Dental Exclusions and Limitations

Dental Benefits are not paid for:

- Any charge made for treatment by anyone other than a dentist, except that scaling or cleaning of teeth and topical fluoride application may be performed by a licensed dental hygienist if rendered under the supervision and guidance of a dentist.
- Any charge for veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth.
- Any charge for services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures, bleaching, or for inlays without onlays.
- Any charge for the replacement of a lost, missing, or stolen prosthetic device.
- Any charge for any duplicate prosthetic device or other duplicate appliance.
- Any charge for sealants, except Type II dental service sealants for Dependent children under the age of 14, and for oral hygiene and dietary instruction.
- Any charge for a plaque control program.
- Any charge for services or supplies received because of dental disease, defect, or Injury due to war, declared or undeclared, or any act of war or aggression.
- Any charge for dental care or services paid for, furnished by, or at the direction of any governmental agency, but only to the extent paid for or furnished.
- Any dental expenses for which benefits may be payable under any other portion of this Plan.
- Any charge for prosthetic devices, including bridges and crowns, and the fitting of such devices incurred before a Person is Eligible for Dental Benefits.
- Any charge for treatment started before the Person is Eligible for Dental Benefits. Treatment is considered to begin for:

  - Full or partial dentures, when the impression is taken for the appliance;
  - Fixed bridgework, crowns, and other gold restorations, when the tooth is first prepared; or
  - Root canal treatment, when the tooth is opened.
- Diagnostic cast when done as part of routine checkup.
- Any charge for services, treatment, or procedures that are considered Experimental in nature.
- Any charge for the treatment of temporomandibular joint dysfunction (TMJ). Plan coverage provisions for TMJ charges are indicated under the applicable "Comprehensive Major Medical Benefit" section of this SPD.
- Any charge for oral appliances and home sleep studies that are prescribed by a dentist to treat mild to moderate sleep apnea. Note that treatments for sleep apnea are covered under the applicable "Comprehensive Major Medical Benefit" when Medically Necessary and prescribed by a medical Doctor.
- Any of the circumstances described in the Plan's general exclusions and limitations (see page 118).
- Any services, expenses, or charges that are not a Covered Dental Expense.

Charges exceeding the Plan's Dental Benefits may not be used to meet the Deductible under other provisions of the Plan.

Extension of Dental Benefits During Periods of Disability

There is limited extension of coverage if you or a Dependent is Totally Disabled on the date your Eligibility would otherwise end.

Benefits are extended under the Dental Benefit for a period of three months for dental expenses incurred for:

- Bridgework, crowns, or gold restorations, provided the tooth was prepared while you were Eligible;
- Full or partial dentures, provided the impression for the appliance was taken while you were Eligible;
- Endodontic treatment, provided the tooth was opened for root canal therapy while you were Eligible;
- Injury to natural teeth if you were Eligible at the time of the Injury.

This extension of Dental Benefits will end on the earliest of the 91st day following the date your Dental Benefits terminate under the regular Plan, the date you become covered under another group welfare plan, or the date you become Eligible for coverage under another group welfare plan.

Vision Benefits

The Plan pays 100% of Covered Vision Expenses up to the Calendar Year maximum for Participants and Dependents over age 19 (there is no dollar maximum for Dependents under age 19) as shown in the applicable schedule in the "Schedules of Benefits" document. You may go to any qualified ophthalmologist, optometrist, or optician to receive covered vision services and/or materials related to vision correction. You may need to pay your vision provider at the time you receive the services or materials and then submit an itemized bill, prescription or other clinical information, and proof of payment to the Fund Office for reimbursement. Certain providers may file a claim with the Fund Office directly. Since the Plan only pays up to a Calendar Year maximum, this amount may not be sufficient to pay for the entire cost of the eye examination and/or materials, so be sure to use your benefits wisely.

Eligibility for Vision Benefits

Participants and Dependents in the Base Plan are Eligible for Vision Benefits described in this section. Effective January 1, 2020, retirees who elect coverage and benefits under the Base Plan under the Supplemental Retirement Plan are Eligible for Vision Benefits. Prior to January 1, 2020, retirees were not Eligible for Vision Benefits.

Participants and Dependents in the Alternative Plan, including retirees who elect the Alternative Plan coverage and benefits under the Supplemental Retirement Plan, are not Eligible for Vision Benefits described in this section.

How to Opt Out of Vision Coverage

If you wish, you may elect to cease coverage for vision benefits under the Plan for yourself or your Dependents at any time by providing written notice to the Fund Office of your intention to cease vision coverage. Cessation of vision coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you.

If you previously elected to cease coverage for vision benefits under the Plan, you may reinstate coverage by providing written notice to the Fund Office. Reinstatement of vision coverage will be effective as of the first day of the month immediately following the date the Fund Office receives such written notice from you.

Covered Vision Expenses

You are Eligible to receive covered vision care services up to the Calendar Year (January 1 – December 31) maximum, as shown in the applicable schedule in the "Schedules of Benefits" document. Eligible Persons may use any provider they would like. Covered Vision Expenses include:

- Complete eye examination, including dilation of pupil and/or relaxing of focusing muscles by drops and refraction for vision by a legally qualified ophthalmologist or optometrist; and

- New or replacement frames and lenses and contact lenses prescribed by an ophthalmologist, optometrist, or optician, including fitting. This also includes charges associated with the provision of frames, lenses, and/or contact lenses, such as tax and shipping and handling fees.

All expenses are considered to be incurred on the date on which the services that gave rise to the expense are rendered/performed.

Vision Exclusions

Vision Benefits are not paid for:

- Vision care treatment incurred before the date the Person became Eligible under this Plan.
- Services or supplies that are covered in whole or in part under any other portion of this Plan.
- Special procedures, such as orthoptics, vision training, or special supplies such as non-prescription sunglasses or subnormal vision aids.
- Services or supplies not listed as Covered Vision Expenses.
- Plano lenses (non-prescription).
- Medical or surgical treatment of the eyes that requires the services of a Physician.
- Non-prescription items. (Covered Persons must provide proof of a valid prescription or vision exam in order to substantiate each claim for Vision Benefits.)
- Services and/or materials covered under any workers' compensation or governmental program.
- Eye examinations required for employment.
- Contact lenses required after cataract surgery; however, these lenses may be covered under the Plan's Comprehensive Major Medical Benefit.
- Any of the circumstances described in the Plan's general exclusions and limitations (on page 118).
- Any charges or expenses that are not Covered Vision Expenses.

Charges exceeding the Plan's Vision Benefits may not be used to meet the Deductible under other provisions of the Plan.

Wellness Power: Wellness and Disease Management Program

Under the Wellness Power program, the Fund provides wellness and disease management benefits for Eligible Participants and Dependents, including health tools and access to health care professionals who can provide health advice and assistance. All Covered Persons, including retirees over age 65 and Eligible Dependents over age 18, can participate in the programs discussed in this section. Retirees over age 65, their spouses, and all covered Dependent children are not Eligible to earn Health Reimbursement Account (HRA) rewards.

Health Risk Assessment

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

The results of the Health Risk Assessment are confidential and are available only to you. Results are not available to the Fund Office, your Employer, or your Union. Your Health Risk Assessment will not affect your Eligibility or benefit payments. You can complete the assessment online or on paper.

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

Wellness/Lifestyle Management Programs

Retirees and Eligible Dependents also have access to health improvement programs including interactive tools, resources, information, and online lessons, as well as access to health care professionals to help you achieve and maintain a healthy, balanced lifestyle. The Wellness Programs offered include weight loss, smoking cessation, exercise, stress relief, diabetes, heart health, and nutrition programs.

Biometric Screenings

A Biometric Screening is a measurement of physical characteristics such as height, weight, body mass index, blood pressure, blood cholesterol, and blood glucose that can be taken at an onsite event, a LabCorp location, or a Physician's office. Biometric Screenings can be used to benchmark and evaluate changes in health status over time.

Online Health Challenges

An Online Health Challenge is offered to encourage Participants to track activities such as daily steps, healthy eating, physical exercise, and sleep schedules.

Disease Management Programs

The disease management programs are designed to help you manage chronic conditions—asthma, chronic obstructive pulmonary disease, diabetes, low back pain, depression, gastroesophageal reflux disease, coronary artery disease/chronic heart failure, osteoporosis, chronic renal disease, arthritis, and metabolic syndrome—and reduce the risk of complications. If you have one or more of these chronic conditions, a health care professional will contact you to discuss the benefits of participating in a disease management program and help you learn about ways to modify your lifestyle for better health. They will also monitor your progress and work with you and your Physician to make sure your treatment is appropriate.

Earning Health Reimbursement Account Rewards

Participants, covered spouses, retirees under age 65 and their covered spouses are Eligible to receive rewards for participating in the wellness and disease management programs. When you or your spouse enrolls and complies with the requirements of the programs, you will receive a reward in the form of a contribution to your Health Reimbursement Account. Wellness Power program rewards are subject to change from time to time, subject to action by the Trustees. To find out the current reward levels, please contact the Welfare Trust Fund Administrative Office at 800-765-4239. The Trustees reserve the right to modify the reward structure at any time. You can use your rewards to pay for health care expenses as defined by Internal Revenue Code (IRC) Section 213, including medical expenses and prescription medications that are not covered by the Fund. The Health Reimbursement Account (HRA) program is described starting on page 97 of this SPD.

Wellness Power Program Services (Effective January 1, 2020)

The program is administered by Telligen.

The free Telligen app is called “Health by Telligen” and can be found on your Apple or Android device. The Wellness Power website address is https://necaibew.totalwellbeinglife.com. You can also access the site by first going to the Fund’s website at www.neca-ibew.org.

Under the Wellness Power program, you and your spouse will be Eligible to complete a Health Assessment and Biometric Screening. After you complete your Health Assessment, you will be provided a Health Advising Call. On the Health Advising Call, you will be made aware of the Biometric Screening option, if you have not yet completed it. You will also then be Eligible for free Lifestyle Management or Disease Management Coaching, depending on your needs. You and your spouse will also be Eligible to participate in Online Health Challenges, which are offered throughout the year.

You and your spouse will each receive reward contributions to your Health Reimbursement Account (HRA) when you participate in and complete the following wellness and disease management programs. Please note that retirees over age 65, their spouses, and all covered Dependent children are not Eligible for reward contributions but are Eligible to participate in the Wellness Power programs.

- **Download the free Telligen app** and register your wellness account, or register your wellness account on the Wellness Power website, and receive a $25 HRA contribution. Details on downloading the app can be found on the Wellness Power website.

- **Complete a Health Assessment *and* Health Advising Call** each year and receive a $75 HRA contribution. The Health Assessment can be completed through the Wellness Power website, mobile app, or by paper. You can receive a paper copy of the Health Assessment by contacting Telligen toll-free at 833-226-7276.

- **Complete a Biometric Screening** and receive a $50 HRA contribution. This can be done at an onsite event in your area, at a local LabCorp location, or at your Physician's office. Printable forms for either LabCorp or your Physician to complete are available on the Wellness Power website. *Please note that standard Fund coverage provisions, like Deductibles and Coinsurance, apply to physicals conducted with claims submitted by your Physician.*

- **Participate in and complete a Lifestyle Management or Disease Management Coaching program** and receive a $100 HRA contribution each year. The Telligen Lifestyle Management and Disease Management Coaching programs will be similar to the ones provided by MCM.

- Complete an **Online Health Challenge** and receive a $50 HRA contribution. Challenges will be offered four times per year. You can earn up to one $50 Online Health Challenge reward per year, but you can participate in all Online Health Challenges. Details on the challenges are available on the Telligen app and Wellness Power website.

You can earn HRA reward contributions of up to $300 per Participant and $600 per Participant and spouse each year (excluding retirees over age 65, their spouses, and all covered Dependent children). The Wellness Power programs are available to all Participants, but the rewards do not apply to retirees over age 65 and their spouses, or to any covered Dependent children.

For more information about the Wellness Power program or to receive a paper copy of the Health Assessment, contact Telligen toll-free at 833-226-7276 or go to www.neca-ibew.org/wellness-power. For information about the HRA awards or your benefits generally, please contact the Fund Office (217-875-0254 or 800-765-4239).

Refer to page 97 for more information about the Plan's HRA offering.

The Trustees have the sole right at any time to amend or modify these rules and rewards or terminate the wellness and disease management program entirely.

Employee Assistance Program

LifeWorks is a free Employee Assistance Program offered by the Fund. LifeWorks can help you manage personal issues at work or at home. Whether you are facing challenges at work, looking for help with parenting, health, or your personal finances, or coping with a personal or family issue, you will find fast, expert help at www.lifeworks.com (Username: Decatur; Password: fund) or by contacting one of the numbers listed below.

You can also find information about the program on our website (www.neca-ibew.org/lifeworks), or you can call LifeWorks toll-free at 888-456-1324, 888-732-9020 (en español), or 800-999-3004 (TTY).

LifeWorks consultants are available 24 hours a day, seven days a week, 365 days a year.

There is no cost to you to utilize this program for up to three counseling sessions, and it is completely confidential.

Health Reimbursement Account (HRA)

Establishment of the HRA Benefit

Effective June 1, 2007, the Fund began permitting reimbursement of Medical Care Expenses on a non-taxable basis from the Health Reimbursement Account. A Health Reimbursement Account, or HRA, is a health care reimbursement account that allows you to obtain reimbursement of Covered Medical Expenses incurred by you or your covered Dependent(s) on a tax-free basis.

The HRA is intended to be a tax-exempt employer-provided medical care reimbursement plan with the intention to qualify as a medical reimbursement plan within the meaning of Sections 105 and 106 of the Internal Revenue Code of 1986 (Code) and regulations issued thereunder, and as a health reimbursement account as defined under IRS Notice 2002-45 and applicable regulations, and will be interpreted to accomplish that objective. The HRA benefit is provided as part of the Fund. The HRA complies with applicable federal laws and regulations including COBRA, USERRA, FMLA, and HIPAA Privacy and Security.

Eligibility (Participation in the HRA Benefit)

The HRA is not a stand-alone plan and is intended to be made available only in conjunction with the Medical Benefits of the Welfare Fund for you and your Dependents. This means that Participants may not participate in the HRA without being Eligible for and enrolled in group Medical Benefits. See the “Integration and Opt-Out” section for requirements for Dependents.

Active Status. You must be a Participant in the Fund in order to be Eligible to receive benefits from the HRA benefit. Eligibility for the HRA begins when Eligibility for other Medical Benefits begins. Participation in the HRA will continue until the Participant is no longer Eligible, as outlined in this section.

Retirees. When you terminate employment and retire, you may continue to participate in the HRA, even if you have other group coverage, to spend down the balance in the HRA on qualified Medical Care Expenses. However, premiums and expenses (such as Copayments, Deductibles, or cost sharing) related to an individual plan (i.e., individual coverage through the Federal Marketplace, a State Exchange or the individual market outside of the Marketplace/Exchanges) cannot be reimbursed under the HRA.

Dependent Eligibility. Your Dependents are Eligible to have their medical expenses reimbursed from the HRA if they are Eligible and enrolled for coverage under the Fund at the time the medical expenses are incurred. Coverage for Eligible Dependents becomes available when your coverage begins, as long as they have been properly enrolled. Dependents are also Eligible to have their medical expenses reimbursed from the HRA if they are not actually enrolled in the Fund because they have other group health coverage that meets the integration requirements outlined below.

Integration and Opt-Out

In order to comply with the Affordable Care Act, its implementing regulations, and Internal Revenue Service Notice 2013-54, the following rules apply to the HRA account.

Integration: Coverage Under a Group Health Plan

Your Participation. In order for you to obtain reimbursement of HRA reimbursable expenses, the HRA must be "integrated" with a group health plan that provides minimum value coverage, and you must actually be enrolled in the group health plan that provides minimum value coverage. Medical coverage under the Fund's Base and Alternative Plans provides minimum value and meets the requirement that the HRA be integrated. In addition, coverage under another group health plan not sponsored by the Trustees of the Fund may also meet the integration requirement if such coverage provides minimum value coverage and you are enrolled in another group health plan that provides minimum value coverage. To be covered under the HRA, you must waive/opt out of medical coverage by completing the applicable paperwork supplied by the Fund Office and provide the necessary proof of enrollment in other minimum value coverage.

Dependents. In order for your Dependents to obtain reimbursement of HRA reimbursable expenses, the HRA must be integrated with a group health plan that provides minimum value coverage, and your Dependents must actually be enrolled in the group health plan that provides minimum value coverage. Medical coverage under the Fund's Base and Alternative Plans provides minimum value and meets the requirement that the HRA be integrated. In addition, coverage under another group health plan not sponsored by the Trustees of the Fund may also meet the integration requirement if such coverage provides minimum value coverage and the Dependent(s) is actually enrolled in the other group health plan that provides minimum value coverage. To be covered under the HRA, the Dependent(s) must meet the Eligibility requirements of the Fund or you must have properly waived medical coverage for your Dependents by completing the applicable paperwork supplied by the Fund Office and provide the necessary proof of enrollment in other minimum value coverage.

Freezing Unused HRA Balances and Permanent Opt-Out

Freezing Unused HRA Balances. You may elect to suspend (or "freeze") your HRA account by contacting the Fund Office before the beginning of the Plan Year to which the suspension would apply. Your suspension election will remain in effect for the entire Plan Year (or Plan Years) to which it applies, unless a reinstatement event (defined below) occurs before the end of the applicable Plan Year. You will not receive reimbursements for any Medical Care Expenses incurred during the period to which the suspension election applies.

Following an election to freeze your HRA account balance, neither you nor your spouse or Dependents may have access to the HRA after the effective date of the election to temporarily opt out of HRA coverage and, upon reinstatement of the HRA, the HRA cannot reimburse any expenses incurred from the date the HRA was frozen up to the date the HRA is reinstated.

Reinstatement Event. Participation in the HRA may be reinstated, and the balance unfrozen, upon the earliest of the following events:

- The first day of the Plan Year following the year or years of the opt-out, provided that you notify the Fund of this request;
- The date the Participant becomes Eligible for and enrolls in Medicare Parts A and B (if you have elected this as a reinstatement event); or
- Your date of death.

For enrollment in Medicare Parts A and B to be treated as a reinstatement event, you must have selected that date as a reinstatement event on your Suspension Election Form, and you must notify the Fund when you enroll in Medicare. If you do not select that date, the suspension will continue until the end of the applicable Plan Year or your death, whichever occurs first. If you fail to notify the Fund of your enrollment in Medicare, the suspension will continue until the end of the applicable Plan Year or your death, whichever occurs first.

You will not have access to the HRA balance after the effective date of the opt-out election and, upon reinstatement, cannot submit for reimbursement any claims incurred during the suspension and before the reinstatement. However, after the reinstatement event, access to the HRA balance is available for medical services incurred after the reinstatement event.

During the period in which your HRA is frozen, contributions may continue to accrue if otherwise permitted under the Plan or Collective Bargaining Agreement.

Permanent Opt-Out. You may permanently opt out of and waive future reimbursements from the HRA once per year, in a time and manner determined by the Trustees. The Fund Office will maintain forms to permanently opt out of the HRA. If you make such an election, the Fund will discontinue contributions to your HRA and you will not receive reimbursements for any Medical Care Expenses incurred after the permanent opt-out election takes effect.

Your HRA Account Balance

Your HRA balance is the total employer contributions made on your behalf for the HRA minus a 5% administrative fee on each employer contribution, plus any interest earned, minus any claims from your HRA (wellness rewards do not apply to this requirement). The amount available for payment or reimbursement of HRA-eligible expenses is the amount credited to your HRA. Contributions made on your behalf will not be credited to your HRA until after they are received by the Fund. Such contributions will be credited within 30 days after they are received. In other words, there may be a lag between the time contributions are made on your behalf and when they are available to you to use. Keep in mind that any unused amounts in your HRA account at the end of a Calendar Year are carried over into the next year and even into retirement. This allows you to save for future HRA expenses.

Source and Amount of Contributions

Contributions to the HRA consist solely of employer contributions made in accordance with a Collective Bargaining Agreement. No Employee contributions or other contributions are allowed, except for incentives earned under the Fund's Wellness Power program. Under no circumstances will the benefits of the HRA be funded with salary reduction contributions,

employer flex credit contributions, or otherwise under a cafeteria plan under Section 125 of the Internal Revenue Code.

When you work for a Participating Employer, an HRA contribution is made on your behalf and credited to your HRA for each hour that you work. In other words, the more hours you work, the more contributions that are made to your HRA. Incentives received through the Fund's Wellness Power program will also be credited to your HRA.

Upon termination of the Plan, the HRA Participant's coverage ceases. This means that there is no cash-out, reimbursements, or debits from any remaining balance in that HRA account.

Eligible Medical Care Expenses

The Fund reimburses only for "Eligible Medical Care Expenses," as described below. To be considered an "Eligible Medical Care Expense" that qualifies for reimbursement, an expense must:

- Be incurred and claimed while a Participant or Dependent is Eligible for reimbursement in accordance with all provisions of the Plan; and
- Not be reimbursable from any other health plan or insurance; and
- Be incurred by a Participant or covered Dependent for "medical care," as defined in Internal Revenue Code Sections 105 and 213(d).

An HRA reimbursable expense is incurred at the time the medical care item or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care.

Medical Care Expenses

In general, Medical Care Expenses include, but are not limited to, amounts for such services as Hospitalization, Doctors and dentists, and prescription drugs. Such expenses include amounts paid by the Participant or covered Dependent for Deductibles, Copayments, and Coinsurance, including out-of-pocket expenses incurred for services.

Medical Care Expenses also will include COBRA premiums or premiums for any qualified long-term care insurance contract as defined in Code Section 7702B(B) provided, premiums for Part B of Title XVIII of the Social Security Act (Medicare Part B premiums), premiums for group health insurance covering medical care (including premiums for group Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies).

Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's spouse or Dependents will be charged against the Participant's HRA account.

However, not all Medical Care Expenses will be considered "Eligible Medical Care Expenses" that qualify for reimbursement under the Fund. Generally, only Medical Care Expenses within the meaning of Sections 105 and 213(d) of the Internal Revenue Code are eligible.

A partial list of reimbursable expenses includes:

- Acupuncture.
- Alcoholism, including inpatient treatment at a therapeutic center for alcohol addiction, including meals and lodging provided by the center during treatment.
- Artificial limbs.
- Artificial teeth, for other than cosmetic reasons.
- Birth control pills prescribed by a Doctor.
- Breast reconstruction surgery following a mastectomy for cancer.
- Chiropractic care.
- Contact lenses needed for medical reasons, including cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner.
- Crutches (rental or purchase).
- Dental treatment, including fees paid to dentists for X-rays, fillings, braces, extractions, dentures, etc. (teeth whitening, as described later, is not covered).
- Diagnostic devices used in diagnosing and treating Illness and disease.
- Drug addiction for inpatient treatment at a therapeutic center for drug addiction, including meals and lodging at the center during treatment.
- Eye or vision correction surgery, including eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.
- Eyeglasses needed for medical reasons, including fees paid for eye examinations.
- Fertility enhancement to overcome an inability to have children, including:
  - Procedures, such as in vitro fertilization and temporary storage of eggs or sperm; and
  - Surgery, including an operation to reverse prior surgery that prevented the Person from having children.
- Health institute if the treatment is prescribed by a Physician and the Physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or Illness of the individual receiving the treatment.
- Hearing aids, including batteries.
- Home Care (see “Nursing services” below).
- Inpatient care at a Hospital or similar institution if a principal reason for being there is to receive medical care; this includes meals and lodging (see “Lodging at a Hospital or similar institution” below).
- Laboratory fees for medical care.
- Legal abortion.
- Legal medical services provided by Physicians, Surgeons, specialists, and other medical practitioners.
- Lodging at a Hospital or similar institution while away from home if:
  - The lodging is primarily for and essential to medical care;

- The medical care is provided by a Doctor in a licensed Hospital or in a medical care facility related to or the equivalent of a licensed Hospital;
- The lodging is not lavish or extravagant under the circumstances; and
- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

Expenses for lodging cannot be more than $50 for each night for the individual receiving medical care and a person traveling with that individual. Expenses are not eligible if treatment is not received from a Doctor in a licensed Hospital or in a medical care facility related to, or the equivalent of, a licensed Hospital or if the lodging is not primarily for or essential to the medical care received.

- Medical supplies, such as bandages used to cover torn skin.
- Medicines that require a prescription by a Doctor for use by an individual, including insulin.
- Mentally handicapped special home, which includes the cost of keeping a mentally handicapped Person in a special home, not the home of a relative. The stay at the mental health facility must be based on the recommendation of a psychiatrist to help the Person adjust from life in a mental Hospital to community living.
- Menstrual care product expenses (if expenses incurred on or after January 1, 2020).
- Nursing home medical care (including care in a home for the aged or similar institution), meals, and lodging if a principal reason for being there is to get medical care.
- Nursing services, including wages and other amounts paid for nursing services provided by a nurse licensed in the jurisdiction where services are provided.
- Operations or surgery, when legal and not performed for unnecessary cosmetic surgery. Cosmetic surgery is a non-Covered Expense; see page 6.
- Service provided by an optometrist.
- Organ donors (see “Transplants” below).
- Services provided by an osteopath.
- Over-the-counter medicine and drug expenses (without a prescription only if incurred on or after January 1, 2020).
- Oxygen, including equipment, to relieve breathing problems caused by a medical condition.
- Prosthesis.
- Psychiatric care, including the cost of supporting a mentally ill Dependent at a specially equipped medical center where the Dependent receives medical care.
- Psychoanalysis (however, psychoanalysis that is part of required training to be a psychoanalyst is not eligible).
- Services provided by a psychologist.
- Sterilization (a legally performed operation to make a Person unable to have children).
- Smoking cessation programs (including medications that do not require a prescription, such as nicotine gum or patches, only if incurred on or after January 1, 2020).

- Telephone special equipment that lets a hearing-impaired Person communicate over a regular telephone, including teletypewriter (TTY) and telecommunications device for the deaf (TDD), as well as equipment repair costs.
- Television equipment that displays the audio part of television programs, such as subtitles, for hearing-impaired Persons (this is an adapter that attaches to a regular set or some of the costs associated with a specially equipped television that exceeds the cost of the same model regular television set).
- Therapy received as medical treatment.
- Transplants as a donor or possible donor of an organ.
- Transportation expenses to receive medical care.
- Vasectomy.
- Wheelchair used mainly for the relief of Sickness or Disability, and not just to provide transportation to and from work; this includes the cost of operating and maintaining the wheelchair.
- Wig purchased upon the advice of a Physician for the mental health of a patient who has lost all hair from disease.
- X-rays for medical reasons.

Excludable Expenses

The HRA does not pay for any item that does not constitute "medical care" as defined under Internal Revenue Code Sections 105 and 213(d). The following expenses are examples of the kinds of expenses that are not reimbursable, as they generally do not meet the definition of "medical care" under Code Sections 105 and 213(d). This is not intended to be a complete list of all services that are not payable under the HRA, but an example of more common services that are not payable from the HRA.

- Long-term care services.
- Cosmetic or Reconstructive Surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic or Reconstructive Surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat Sickness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified Physician due to a Participant's or Dependent's inability to perform physical housework).
- Massage therapy, except that which is provided with a letter of Medical Necessity.

- Home improvements or equipment unless the improvements or equipment qualify as capital expenses under applicable guidance.
- Custodial Care.
- Costs for sending an eligible Dependent to a special school for disciplinary problems.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition, such as obesity.
- Social activities, such as dance lessons (even though recommended by a Physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements unless otherwise permissible because the vitamins or supplements are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a Physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Automobile improvements.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a Physician.
- Any item that does not constitute “medical care” as defined under Code Section 213.
- Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan.
- Medical care expenses that you or your Dependents are reimbursed or reimbursable for through another health plan, insurance, or other accident or health plan. If only a portion has been reimbursed elsewhere (e.g., because another health plan imposed Copayment or Deductible limitations), the funds in the HRA can be used to reimburse the remaining portion if it otherwise meets the requirements.
- Premiums for individual market coverage or insurance plans purchased from a state or federal Health Insurance Marketplace.
- Individual Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies are also not reimbursable.

Nondiscrimination

Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code Section 105(h), as may be determined by the Plan Administrator in its sole discretion.

Automatic Reimbursement of Retiree Premiums

Retirees who participate in the NECA-IBEW Retiree Plan and who have HRA funds available can complete and return the agreement form that is included in their retiree packet in order to be automatically reimbursed for your retiree premium. There is no need to fill out a claim form.

Access Your HRA Online and On the Go

If you have an HRA account, visit the Fund's HRA Participant Portal where you can view your current HRA balance and claims information. You can use this portal to file claims online and upload your receipts. You can also use the free app on your iOS and Android devices. Find it by searching for "NECA IBEW Benefits."

You can file HRA claims using the mobile app and use your phone's camera to take a photo of the receipt to submit with your claim. If you have questions about your HRA, the Participant Portal, or the Benny Card, go to www.neca-ibew.org, where you can find step-by-step guides, FAQs, and other helpful information. Remember to use your unique ID number as your user name for the HRA Participant Portal. Your unique ID number is the nine-digit number that begins with the numbers "801" (after the "NEC") on your BCBS card.

Filing a Claim for Reimbursement

If the Plan Administrator is unable to make payment to any Participant or other Person to whom a payment is due under the HRA because it cannot ascertain the identity or whereabouts of such Participant or other Person after reasonable efforts have been made to identify or locate such Person, then such payment and all subsequent payments otherwise due to such Participant or other Person will be forfeited following within the 12-month period following the close of the Period of Coverage in which the Medical Care Expense was incurred.

The following procedures must be followed in order to receive a reimbursement from an HRA account.

Claims Filing and Substantiation

Filing/Reimbursement Through Debit Card. Benny Card will make available to each Participant an HRA debit card that can be used to access the funds in your HRA account. Participants can use the card at the point-of-sale for HRA reimbursable expenses when incurred at a qualified provider (such as an office visit Copayment or a prescription at a pharmacy) for Medical Care Expenses. Benny Card may request verification that a particular purchase is actually for a medical expense as required under the Internal Revenue Code.

Claim and Reimbursement Procedures

You must submit a claim for reimbursement of any expense. Claims can be submitted via the HRA Portal (https://necaibew.lh1ondemand.com), via the NECA-IBEW HRA mobile app powered by Wex Health Inc. (for both iPhone and Android devices), or by submitting a paper claim. When you use your Benny Card to pay for an expense, a claim will automatically be submitted for you within a few days; it is not necessary to submit a claim manually through the portal, mobile app, or with a paper claim form. However, for Benny Card payments, you may be required to submit a substantiating document to the Fund, such as an Explanation of Benefits (EOB), statement of account, or other receipt, which shows the amount and type of expense.

If you, your spouse, and/or your Dependents are Eligible for other coverage (including a health care Flexible Spending Account (FSA), if applicable), you may be required to provide proof, such as an Explanation of Benefits (EOB) or statement of account, to this Plan which shows that the expense has not been submitted to such other coverage for payment. Only eligible expenses that have not been reimbursed will be considered for reimbursement or substantiation.

The amount paid or reimbursed for any eligible expense cannot exceed your HRA balance at the time the claim or reimbursement is requested. If an eligible expense exceeds the HRA balance, you will be reimbursed up to the amount available, and you will continue to be reimbursed as additional funds become available. For example, if you submit a claim for $500, but only have a $250 balance in your account, you will be reimbursed $250 to start, and will receive additional reimbursements as additional contributions are credited to your account.

To receive reimbursement for an eligible expense, you must submit a claim within 12 months of the date the expense is incurred and in accordance with the Plan's claims procedures.

Within 30 days after receipt by the Plan, the Fund will approve and reimburse the claim, or will notify you that the claim has been denied.

If you fail to timely submit a claim for reimbursement, your claim may be denied. In addition, any HRA payments that are unclaimed (e.g., uncashed checks) by the end of the 12-month period following the Calendar Year in which the claim was incurred will remain the property of the Fund, but will be credited back to your HRA balance.

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

- The eligible expense has not been otherwise reimbursed, nor will it otherwise be reimbursed, through any other source (including a health care Flexible Spending Account (FSA), if applicable);
- For premiums paid for other coverage, the eligible expense has not been paid or is not eligible for payment on a pre-tax basis; and
- The eligible expense has not been taken, nor do you intend to take it, as a tax deduction.
- The following documentation, as applicable, may be required to verify your claim as an eligible HRA expense:
  - An itemized bill from the service provider that includes the name of the Person incurring the charges, date of service, description of services, name of provider, and amount of charge.

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

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

Claim Submission

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

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

Claim Denial

The denial of any HRA claim will be subject to the Fund's claims and appeals procedures applicable to post-service claims as explained on page 124.

Debit Cards

If the amount charged to the debit card exceeds the amount substantiated, the Plan or its designee will take the following steps:

- The Fund will notify you and/or your spouse or Dependent if a claim is not properly substantiated.
- You and/or your spouse must provide all required documentation to substantiate the transaction within the time periods required by the Fund.
- Until the amount of the improper payment is recovered or additional documentation is received, the card will be deactivated.
- The Participant will be required to repay the improper payment or provide additional documentation.
- If any portion of the improper payment remains outstanding, the Plan will impose a claims substitution or offset approach to resolve improper payments, such as a reimbursement for a later substantiated expense claim is reduced by the amount of the improper payment.
- If, after applying all of the above procedures, the Participant remains indebted to the Plan for improper payments, the Plan will, consistent with its business practices, treat the unpaid amount as it would have any other business indebtedness.

Termination Due to Inactivity

- Your HRA account balance rolls over into the following year, even after retirement. This allows you to save for future expenses. Once you are no longer Eligible for Plan coverage, your HRA account balance can be carried over for up to three years after Plan coverage ends (for reasons other than retirement). You can continue to use your HRA during the three-year period.
- Upon termination of covered employment, no contributions will be made to your HRA. Your HRA account balance will be carried forward until no balance remains or until three years (36 consecutive months) after you are no longer covered under the Plan.

Forfeiture

Your HRA account balance will be forfeited on the first day of the month following 36 consecutive months of inactivity, provided that on such date, the HRA account is $500 or less.

Death

Upon your death, your surviving spouse and other Dependents can still obtain reimbursements for Eligible Medical Expenses if your surviving spouse and other Dependents are enrolled in group health plan coverage. Your surviving spouse and other Dependents will be required to provide proof of enrollment in group health plan coverage.

Your surviving spouse will continue to be entitled to reimbursements for Eligible Medical Expenses until the earliest of:

- The date the HRA account balance reaches zero;
- The date the HRA terminates; or
- The end of the third year from the date hours were worked.

Your other Dependents may continue participation in the HRA until the earliest of:

- The date they no longer meet the definition of Dependent;
- The date the HRA account balance reaches a zero balance;
- The date of termination of the HRA.

All HRA account balances will be forfeited on the first day of the month following 36 consecutive months of inactivity, provided that on such date, the HRA account is $500 or less.

Termination of Eligibility

Participation in the HRA will terminate on the earlier of the following dates to occur, subject to the right (if any) to continue coverage under COBRA:

- The date the Participant no longer meets the Welfare Fund Eligibility requirements.
- The date on which the HRA is terminated in accordance with the termination provisions of the Plan.

When Eligibility under the HRA terminates, no further contributions will be credited to an individual's HRA account. However, reimbursements after termination will be provided as described under the "Reimbursements After Termination of Eligibility" section below.

Reimbursements After Termination of Eligibility

When participation under the HRA terminates, a former Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates, unless there is an account balance, in which case claims can be reimbursed from the HRA after the date of termination if the former Participant is enrolled in another group health plan.

A former Participant will not be entitled to continue coverage under COBRA Continuation Coverage unless such termination of coverage constitutes a COBRA qualifying event.

For Eligible retirees, as defined by the Plan's Eligibility rules, contributions to the HRA will stop, but the HRA account will continue to be available for as long as the retiree maintains Eligibility as a retiree or is covered under a group health plan.

Tax Consequences

The Fund does not guarantee that amounts reimbursed from the HRA will be excludable from gross income for income tax purposes. A Participant must determine whether HRA payments are excludable, and notify the Fund Office if a payment is not excludable. If a Participant receives reimbursement from the HRA on a tax-free basis and the payment does not qualify for tax-free treatment under the Internal Revenue Code, the Participant will be required to reimburse the Fund for any liability it incurs for failure to withhold taxes.

Amendment/Termination of HRA Benefit

The Board of Trustees reserves the right to amend or terminate the HRA at any time and for any reason including and not limited to zeroing out any and all account balances. The Trustees reserve the right not to make an HRA contribution in any given month or year. A Participant does not have a vested right to any HRA account or the contributions credited to it, and balances may be forfeited at any time.

Effect of Mistake

In the event of a mistake as to the Eligibility or participation of a Participant, or the allocations made to the HRA account of any Employee, or the amount of benefits paid or to be paid to an Employee or other Person, the Plan Administrator or its designee will, to the extent that it deems administratively possible and otherwise permissible under Code Section 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Employee or other Person the credits to the HRA account or distributions to which he or she is properly entitled under the HRA.

Code and ERISA Compliance

It is intended that the HRA meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. The HRA will be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of the HRA and the Code and/or ERISA, the provisions of the Code and ERISA will be deemed controlling, and any conflicting part, clause, or provision of the HRA benefit will be deemed superseded to the extent of the conflict.

Non-Assignability of Rights

The right of any HRA Participant to receive any reimbursement from the HRA will not be alienable by the Participant by assignment or any other method and will not be subject to claims by the HRA Participant’s creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law. The

Plan will not accept any assignment of benefits, and all benefits will be payable to the Participant (except to the extent that benefits are payable in accordance with the terms of the Debit Card).

Other Plan Features

Coordination of Benefits

If you or your Dependents are covered by another health (medical, prescription drug, dental, and/or vision) plan ("Other Plan"), then, the combined benefits paid to you may not exceed 100% of the charges. If you or a Dependent is covered by another plan, you must submit your claim to both plans. You will receive payment from our Plan (if appropriate) showing how your claim was calculated.

As used in this section, "Other Plan" means any plan providing benefits or services for or by reason of medical, prescription drug, dental, or vision care or treatment for which benefits or services are provided by:

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

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

"Allowable Expense" means any necessary Allowable Charges incurred by an Eligible Person during a Plan Year and while Eligible under this Plan for medical, prescription drug, dental, and/or vision care or treatment, part or all of which would be covered under any Other Plan.

When any Other Plan provides services rather than cash payment, the reasonable cash value of each service will be an Allowable Expense.

The lesser of the amounts allowed by a health care provider to either this Plan or the Other Plan will be considered as the amount such provider accepts as payment in full for the service or supply. If such amount the provider allows to the Other Plan differs from the Allowable Charge reported to this Plan, Allowable Expenses for the service or supply will not exceed the lesser of allowed amounts.

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. The following four rules override any Other Plan rules:

- If the Other Plan does not have a coordination of benefits provision, that plan will be the primary plan and will pay benefits first.
- If your spouse is offered any comprehensive major medical coverage through his or her employer, your spouse must accept the coverage. This applies if your spouse works full-time or part-time. If your spouse does not accept such other coverage, he or she will not be covered under this Plan.

- No coverage of any kind will be provided under this Plan to Dependents who have medical coverage under an employer's plan that provides lower maximum benefits because the Employee is entitled to Dependent coverage under another plan, except that this Plan will coordinate coverage for adult Dependent children who have other coverage through an employer group health plan.
- If an Eligible Dependent has primary coverage under a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), Preferred Provider Organization (PPO), or any other managed care program and voluntarily elects not to use the facilities or services of the HMO, EPO, or PPO, no benefits will be paid from this Plan. This rule also applies to Dependent children whose coverage would be primary under the HMO, EPO, or PPO.

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

- **Non-Dependent/Dependent.** The plan that covers a Person as an Employee, retiree, member, or subscriber (other than as a Dependent) is primary and pays benefits first. (Except if the Person is also a Medicare beneficiary and Medicare is secondary, then the order of benefits is reversed so that the plan covering the Person as a Dependent of an active Employee pays first and the plan covering the Person other than as a Dependent [that is, as a retired Employee] pays second.)
- *Dependent child covered under more than one plan when the parents are married, not separated (whether or not they have ever been married), or a court decree awards joint custody (without specifying that responsibility for the child's health care coverage):*
  - The plan that covers the parent whose birthday falls earlier in the Calendar Year is primary and pays first.
  - If both parents have the same birthday, the plan that has covered one of the parents for a longer period is primary and pays first and the plan that has covered the other parent for the shorter period pays second.
  - The word "birthday" refers only to the month and day in a Calendar Year; not the year in which the Person was born.
  - If a court decree specifies that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan is primary and pays first. If the parent with financial responsibility has no coverage for the child, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility is primary and pays first. However, this does not apply during any Plan Year during which any benefits were actually paid or provided before the Plan had actual knowledge of the specific terms of that court decree.
- Dependent child covered under more than one plan when the parents are not married, are separated (whether or not they ever were married), or are divorced and there is no court decree specifying responsibility for the child's health care coverage:
  - The plan of the custodial parent is primary and pays first;
  - The plan of the custodial parent's spouse (if any) pays second;
  - The plan of the non-custodial parent pays third; and

- The plan of the non-custodial parent's spouse (if any) pays last.

- Dependent child covered under more than one plan when the parents are not married, are separated (whether or not they ever were married) or divorced and there is a court decree specifying responsibility for the child's health care coverage:
  - The plan of the specified parent is primary and pays first;
  - The plan of the custodial parent pays second; and
  - The plan of the custodial parent's spouse pays last.

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

- **Active/Laid-Off or Retired Employee.** The plan that covers a Person either as an active Employee (who is neither laid-off nor retired) or as that active Employee's Dependent is primary and pays first. If the Other Plan does not have this rule regarding active/laid-off or retired Employee, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. If a Person is covered as a laid-off or retired Employee under one plan and as a Dependent of an active Employee under another plan, the order of benefits is determined by the Dependent/non-Dependent rule rather than by this rule. For purposes of this rule, a person continuing coverage through use of the Hour Bank is considered a laid-off Participant, member, or Employee.

- **Continuation Coverage.** If a Person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the Person as an Employee, retiree, member, or subscriber (or as that Person's Dependent) is primary and pays first. If the Other Plan does not have this continuation coverage rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. If a Person is covered other than as a Dependent (that is, as an Employee, former Employee, retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan, and as a Dependent of an active Employee under another plan, the order of benefits is determined by the Dependent/non-Dependent rule rather than by this rule.

- **Length of Coverage.** If none of the previous rules determines the order of benefits, the plan that covered the Person for the longer period is primary and pays first; and the plan that covered the Person for the shorter period pays second.
  - To determine how long a Person was covered by a plan, two plans are treated as one if the Person was Eligible for coverage under the second plan within 24 hours after the first plan ended.
  - The start of a new plan does not include a change:
    - In the amount or scope of a plan's benefits;
    - In the entity that pays, provides, or administers the plan; or
    - From one type of plan to another (such as from a single employer plan to a multiple employer plan).

– The length of time a Person is covered under a plan is measured from the date the Person was first covered under that plan. If that date is not readily available, the date the Person first became a member of the group will be used to determine the length of time that Person was covered under the plan presently in force.

Coordination with Medicare

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

This Plan is also the primary plan for the 30-month period prescribed by law for Eligible Employees and their Eligible Dependents who have end stage renal disease (ESRD).

Termination

The benefits payable under this Plan will not be coordinated with any Other Plan upon termination of a Person's Eligibility in accordance with the provisions of this Plan, or upon termination of the Plan.

If you have questions regarding the Plan's rules for coordinating benefits, call the Fund Office. You will be furnished with an explanation of the coordination of benefits rules. The preceding entails the Fund's coordination of benefits rules.

Reimbursement, Subrogation, and Loan Agreements

The Plan can recover the amount of benefits it pays on your (Participants and/or their Eligible Dependents) behalf for covered medical, dental, vision, prescription drug, and Weekly Income Benefits, resulting from an Injury or Sickness for which someone else (a third party) is legally responsible and required to pay under its right of reimbursement and subrogation. For instance, you receive treatment because of a car accident or when the court requires a parent to be financially responsible for providing health care benefits and this Plan pays because the parent is not fulfilling his or her responsibility. If this occurs, the Plan has special processing procedures for handling your claim, including completing subrogation and loan agreements. A third party includes but is not limited to: Employee welfare plan or arrangement; medical and Hospital Benefit Plan; no-fault or other car insurance policy; uninsured or underinsured motorist provision of medical pay provision of a vehicle insurance policy; third party or tort-feasor; or others.

Expenses related to Injuries or Sicknesses that arise out of or in the course of any occupation or employment for wage or profit are not Covered Expenses and are not subject to this subrogation and loan provision.

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

- The Participant and/or Dependent (and the Participant's and/or Dependent's attorney, if applicable) must provide the Plan with written subrogation documents or loan agreements in

which the Participant and/or Dependent agree to repay the Plan the amount of benefits the Plan pays on a claim out of any recovery of expenses you receive. The Plan will not expect repayment of more than the benefits it pays on a claim or more than the amount a Participant and/or Dependent receives in recovery. The Plan has the right, subject to written waiver by the Fund, to recover 100% of the amounts paid to an Eligible Person and/or the Eligible Person's health care providers without regard to the "Common Fund" Doctrine (or state statutes purporting to impute legal fees for the collection of monies by the attorney retained by a Participant or beneficiary to pursue legal actions against liable third parties) or the "Make Whole" Doctrine.

- If a Participant and/or Dependent receives payment from the responsible party and does not repay the Plan, the Plan has the right to withhold any future benefits to which the Participant and/or Dependent may become entitled, based on claims for treatment received and/or Weekly Income Benefits, until the proper amount has been repaid.
- The Participant and/or Dependent must sign an agreement not to assign any other Person the right to recover the amount of the expense.
- If a claim is for a minor child, the child's parent or guardian must sign the required documents on behalf of the child, including, but not limited to, the Subrogation Agreement – "Deadbeat" Responsible Parent, if applicable.
- If the responsible third party does not voluntarily pay for expenses and the Participant and/or Dependent does not file suit against the party to recover expenses, the Participant and/or Dependent must provide the Plan with a written agreement giving the Plan the right to file suit in the Participant's and/or Dependent's name to recover expenses the Plan paid on the claim. In the event the Plan files suit and makes a recovery, the Plan's expenses, costs, and attorneys' fees will be paid out of the recovery settlement. In the event the Participant and/or Dependent files suit and makes a recovery, the Plan will not be liable for any expenses incurred or attorneys' fees arising out of the litigation or recovery unless written authority from the Plan is first obtained.
- If the Participant and/or Dependent provides proof that is acceptable to the Trustees that the Participant and/or Dependent has not received any recovery from a third party and that there is no possibility of any recovery, the Plan will pay Covered Expenses, but only after the subrogation documents or loan agreements are signed according to Plan procedures.
- If the Participant and/or Dependent receives any recovery, by way of judgment, settlement, or for any other reason, from any other Person or business entity, the Participant and/or Dependent agrees to hold such recovery in a constructive trust for the Plan and to reimburse the Plan in full, in first priority, for any claims for treatment received and/or Weekly Income Benefits paid by the Plan (i.e., the Plan will be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the Participant and/or Dependent).
- The Plan's right to full recovery, either by way of subrogation or right of reimbursement, may be from funds the Participant, Dependent, and/or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, the underinsured motorist's insurance, any medical payments, and any no-fault or school insurance coverage paid or payable.

- The Plan's right to recovery survives the death of the Participant and/or Dependent, and will automatically bind the decedent's successors, assignees, executor, or estate.

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

Recovery of Overpayments and Erroneous Payments

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

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

Provider Self-Audit Program

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

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

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides medical and surgical benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). These benefits are subject to the Plan's Deductible and Coinsurance rules.

General Limitations and Exclusions

The following list explains important limitations on benefit payments from the Plan. This list is in addition to any other limitations or exclusions listed throughout this document.

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

12. Any loss, expense, or charge resulting from a claimant's participation in a riot or during the commission of an assault or a felony, except Injuries or Sicknesses that are the result of acts of domestic violence.

13. Any loss, expense, or charge that results from an act of declared or undeclared war or armed aggression.

14. Any loss, expense, or charge incurred while an Eligible Person is on active duty or in training in the armed forces, National Guard, or reserves of any state of any country.

15. Any supply or equipment for personal hygiene, comfort, or convenience, except as specifically provided otherwise.

16. Special home construction to accommodate a medical condition.

17. Ambulance service, except as specifically provided otherwise.

18. Any service or supply received from a Hospital that does not meet the Plan's definition of Hospital.

19. Any charge incurred for services or treatment rendered by a member of the Eligible Person's immediate family.

20. Any charge incurred for treatment of a Behavioral Health Disorder while confined in an institution operated by any government or government agency.

21. Any charge incurred for education, training, or room and board at an institution that is primarily an institution of learning or training.

22. Any charge incurred for special education, regardless of the type of education, purpose of education, recommendation of the attending Physician, or the qualifications of the individual rendering the special education, except for approved educational programs for treating diabetic and cardiac patients.

23. Any expense or charge incurred by an Eligible Person confined in an institution that is primarily a place of rest, a place for the aged, or a nursing home.

24. Any expense or charge incurred for treatment or consultation with a social worker, registered nurse, or certified addictions counselor, unless the professional has a master's degree in social work and the charge for such services is recommended by and/or under the supervision of a medical Physician or psychiatrist.

25. Any of the following charges for the treatment of gender dysphoria:

    a. Treatment outside the United States;

    b. Transportation, meals, and lodging;

    c. Reversal of genital surgery; and

    d. Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm, and host uterus, except to the extent covered under the Plan.

26. Any of the following in conjunction with Virtual Care that is covered by the Plan are considered non-covered and non-reimbursable services:
    a. Non-secure email and facsimile transmissions;
    b. Medical evaluations that occur within seven days after a face-to-face evaluation and management service for the same condition or same episode of care performed by the same practitioner;
    c. Follow-up phone calls;
    d. Communications to provide test results;
    e. Triage to assess the appropriate place of services and/or appropriate provider type for the member to be seen; and
    f. Requests for medication refills.
27. Additional items excluded from coverage may be listed in the specific benefit sections of this SPD.

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

Claims and Appeals Procedures

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

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

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

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

All requested information should be submitted with claims. The Employee's full name, address, and BlueCross BlueShield unique ID number (or your Social Security number if you do not have a unique ID number) should be included on all claims. Claims submitted more than one year after the date incurred will be denied. In addition, if a claim is filed within 12 months, but additional information is requested and not received within that 12-month period, the claim may be denied. When filing a claim, please wait at least four weeks from the date you had the service performed before you contact the Fund Office. You may also check your claims through the Fund's website.

Data Card

All Participants are required to complete an enrollment form, known as a Data Card, annually or when any information, such as address or status of a Dependent, has changed. If you do not complete and return the card when requested, claims will not be paid until the card is returned. In addition, you and your Dependents are required to complete and return an accident form for each accident before benefits will be paid relating to that accident.

Death Benefit Claims

The Death Benefit is paid to your designated beneficiary or beneficiaries promptly upon submission of the appropriate application form provided by the Fund Office and upon receipt of a certified copy of the death certificate. Be sure to update your beneficiary information as you have changes in your life.

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

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

Accidental Death and Dismemberment Benefit Claims

The Accidental Death and Dismemberment Benefit is paid to you in the event of Disability or to your designated beneficiary or beneficiaries in the event of your death. Benefits are paid promptly upon submission of the appropriate application form provided by the Fund Office and upon receipt of a Physician statement certifying your Disability or a certified copy of your death certificate.

The Plan will make a decision on an Accidental Death and Dismemberment Benefit claim and notify you or your beneficiary of the decision within 90 days of receiving the claim. If the Plan needs additional information to make a decision, you or your beneficiary will be notified as to what information must be submitted. You or your beneficiary will have up to 45 days to submit the additional information. Once the Plan receives the information, you or your beneficiary will be notified of the Plan's decision on the claim within the 90-day period.

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

Weekly Income Benefit Claims

Weekly Income Benefits are paid to you promptly upon submission of the appropriate application form provided by the Fund Office and upon receipt of an Attending Physician Statement. Claims should be submitted to the Fund Office as soon as possible after you become Disabled. You must include an Attending Physician Statement. Proof of Eligibility or continued Disability may be required periodically for continuation of this benefit. If you are performing light-duty work, you are not Eligible for Weekly Income Benefits.

The Plan will make a decision on a Weekly Income Benefit claim and notify you of the decision within 45 days of receiving the claim. If the Plan requires an extension of time, due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the original 45-day period. A decision will be made within 30 days of the time the Plan notifies you of the delay. If a determination is not made within the first 75 days, the Plan will notify you within that time if an additional 30 days is needed to make a decision on your claim. A decision will be made within the second 30-day extension of the decision period.

If the Plan needs additional information to make a decision, you will be notified as to what information must be submitted. You will have up to 45 days to submit the additional information. Once the Plan receives the information, you will be notified of the Plan's decision on the claim within 30 days of the Plan's receipt of the information.

Medical Benefit Claims

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

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

Pre-Service Claims Under the Pre-Admission Review Process

You are required to obtain Pre-certification for transplant surgery, bariatric surgery, and surgical services and/or hormone therapy related to gender dysphoria. When Pre-certification is required or when you request a pre-determination of Coverage, the claim is considered a pre-service claim. The Plan will make a decision on your pre-service claim and notify you of the decision within a reasonable period appropriate to the medical circumstances, but no later than 15 days after receiving your pre-service claim. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the original 15-day period. A decision will be made within 15 days of the time the Plan notifies you of the delay.

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

To start the Pre-certification process for transplant surgery, bariatric surgery, or surgical services and/or hormone therapy related to gender dysphoria, or the pre-determination process for any other services, you must call the Fund Office at 217-875-2947 or 217-875-3017 before admission. You are encouraged to utilize a Centers of Excellence (COE) facility for transplant surgery. In addition to saving you money, COE facility Doctors specialize in transplant surgeries,

and surgeries performed at a COE facility often have a higher success rate than those performed at a non-COE facility.

Urgent Care Claims

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

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

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

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

Post-Service Claims

Medical claims you submit after you have received the services are considered post-service claims. The Plan will make a decision on your post-service claim and notify you of the decision within 30 days of receiving a post-service claim. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the original 30-day period. A decision will be made within 15 days of the time the Plan notifies you of the delay.

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

Prescription Drug Benefit Claims

When you go to a participating pharmacy, Prescription Drug Benefits are obtained by showing the pharmacist your prescription drug ID card and paying the applicable Copayment. You must meet your prescription drug Calendar Year Deductible before the Plan begins to pay Prescription Drug Benefits. If you go to a pharmacy that does not participate in the pharmacy network, you must file a claim. Claims for Prescription Drug Benefits obtained at a non-participating pharmacy should be submitted to the Welfare Trust Fund Administrative Office and will be reimbursed at 50%, provided the prescription is a Covered Expense under the Plan.

Information regarding mail-order claims is available from CVS Caremark at the telephone number stated on your CVS Caremark prescription drug card or through its website, www.caremark.com. Please contact the Fund Office if you need assistance.

Dental Benefit Claims

Claims for Dental Benefits should be filed by your Provider directly to the Fund Office.

Vision Benefit Claims

Claims for Vision Benefits should be filed by you or your Provider directly to the Fund Office.

Health Reimbursement Account (HRA) Claims

You must submit a claim for reimbursement of any eligible expenses, as described starting on page 100. A request for reimbursement of an eligible expense is considered a claim. Claim decisions are subject to the Plan's claims procedures for post-service claims listed in this section.

If Your Claim Is Denied

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

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

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

If Your Weekly Income Benefit Claim Is Denied

In the case of a denial of a claim for a Weekly Income Benefit, the following rules will apply, including the following requirements for the written statement provided to a claimant.

- The views presented by the claimant to the Plan of the health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- A Disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration:
  - If the adverse benefit determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
  - Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and
  - A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Effective January 1, 2018, in the case of an adverse benefit determination with respect to a claim for Weekly Income Benefits, the notification will be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor Regulation Section 2560.503-1(o).

Appealing the Denial of Your Claim

If your claim is denied, you are entitled to a full and fair review of your claim, known as an appeal. You or your authorized representative must submit your written appeal within 180 days of the denial of your claim (60 days for a claim for Death and/or Accidental Death and Dismemberment Benefits). If your claim involves urgent care, you may make your request for review orally.

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

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

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit or your Eligibility to participate in this Plan or a determination that a benefit is not a covered benefit;

- A benefit reduction resulting from the application of any Pre-certification or Utilization Review decision, source-of-Injury exclusion, network exclusion, other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate;
- The Plan's payment of less than the total amount of expenses submitted with regard to a claim, even where the Plan is paying the portion of the claim that is covered under the terms of the Plan; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

Generally, a decision on your appeal will be made as soon as possible and no later than:

- 30 days of receiving your written appeal for pre-service health care claims;
- 72 hours for urgent care health care claims; or
- As provided under the Quarterly Meeting Rule: Death, accidental death and dismemberment, and post-service health care claims will be reviewed at the next regularly scheduled Claim Appeal Committee meeting. Meetings are held quarterly. If the Trustees receive the request for review of such claim within 30 days of the next regularly scheduled Claim Appeal Committee meeting, the request for review may be considered at the second regularly scheduled Claim Appeal Committee meeting. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third regularly scheduled board meeting. You (or your beneficiary) will be advised in writing in advance if this extension will be necessary. Once a decision on review of the claim is reached, you (or your beneficiary) will be notified of the decision as soon as possible, but no later than five days after the date of the meeting at which the decision was reached.

The written notice of the decision on review will include:

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

The Trustees have broad discretionary authority to determine all benefit claim appeals and to interpret the Plan. The Trustees' decision on appeal will be given judicial deference in any later court action or administrative proceeding. You must follow and exhaust the Plan's claims and appeals procedures before you are permitted to bring any court action against the Plan.

You may appear before the Claim Appeal Committee, or may designate someone else to represent you at such a hearing. If you designate someone as your representative at the meeting, the Fund will require a written authorization. If you decide to make a personal appearance or have someone do so on your behalf, it must be done at your own expense. The Trustees reserve

the right to hold any meeting to consider appeals by telephonic conference call. Your right "to appear before" the Trustees considering the appeal in this instance is limited to participating in the telephone conference at the time the appeal is presented.

Appealing the Denial of Your Weekly Income Benefit Claim

- Prior to the date that the Plan issues an adverse benefit determination on an appeal of a claim for Weekly Income Benefits, the Plan will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other Person making the benefit determination (or at the discretion of the Plan, insurer, or such other Person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date; *and*
- Prior to the date the Plan can issue an adverse benefit determination on an appeal of a Weekly Income Benefits claim based on a new or additional rationale, the Plan Administrator will provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

In the case of an adverse benefit determination on an appeal with respect to a claim for Weekly Income Benefits, the determination will include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the Plan of the health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A Disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.
- If the adverse benefit determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- Either specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

Effective January 1, 2018, in the case of an adverse benefit determination on an appeal with respect to a claim for Weekly Income Benefits, the notification will be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor Regulation Section 2560.503-1(o).

Authorized Representative

You must provide written authorization for a representative to act on your behalf to file a claim under this Plan. Authorization forms will be provided with the appeal form. Only the Fund's Appointment of Personal/Authorized Representative Designation Form will be accepted. No other authorized personal representative designation forms will be accepted. You can access the form on the Fund's website.

The following individuals may be recognized as your authorized representative:

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

No appointment of an authorized representative provides the representative with any right to maintain an action in contract, tort, or as an ERISA benefit claim against the Fund or the Trustees for recovery of any amounts from the Plan. Any claim brought against the Plan for payment of benefits must be brought in the name of the Eligible Person upon whom services were performed.

Once you name an authorized representative, the Plan will copy all applicable future claims and appeals-related correspondence to your authorized representative in addition to you. The Plan will honor the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization. However, you may revoke a designated authorized representative at any time by submitting a signed statement.

The Plan reserves the right to withhold information from a Person who claims to be an authorized representative if there is suspicion about the qualifications of the individual claiming to be the authorized representative or suspicion of the signature(s) on the designation form.

Non-Assignment of Benefits

The benefits in this Plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any Person or entity. You will not sell, assign, pledge, transfer, or grant any interest in or to these benefits, or any right of reimbursement or payment arising out of these benefits, to any Person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against the Fund and imposes no duty or obligation on the Fund. The Fund will not honor any such purported sale, assignment, pledge, transfer, or grant.

Legal Procedures

You may not bring any action in court to recover benefits:

- Before you have exhausted all of your remedies under the Plan's claims and appeals procedures; and
- After three years from the expiration of the time allowance within which you were required to file your claim with the Plan.

Notwithstanding the foregoing, any legal action must be initiated within 12 months of the date the Plan issues an adverse benefit determination on your appeal.

Any action in court must be brought in the United States District Court for the Central District of Illinois, where the Plan is administered.

Important Information About the Fund

The NECA-IBEW Welfare Trust Fund was established to provide health and welfare benefits to Eligible Participants who have had contributions made to the Fund on their behalf by Participating Employers. Participants in the Plan include Eligible Employees, Eligible retirees, and their Eligible Dependents. There is a list of Participating Local Unions on page 136. For a list of Participating Employers, please contact the Fund Office.

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

This SPD has been prepared in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. It is intended to assist Participants in understanding the benefits provided and the contract provisions governing the administration of the Fund.

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

Plan Name. NECA-IBEW Welfare Trust Fund.

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

Plan Sponsor and Plan Administrator. The Plan is administered by a joint labor-management Board of Trustees. The Board is composed of individuals appointed by the Chapters of the National Electrical Contractors Association, Inc. or other multiemployer groups representing Participating Employers in an area and representatives of Participating Local Unions affiliated with the International Brotherhood of Electrical Workers that have become parties to the Fund Agreement and Declaration of Trust. The Board of Trustees is assisted in the administration of the Fund by an administrative manager.

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

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

Source of Contributions. The Fund receives contributions from Employers pursuant to written agreements requiring contributions to the Fund on behalf of Employees. The contribution rate is set by the Trustees, and contributions are paid monthly. Contributions are also received by the Fund from Employees and retirees Eligible to make self-payments.

Plan Funding. All Plan benefits are self-funded and administered directly by the Trust Fund, except for Prescription Drug Benefits, which are administered by CVS Caremark and

SilverScript, and wellness and disease management programs, which are administered by Telligen.

Providers. All Providers engaged by the Fund are identified in this SPD. All Providers are specified in the "Schedules of Benefits" document.

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

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

Plan Type. This Plan provides death, Disability, disease management, health reimbursement account, medical, prescription drug, and wellness benefits for active Participants. It also provides death, disease management, health reimbursement account, medical, prescription drug, and wellness benefits for retirees.

Plan Amendment. The Alternative Plan is summarized and detailed in this document. The Trustees have the right to amend or terminate the Plan at any time in whole or in part in accordance with the Trust Agreement. You will be notified, in writing, of any Plan amendments. In the event the Plan is terminated, any and all assets remaining after the payment of all obligations and expenses will be used in accordance with the purposes determined by the Trustees according to the Trust Agreement. However, any use of such assets will be made only for the benefit of the Plan Participants who were covered under the Plan at the time of the Plan's termination.

Benefits Are Not Vested. You do not have a vested right to benefits under the Plan, and benefits may be amended or terminated at any time. Further, your participation in the Plan is not a guarantee of continuing employment.

Plan Documents. Copies of the Trust Agreement and Plan amendments are available for review by Participants. They are available on the Fund's website. Participants may also arrange to review and obtain these documents at the Fund Office or at the office of Participating Local Unions. In addition, a complete set of these documents may be requested, in writing, from the Fund Office. The Fund may charge a reasonable fee to cover the cost of reproducing documents. Requests for documents should be addressed to:

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

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

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

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

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

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

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

HIPAA Privacy Officer
NECA-IBEW Welfare Trust Fund
2120 Hubbard Avenue
Decatur, IL 62626-2871
800-765-4239

ERISA Rights

As a Participant in the NECA-IBEW Welfare Trust Fund's Base Plan, Alternative Plan, or Supplemental Retirement Benefit 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 the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Office, 2120 Hubbard Avenue, Decatur, IL 62526-2871, and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated SPD (the Fund Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Fund Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, your spouse, or your Dependents if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. (You have the right to review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.)

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other Person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or latest summary annual report from the Plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Administrator.

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

Assistance with Your Questions

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

National Office:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
866-444-3272

OR

Nearest Regional Office:

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

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

The Board of Trustees reserves the right to amend, modify, or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. In addition, the Board of Trustees reserves the right to instigate, increase, and/or decrease self-payments.

Participating Local Unions

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

Board of Trustees

Union Trustees	Employer Trustees
Mike Arbuckle	Bryan Allison
Jim Clarida	Charles Crow
Jarrett Clem	Kurtis Fredrick
Jimmy Evans	William Fricke
Paul Flynn	Terry Gipson
Neil Hervey	Scott Hartig
Kristopher Howard	Jon Huston
Steve Hughart	Beth Iding
David Karcher	Mark Kawolsky
Nathan Knott	Matthew LaFree
Tony Quillen	Mark Laughery
Mike Raikes	Jeff Linkenhelt
Jeff Rodeffer	Ron Masters
Josh Sapp	William Meyer
Larry Spencer	Blaine O'Connell
R. Todd Thacker	Billy Serbousek
Dean Warsh	Carl Tirone
Brandon Wongnamnit	Ted Uppole
Mike Young	Larry Van Tries

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

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

Non-Discrimination Notice Under Section 1557 of the Affordable Care Act

Note that effective August 18, 2020, this notice is no longer applicable.

Discrimination is against the law.

The NECA-IBEW Welfare Trust Fund complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, Disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, Disability, or sex. The Fund:

- Provides free aids and services to people with Disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact Mr. Kevin Cope, the Civil Rights Coordinator. If you believe that the Fund has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, Disability, or sex, you can file a grievance with:

Mr. Kevin Cope
Civil Rights Coordinator
NECA-IBEW Welfare Trust Fund
2120 Hubbard Avenue
Decatur, IL 62526-2871
[t] 800-765-4239
[f] 217-875-2084
kcope@neca-ibew.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mr. Kevin Cope is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, DC 20201
800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/filing-with-ocr/index.html.

Illinois/Indiana Languages

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-765-4239.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-765-4239.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-765-4239.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-765-4239.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-765-4239.
Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800-765-4239.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-765-4239. 번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-765-4239.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-765-4239.
Hindi	ध्यान द: यद आप हदी बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 800-765-4239. पर कॉल कर।
Panjabi	ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-765-4239. 'ਤੇ ਕਾਲ ਕਰੋ।
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 800-765-4239.
Dutch	AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 800-765-4239.
Gujarati	ચના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 800-765-4239.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-765 4239. まで、お電話にてご連絡ください。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-765-4239.

Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-765-4239.
Urdu	نیرک رادربخ: رگا پآ ودرا ےتلوب نیہ، وت پآ وک نابز یک ددم یک تامدخ تفم نیم بایتسد نیہ ۔ لاک 800-765-4239.
Arabic	ركذا ةغلاا، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت كل ناجملاب. لصتا مقرب 800-765-4239 (مقر اهـ . ةظوحلم: اذإ تنك ثدحتت

NECA-IBEW Welfare Trust Fund
2120 Hubbard Avenue
Decatur, IL 62526-287
1-800-765-4239
www.neca-ibew.org

GCC/IBT 44-L

2020