

Working with You to Provide the Best Healthcare.

NECA FMCP

Family Medical Care Plan

Plan 17

Summary Plan Description

January 1, 2021

IMPORTANT CONTACT INFORMATION

NECA/IBEW Family Medical Care Plan Benefit Office
410 Chickamauga Avenue, Suite 301
Rossville, GA 30741

Phone: 1-877-937-9602 or 1-706-841-7000
Fax: 1-706-841-7020

Contact the FMCP Benefit Office if you have:
- Questions regarding claims or eligibility;
- Need a new medical I.D. card;
- If you or a dependent moves, if your family/ dependent status changes, if anyone in your family acquires other coverage, or if you retire or enter active military service.

Anthem Blue Cross
Blue Card through Anthem/BSBSGA

Members - To find a PPO Provider:
- www.anthem.com
- Call 1-800 810-BLUE (2583)

Providers - To verify eligibility / benefits:
- Call 1-844-594-0393
- Providers should file claims through their local Blue Cross affiliate.

Utilization review, care management & pre-certification
- Call 1-855-343-4852

Important:
- If you use a Blue Card PPO provider, covered services will be paid at the high in-network benefit level.
- Your group identification number is on your ID card.

Vision Benefits - if applicable

VSP
PO Box 385018
Birmingham, AL 35238-5018

For customer service or to find a PPO provider:
- www.vsp.com
- Call 1-800-877-7195

Important:
- Vision claims should NOT be sent to the Benefits Office or Anthem BCBS.

Dental Benefits - if applicable

MetLife®

PO Box 981282
El Paso, TX 79998-1282

For customer service or to find a PPO Provider:
- www.metlife.com/mybenefits
- Call 1-800-942-0854

Important:
- Your group account number is 304133.
- MetLife handles all dental claims.

Treatment Plan Review

Best Doctors
60 State Street, Suite 600
Boston, MA 02109

For customer service:
- Phone: 1-800-497-1634
- https://members.bestdoctors.com/

Prescription Drug Benefits

Sav-Rx

For customer service:
- www.savrx.com
- Call 1-866-233-IBEW (4239)

Important:
- Contact Sav-Rx if you have questions about your prescription drug benefits.

24/7 Virtual Doctor Visits

LiveHealth Online

To access this service:
- Visit livehealthonline.com or download the free LiveHealth Online app to your mobile device.

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INTRODUCTORY INFORMATION

About This Booklet

This booklet outlines the health care benefits provided to participants in Plan 17 provided by the NECA/IBEW Family Medical Care Plan (referred to as "the Plan" in this booklet).

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

If you are a Plan 17 participant who meets the Plan's eligibility requirements, you and your family members who meet the Plan's definition of a *dependent* (on page 70 of this booklet) will be eligible for the benefits described herein.

The following benefits that are discussed in this booklet are considered ancillary benefits, and you will only be entitled to these coverages if they are included in your employer's contract with the Plan:

Dental	Vision
Weekly Disability	Life insurance
AD&D insurance	Individual Special Fund Account

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

Other Benefit Plans Provided by the Fund

The NECA/IBEW Family Medical Care Trust Fund (referred to as the "Fund" in this booklet) provides benefit schedules that differ from the benefit plan described in this booklet. Because the benefits differ, those plans are described in separate booklets. (The plan of benefits that applies to a specific Plan participant is determined by the participant's employer's agreement with the Trustees of this Plan.)

Be Sure to Carry and Use Your I.D. Cards

You and your spouse should both carry an Anthem Blue Cross Blue Shield I.D. card or a United Healthcare (UHC) Medicare Advantage I.D. card if you are a Medicare-eligible retiree or the dependent of a Medicare-eligible retiree covered under the UHC Medicare Advantage Plan. Show your card whenever you or a family member receives medical care at a hospital, doctor's office or other medical facility. Call the Benefit Office if you need another medical I.D. card.

If you are on the UHC Medicare Advantage Plan, be sure to carry both your UHC I.D. card and Sav-Rx prescription drug card, as your prescription drug benefits are administered jointly by UHC and Sav-Rx. Call the Sav-Rx customer service line if you need prescription cards.

Does the Benefit Office Have Your Current Address?

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

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

SPECIAL PLAN FEATURES

Your Blue Card PPO Network

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

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

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

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

The phone number and website address are also on the back of your I.D. card.

Your Anthem I.D. Card

Your Anthem/BCBS I.D. card gives you access to BCBS network providers throughout the United States. The three-letter alpha prefix that precedes your subscriber number on your I.D. card identifies Anthem/Blue Cross and Blue Shield of Georgia (BCBSGA) as your home plan.

Preferred and Participating Providers

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

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

Pre-Certification Requirements

Call 1-855-343-4852 for pre-certification.

The number to call for pre-certification is also on your I.D. card.

- **Inpatient Confinements -** You and your dependents are required to pre-certify each inpatient hospitalization by calling Anthem prior to admission. A $250 benefit reduction will apply to each hospitalization that is not pre-certified.
- **Home Health Care and Durable Medical Equipment -** You should also call for pre-certification prior to receiving home health care, and durable medical equipment that costs at least $500.
- **Diagnostic Imaging – AIM Specialty Health -** You must also obtain pre-certification for imaging procedures and specialized cardiovascular treatments in order for these benefits to be covered by the Plan. Pre-certification for these services is done by AIM Specialty Health, an Anthem affiliate, but you can access AIM through the same telephone number (1-855-343-4852). AIM Specialty Health will pre-certify services such as:

- Computed tomography (CT)
- Magnetic resonance imaging and angiogram (MRI/MRA)
- Positron emission tomography (PET)
- Heart/cardio procedures such as myocardial perfusion imaging (MPI), stress echocardiography, transthoracic echocardiography, transesophageal echocardiography, arterial ultrasound, cardiac catheterization and percutaneous coronary intervention (PCI)

Pre-certification is NOT a guarantee of payment.

Services are approved based on medical necessity and appropriateness. Actual payment is dependent upon that person meeting the Plan's eligibility rules and other provisions. See page 36 for more information about the *Utilization Review Program*.

Your Dental PPO Network (if applicable)

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

For customer service or to find a PPO provider:
Call MetLife at 1-800-942-0854 or go to www.metlife/mybenefits.
Refer to group account number 304133.

You do not need any authorization from MetLife or the Benefit Office to choose a dentist. See page 48 for more information about Your Dental PPO Network.

Your Vision Plan (if applicable)

Vision Service Plan (VSP) administers the Plan's vision benefits and provides a network of VSP doctors who will provide basic vision services to you at no charge and with no claims to file. See the *Vision Benefits* section starting on page 52 for more information.

Your Medicare Advantage Plan (if applicable)

United Healthcare (UHC) administers the Plan's Medicare Advantage Plan for Medicare eligible retirees and their dependents. For a summary of benefits provided by UHC, please review your UHC Medicare Advantage Plan information packet or call UHC at 1-800-457-8506.

Your Prescription Drug Program

The Plan provides its prescription drug benefits through a program administered by Sav-Rx. You can use your medical I.D. card to purchase short-term or acute prescription drugs (such as antibiotics or pain relievers) from any participating retail pharmacy. There is also a mail-order feature allowing you to save even more money on your long-term and maintenance prescription drugs. See page 45 for more information about your prescription drug program.

If you are on the UHC Medicare Advantage Plan, your prescription drug coverage is administered jointly by UHC and Sav-Rx. UHC is the primary prescription drug plan and Sav-Rx is secondary, but your benefits will not change if both prescription drug programs are used.

You can contact Sav-Rx for customer service at 1-866-233-IBEW (4239)
or at www.savrx.com.

Note: If your spouse has coverage under another health plan, he or she must follow the rules of her prescription drug plan first and then file a claim with Sav-Rx for consideration of the remaining charge. The same applies to

prescription drugs for any children for whom your spouse's plan pays primary benefits.

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

LiveHealth Online

LiveHealth Online is a new benefit that uses two-way video to connect you with board-certified physicians that can help diagnose minor illnesses or injuries. Doctors using LiveHealth Online can answer your questions, assess your condition and even provide certain prescriptions if needed.

You can utilize this service with your smartphone, tablet or computer with a webcam. To begin using this program, visit www.livehealthonline.com and sign up for an account using your Plan information. Once your account is set up and your insurance information is entered correctly, you can begin connecting with doctors immediately.

LiveHealth Online is a great tool to use when you don't have time to get to your primary care physician or you want to avoid an unnecessary trip to the emergency room.

For more information, please contact the Benefit Office or go to www.livehealthonline.com.

Best Doctors

Best Doctors helps ensure you are receiving the best medical care from all of your providers. At your request, Best Doctors can review your medical records and provide helpful information and advice from a world-renowned medical expert in the appropriate field when you or your dependent are facing a critical medical decision that involves a serious diagnosis like cancer or surgery. It's a great tool to ensure that your physician is treating whatever illness or injury you have using the best possible treatments available.

For more information or to discuss your medical case with a Best Doctors' representative, call 1-800-497-1634 or visit https://members.bestdoctors.com/.

The Working Spouse Rule

Basic Rule

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

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

Hardship Exemption

The working spouse rule will NOT apply if your spouse:

1. Has gross annual wages of less than $23,000; or
2. Has gross annual wages greater than or equal to $23,000 but less than $35,000 and must pay more than $200 per month toward the cost of the least expensive health plan offered by her employer.

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

Additional Provisions and Exceptions to the 20% Plan Payment Rule

1. The Working Spouse Rule does not apply to Plan participants whose employers make multi-tiered contributions to this Fund. To determine if your employer makes multi-tiered contributions on your behalf, please contact the Benefit Office or ask your employer.
2. The working spouse rule only applies to your spouse's claims, not to claims incurred by your children.
3. The rule only applies to medical and drug expenses. Enrollment in the employer's dental and/or vision plan is not required. (However, if your spouse does enroll in the employer's dental program, this Plan will coordinate benefits and pay secondary to the employer's plan.)
4. The working spouse rule applies EVEN IF any of the following apply:
   - The working spouse's employer's plan does not have a single-only coverage option.
   - Medical coverage is an option under a cafeteria plan.
   - The working spouse's employer's plan is an HMO.
   - Your spouse works part-time.
   - You are a retiree, but your spouse is still actively employed.
   - The employer offers an incentive to induce employees not to enroll.
5. The working spouse rule will NOT apply in any of the following situations:
   - Your spouse's employer does not offer medical or prescription drug coverage.
   - Your spouse's employer requires your spouse to pay the full cost of the healthcare coverage.
   - Your spouse's only other option for group insurance is retiree coverage.
   - Your spouse's only other option for group insurance is COBRA coverage.
   - Your spouse's only other coverage option is an HMO and your residence is more than 25 miles outside the HMO service area.
   - Your spouse's claim would have been denied under the working spouse's employer's plan (for example, if the claim was for a preexisting condition incurred during the preexisting waiting period).
6. If this Plan pays 20% of your spouse's claims because of this rule, those coinsurance shares will not apply to the Plan's out-of-pocket limits, nor will the claim be paid at 100% if your spouse's out-of-pocket limit was previously met by other charges.
7. You are required to provide accurate and timely information to the Fund about your spouse's employment status and benefit entitlement, and the Benefit Office may require verification of this information from your spouse's employer.

Dual Coverage Saves You Money

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

PLAN 17 SCHEDULE OF BENEFITS

Life/Accidental Death & Dismemberment Insurance (if applicable)	
Employee life insurance	$10,000
Retiree life insurance	$7,500
Accidental death & dismemberment (AD&D) insurance principal sum (active employees only)	$10,000

Weekly Disability Benefit (employees only – if applicable)	
Weekly Benefit Amount	
Non-occupational disability	$250
Occupational disability	$125
Maximum period payable per disability	26 weeks
Benefits start on the following day of disability: Accident - 1st day; Illness - 8th day. If a disability due to sickness lasts more than 8 weeks, benefits will be retroactively paid for the first 7 days of disability.	

Major Medical Benefit	
Benefits are payable only for covered expenses. Covered expenses do not include amounts in excess of allowable charges, or charges for treatment that is not medically necessary. All benefits are subject to the maximum benefits and limitations stated below and to all Plan conditions and exclusions. All benefits and limitations shown are per covered person unless specifically stated otherwise.	
Your spouse is required to enroll in her employer's health plan. See the *Working Spouse Rule* on page 4.	
Deductibles, co-pays & reductions	
Calendar year deductibles	
PPO	
Per person	$500
Per family (aggregate)	$1,000
Non-PPO	
Per person	$500
Per family (aggregate)	$1,000
Amounts applied to the PPO deductible do NOT apply to the non-PPO deductible or vice versa.	
Emergency room deductible, per occurrence (in addition to above)	$100
Per-service co-pays	
Office visit co-pay for PPO physicians	$10
Specialist visit co-pay for PPO physicians	$10
Benefit reduction for failure to pre-certify an inpatient hospitalization	$250
Coinsurance (payment percentages) per calendar year after satisfaction of the calendar year deductible	
BCBS PPO expenses	90%
Emergency room treatment at an out-of-network hospital for an emergency medical condition, including professional fees	90%
Professional charges by an out-of-network radiologist, pathologist or anesthesiologist for services provided at a BCBS PPO hospital	90%
Out-of-network expenses (except as stated above)	70%

Out-of-pocket limits per calendar year	
PPO	
Per person	$2,100
Per family (aggregate)	$4,200
Non-PPO	
Per person	$5,100
Per family (aggregate)	$10,200

- Amounts applied to the PPO out-of-pocket limit do NOT apply to the non-PPO out-of-pocket limit, or vice versa.
- All deductibles, co-payments and coinsurance payments count toward an individual's PPO and non-PPO out-of-pocket limits. Once a person's PPO or non-PPO out-of-pocket limit is met, most covered BCBS expenses (either PPO or non-PPO) are paid at 100% during the remainder of the year.

Special Benefits and Limitations

Normal deductible and coinsurance percentage apply unless otherwise stated.

Preventive care	
Preventive care provided by PPO providers	Payable at 100% – no deductible applies

- The Plan covers a wide range of preventive and wellness services designed to keep participants and dependents healthy. These types of expenses are covered by the Plan at 100% with no deductible or co-pay only when the services are rendered by a PPO provider. *No benefits are payable for preventive services provided by non-PPO providers.*
- Preventive and wellness services covered by the Plan are subject to change pursuant to applicable laws and regulations.
- *For a list of preventive and wellness services covered by the Plan, please see the Appendix starting on page* ***88****.*

Benefit Limitations	
Non-PPO ambulatory surgical centers	Excluded
Chiropractic care - maximum allowable visits per calendar year. (Chiropractic visits are subject to the deductible and coinsurance.)	15 visits per year
Hearing aids - maximum allowable hearing aids, including fitting	One standard hearing aid per ear per lifetime
Speech therapy - maximum allowable visits per calendar year for speech therapy *to restore abilities lost due to stroke or trauma***.** *Speech therapy for the treatment of developmental delays is not covered by the Plan.*	35 visits per year
Skilled nursing facility - maximum allowable days per calendar year	30 days per year
Home health care - maximum allowable visits per calendar year	120 visits per year
Orthotics - Custom molded foot orthotics when prescribed or performed by in-network PPO providers only	1 pair every two years when prescribed or performed by in-network provider
Orthoptics (vision therapy) - maximum allowable visits	20 visits per lifetime

Prescription Drug Program (Sav-Rx)

Sav-Rx administers the Plan's Prescription Drug Program. You pay the following co-pays directly to the participating retail or mail-order pharmacy.

Co-Pays (what you pay)	
Generics	0%
Formulary brands	20%
Non-formulary brands	30% minimum $40 for 30-day supply, $80 for 90-day supply
Out-of-Pocket Limits per Calendar Year	
Individual out of pocket limit	$1,000
Family out of pocket limit (aggregate)	$2,000
Co-payment after out-of-pocket limit of $1,000 per calendar year per person has been met	0%

- *Wal-Mart and Sam's Club are NOT in your network.*
- If you decline a generic substitution, you must pay the cost difference between the brand and generic. The difference does not apply to your out-of-pocket limit and must be paid even after your out-of-pocket limit has been met.
- "Generic drugs" are those with multiple manufacturers. You will have to pay the 20% or 30% co-pay for a generic drug sold by only one or two companies.

Dental Benefits (MetLife®) (if applicable)

Dental Benefits are provided for active employees and their eligible dependents only. These benefits are not provided for retirees or dependents of retirees. You are only entitled to these benefits if they are included in your employer's contract with the Plan. For more information, contact your employer or the Benefit Office.

Maximum	
Maximum payable per person per calendar year *Maximum does not apply to children under age 19.*	$1,000
Orthodontia lifetime maximum per person *(covered for children under age 19 only)*	$1,000
Payment percentages for covered expenses	
Preventive care	80%
Basic restorative care	80%
Major restorative care (crowns and prosthetics)	50%
Orthodontia (children under age 19 only)	50%

Vision Benefits (Vision Service Plan) (if applicable)

The Plan's Vision Benefit is administered by Vision Service Plan (VSP). Vision Benefits are provided for active employees and their eligible dependents only. These benefits are not provided for retirees or dependents of retirees. You are only entitled to these benefits if they are included in your employer's contract with the Plan. For more information, contact your employer or the Benefit Office.

Vision Care Services (one per calendar year)	VSP Doctor	Non-Network Provider
Vision exam	Provided in full	$35
Lenses (per pair):		
Single	Provided in full	$30
Lined bifocal	Provided in full	$40
Lined trifocal	Provided in full	$55
Lined lenticular	Provided in full	$55
Contacts (elective)	Provided up to $150 allowance	$120
Frame	Provided up to $180 allowance	$35
Safety glasses:*		
Frame	Provided up to $65 allowance	$25
Lenses (per pair)		
Single vision	Provided in full	$30
Bifocal	Provided in full	$35
Trifocal	Provided in full	$45
Lenticular	Provided in full	$60

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

ELIGIBILITY FOR HOURLY BARGAINING UNIT EMPLOYEES

This section describes the eligibility rules that apply to active hourly bargaining unit employees whose employers contribute to the Fund based on hours worked. The eligibility rules for non-bargaining unit employees are on page 21. The retiree eligibility section starts on page 22.

Definitions Applicable to Eligibility

Benefit Month

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

Eligibility (Work) Month

A period of one calendar month during which a person meets the applicable eligibility requirements necessary to provide benefit coverage during the corresponding benefit month.

Credited Hour

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

Initial Eligibility Requirements

Initial Eligibility Date

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

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

When Benefits Start (Effective Date of Benefits)

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

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

The Plan's definition of a "dependent" starts on page 70.

Legal documentation (such as an original registered marriage certificate, certified government-issued birth certificate or divorce decree) is required by the Benefit Office before any benefits can be paid. The Benefit Office reserves the right to request additional documentation to determine eligibility status as necessary.

Continuing Eligibility

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

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

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

Your Hour Bank

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

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

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

If your combined hours from work and your hour bank are less than 140, you may make a self-payment for the hours you are short (see the following section for more information). If you don't make the self-payment but return to work within six (6) months, the hours remaining in your hour bank can be used to help you re-establish eligibility. If you do not return to work within the 6-month window, any remaining amounts in your hour bank will be forfeited.

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

Self-Payments for Short Hours

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

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

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

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

Eligibility During Disability (if applicable)

You are only entitled to this benefit if your employer's contract with the Plan includes this benefit. Please contact your employer for more information.

Protection During Short-Term Disabilities

If you become totally disabled, and your employer's contract with the Plan includes disability benefits, your eligibility will continue for **up to twelve (12) months** provided that you meet ALL three of the following requirements:

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

If you meet the above qualifications, you will be credited with eight disability hours each day of the work week, Monday through Friday, during your period of disability. Your disability credit hours will stop accumulating, however, once you reach 140 hours (160 for non-bargaining unit employees who qualify for disability hours) and no credit will accumulate to your hour bank.

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

Additional Rules Governing Eligibility During Disability

1. If you do not qualify for eligibility during disability as explained above, no credit for disability will be granted to you for future use.
2. You can receive disability credit for non-work-related disabilities and work-related disabilities.
3. You cannot receive disability credit if you are retired or making COBRA self-payments.
4. To receive disability credit for an occupational disability you must have become disabled on the job while you were working for an employer who was making contributions to the Fund on your behalf under a collective bargaining agreement or participation agreement. If you became disabled on the job while working for an employer who was not signatory to a collective bargaining agreement or participation agreement, you will NOT be eligible for disability credit.
5. The maximum period that your eligibility will be continued is 12 benefit months. However, if your eligibility is continued under this provision and you return to employment for a contributing employer before the expiration of 12 benefit months, your eligibility will be continued for the rest of the benefit month in which you return to work on a continuous full-time basis and for the next two succeeding benefit months. This permits your eligibility to be continued without interruption while you are working to earn future eligibility.
6. If you qualify for disability credit and you recover in the same month in which your total disability began, you will be eligible in the benefit month related to the eligibility month in which you were totally disabled, provided you would have been eligible if you had worked full-time for a contributing employer during your period of total disability.
7. If you are covered under this provision for the allowed 12 months and are still disabled and unable to go back to work, or if you recover from your total disability but there is no work available in your jurisdiction, you may be entitled to continue coverage by making COBRA self-payments.
8. If you recover after receiving disability credit and you do not go to work for an employer contributing to the Fund, your coverage will terminate on the date you are no longer disabled or the date your coverage terminates under the Plan's continuing eligibility rules unless you make correct and on-time COBRA self-payments.

If you die while you are covered under this provision and you have not accumulated any further eligibility, your dependents will be covered for three (3) more months starting with the first day of the month following the

month in which you die. After the 3-month period, your dependents may be entitled to continue coverage by making COBRA self-payments.

Special Circumstances

Below is a description of special circumstances that may affect your eligibility and coverage under the Plan. However, your employer may have additional or different requirements for Plan coverage under these circumstances. Please contact your employer for more information.

Reciprocity

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

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

Family Medical Leave Act (FMLA)

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

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

Military Leave

If you are called to active military duty in the uniformed services of the United States for *31 days or more*, your eligibility will be frozen until you return, provided you return to covered employment within the time prescribed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Alternatively, this Plan allows you to make self-payments to keep your coverage in force while you are on military leave. You will not need health coverage for yourself during a period of military leave, but you may want to make self-payments to continue coverage for your dependents. The maximum self-payment period during a military leave is 24 months. When you return, you will need to continue making self-payments until you re-establish eligibility under this Plan's eligibility rules and/or your employer's eligibility rules (subject to the 24-month maximum).

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

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

In the Event of Your Death

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

1. Your surviving dependents will continue to be covered through the end of the benefit month in which your death occurs, unless you were covered under the eligibility during disability provisions at the time of your death, then your dependents will continue to be covered for three months starting with the first day of the month following the month in which you die.
2. After that, your dependents can continue their coverage by making COBRA self-payments, or by making survivor self-payments. If your spouse chooses to make COBRA self-payments, the rules governing COBRA cov-

erage will apply. Note that if your spouse elects COBRA, he/she will not be entitled to make survivor self-payments at any future date. Similarly, if your spouse chooses the survivor self-payment option, he/she will lose the right to elect COBRA coverage at any future date.

Remember, your employer may have additional or different requirements for Plan coverage for your surviving dependents in the event of your death. Please contact your employer for more information.

Rules Governing Survivor Self-Payments

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

1. The amount of the monthly self-payment is determined by the Trustees and may be changed at any time.
2. By making the self-payments, your spouse will remain eligible for the same benefits he/she was eligible for when you died.
3. Your spouse must make his/her first self-payment on or before the date on which a self-payment to maintain continuous coverage is due. There must be no lapse in coverage.
4. Each subsequent payment must be postmarked no later than the 15th day of the month preceding the benefit month for which he/she is paying. Payments postmarked after the 15th will not be accepted.
5. If your spouse fails to make a self-payment on or before the date it is due, his/her eligibility and the eligibility of any of your surviving dependent children will terminate at the end of the benefit month for which he/she had already paid. He/she will not be allowed to make any future self-payments.
6. Once a self-payment has been accepted by the Benefit Office, it will not be returned.
7. Your spouse can continue to make self-payments until he/she remarries or until one of the other events specified in *Termination of Dependent Benefits* on page 15 occurs.
8. If your spouse doesn't elect to make survivor self-payments when he/she is first entitled to do so, he/she will not be permitted to make self-payments at any future date.
9. When your spouse becomes age 62, his/her coverage as a dependent of an active employee will terminate and he/she will then be able to make self-payments for the Plan's Retiree Benefits if Retiree Benefits would have been available to the active employee.

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

Termination of Eligibility

Termination of Employee Benefits

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

1. If you fail to meet the continuing eligibility requirements as outlined in your employer's collective bargaining agreement or participation agreement, unless you are terminated or retire and make correct and on-time self-payments for COBRA coverage or Retiree Benefits (if you are entitled to Retiree Benefits).
2. If your coverage is being continued under the eligibility during disability provisions, on the date you fail to meet the applicable requirements.
3. If you are making COBRA self-payments, at the end of the last day of the applicable maximum coverage period to which you were entitled and for which correct and on-time self-payments have been made or, on the

date of occurrence of any of the events stated in *Termination of COBRA Coverage* on page 19, whichever occurs first.

4. The date you enter employment in the electrical industry for an employer who is not signatory to an agreement which requires contributions either to this Plan or another IBEW-affiliated health and welfare trust fund. On this date, you shall forfeit all bank hours, the entire balance of your Special Fund Account, and no self-payments for short hours will be permitted except for COBRA coverage (if required by law). This provision does not apply to a member who is working as a SALT with the permission of an IBEW Local Union Business Manager pursuant to the provisions of an IBEW Salting Agreement.
5. The date on which the Plan discovers that you and/or your dependent(s): a) failed to make a required payment when it is due; or b) made a material misrepresentation or committed fraud against the Plan. This includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of a membership ID card. If the Plan determines that a) or b) occurred, the Plan has the right to rescind (retroactively revoke) coverage under the Plan and may demand repayment of all benefits paid on behalf of you and/or your dependents. "Rescind" means a cancellation or discontinuance of coverage under the Plan that has a retroactive effect. "Rescind" does not include a cancellation or discontinuance of coverage under the Plan if the cancellation or discontinuance of coverage has only a prospective effect. This provision is intended to comply with the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.
6. The date the Trustees terminate the benefits provided by this Plan.
7. The date of your death.

Termination of Dependent Benefits

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

1. The date you cease to be eligible for benefit coverage for reasons other than your death.
2. For your spouse, the date of your divorce.
3. For a child who fails to meet this Plan's definition of a dependent child, at the end of the calendar month in which the child no longer meets the Plan's qualifications.
4. If COBRA self-payments are being made by or on behalf of the dependent, at the end of the last day of the applicable maximum coverage period to which the dependent is entitled and for which correct and on-time self-payments have been made, or on the date of occurrence of any of the events stated in *Termination of COBRA Coverage* on page 19, whichever occurs first.
5. The date the Trustees terminate dependent benefits (or all benefits) under the Plan;
6. In the event of your death:
    a. At the end of the last day of the last benefit month for which you had earned eligibility before your death;
    b. If your eligibility was being maintained under the eligibility during disability provisions, at the end of the last day of the third benefit month following the month in which your death occurred; or
    c. If your surviving spouse is making survivor self-payments to continue coverage for himself/herself and any of your surviving dependent children, on the first of the following dates:
        - The date any of the events in No. 1 through 5 above occurs;
        - The last day of the last benefit month for which a correct and on-time self-payment was made by or on behalf of your surviving spouse;
        - The first day of the month following the month in which your surviving spouse attains age 62 (however, your spouse will then be offered the opportunity to make self-payments for Retiree Benefits);

- The date your surviving spouse becomes covered under another health care plan;
- For a surviving dependent child, the date the child ceases to meet this Plan's definition of a dependent child; or
- The date your surviving spouse remarries.

Your employer may have additional or different requirements for termination of benefits for you and your dependents. Please contact your employer for more information.

Termination Upon Employer Withdrawal

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

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

Termination of Eligibility Procedures

If the Plan determines that you and/or your dependent(s) are not eligible for coverage, the Plan will notify you in writing of its discovery. The ineligible individual's coverage will terminate on the date it is determined that the individual was no longer eligible for coverage through the Plan.

To appeal the Plan's determination of ineligibility, you must respond to the Plan's notice, as set forth below, within 30 days of the date of that notice. Failure to timely respond to the Plan's determination of ineligibility will terminate your right to appeal.

All claims or disputes regarding eligibility and enrollment, including disputes relating to a dependent's eligibility and/or dependents removed from coverage due to failure to provide documentation substantiating their eligibility, must be in writing and must include the following information:

1. The nature of the claim (i.e., appeal of eligibility denial);
2. The name of the individual(s) claiming eligibility and the relationship of such individual(s) to the actual Plan participant;
3. An explanation of why such individual(s) believes he/she is eligible to participate in, or become covered under, the plan(s) in question; and
4. Any documentation that supports your claim for eligibility.

All claims or disputes submitted under these procedures must be submitted in writing to the Benefits Office. Within 60 days after your claim is received, you will receive a written notice of the decision, subject to the Plan's right to request additional information from your or your dependents before it makes a determination on your eligibility. Should the Plan request additional information from you after receipt of your claim, the Plan shall have an additional 30 days to provide written notice of the decision. If the Plan is unable to make a determination on your eligibility appeal, the Benefit Office will present the appeal at the next Board of Trustees meeting and the full Board will make a determination.

If the Plan's determination of ineligibility is reversed, coverage will be reinstated retroactively to the date you or your dependents were removed from coverage. If applicable, your hour bank and the entire balance of your Special Fund Account shall be reinstated, and self-payments for short hours will be permitted. If your coverage level changed, contributions for coverage will be collected from the date coverage was reinstated.

For more information on the Plan's eligibility and claims procedures, contact the Benefit Office at 1-877-937-9602.

COBRA Coverage

Federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), gives you (the employee) and your eligible dependents the right to be offered an opportunity to make self-payments for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "continuation coverage," "COBRA continuation coverage," or "COBRA coverage." Below is an outline of the rules governing COBRA coverage. If you have any questions about COBRA, call the Benefit Office.

Qualifying Events/Maximum Coverage Periods

1. **18-Month Maximum Coverage Period -** You and/or your eligible dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for a maximum period of up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"):
   - A reduction in your hours.
   - Termination of your employment (which includes retirement). (Refer to page 13 for information on continuation of coverage during a military leave.)
2. **29-Month Maximum Coverage Period -** If you or an eligible dependent is disabled (as defined by the Social Security Administration for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or an eligible dependent becomes so disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The COBRA self-payment may be higher for the extra eleven (11) months of coverage for the family. Also, you must notify the Benefit Office within 60 days of the latest of: 1) the date of the disability determination by the Social Security Administration; 2) the date on which the initial qualifying event occurs; or 3) the date on which the qualified beneficiary loses coverage under the Plan as a result of the qualifying event. You must also notify the Benefit Office within 30 days of the date Social Security Administration determines that the person is no longer disabled.
3. **36-Month Maximum Coverage Period -** Your dependents (spouse or children) are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following qualifying events:
   - Your divorce from your spouse.
   - A dependent child's loss of dependent status.
   - Your death.

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

Multiple Qualifying Events - If your dependents are covered under COBRA coverage under an 18-month maximum coverage period due to termination of your employment or a reduction in your hours and then a second qualifying event occurs, their COBRA coverage may be extended as follows:

- If you die, or if you are divorced, or if a child loses dependent status while your dependents are covered under an 18-month COBRA coverage period, your dependent(s) who are affected by the second qualifying event are entitled to COBRA coverage for up to a maximum of 36 months minus the number of months of COBRA

coverage already received under the 18-month continuation.

- Only a person (spouse or child) who was your dependent on the day before the occurrence of the first qualifying event (termination of your employment or a reduction in your hours) is entitled to make an election for this extended coverage when a second qualifying event occurs. Exception: If a child is born to you (the employee), or adopted by you, or placed with you for adoption during the first 18-month COBRA period, that child will have the same election rights when a second qualifying event occurs as your other dependents who were eligible dependents on the day before the first qualifying event.

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

Benefits Provided Under COBRA Coverage

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

Notification Responsibilities

1. If you get divorced, or if your child loses dependent status, you, your spouse or child must notify the Benefit Office and request a COBRA election notice. The Benefit Office must be notified within 60 days of the date of the qualifying event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later.
2. For purposes of extending an 18-month maximum coverage period to 29 months, the Benefit Office must be notified of the person's determination of eligibility for Social Security disability benefits within 60 days of the Social Security notice of such determination and before the end of the initial 18-month period. The Benefit Office must also be notified within 30 days of the date Social Security determines that the person is no longer disabled.
3. It is your employer's responsibility to notify the Benefit Office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you or a dependent should also notify the Benefit Office and request a COBRA election notice any time any type of qualifying event occurs.

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

Electing COBRA Coverage

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

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

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

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

COBRA Self-Payment Rules

1. Self-payment amounts are determined by the Trustees based on federal regulations. The amounts are subject to change, but not more often than once a year unless substantial changes are made in the benefits.
2. A person electing COBRA coverage has 45 days after the signed election form is returned to the Benefit Office to make the initial (first) self-payment for coverage provided between the date coverage would have terminated and the date of the payment. (If a person waits 45 days to make the initial payment, the next monthly payment may also fall due within that period and must also be paid at that time.)
3. The due date for each following monthly self-payment is the first day of the month for which payment is made. A monthly self-payment will be accepted if it is received by the Benefit Office within a 30-day grace period after the due date. Your self-payment will be considered on time if it is personally delivered or mailed by the due date.
4. COBRA coverage self-payments must be made monthly and must be received by the Benefit Office in a timely manner. Your self-payment will be considered on time if it is personally delivered or mailed by the due date. (Postmarks affixed by the U.S. Postal Service will be considered proof of date of mailing. Postage meter imprints or any other evidence of mailing date, including date imprints by overnight courier services such as UPS or Airborne, will not be considered proof of date of mailing unless payment is actually delivered to the Benefit Office no later than the first business day immediately following the mailing date shown.)
5. If a self-payment is not made within the time allowed, COBRA coverage for all affected family members will terminate. You may not make up the payment or reinstate coverage by making future payments.

Additional COBRA Coverage Rules

1. COBRA coverage may not be elected by anyone who was not eligible for Plan benefits on the day before the occurrence of a qualifying event.
2. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage.
3. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents.
4. If coverage is going to terminate due to your termination of employment or reduction in hours and you don't elect COBRA coverage for your dependents when they are entitled to the coverage, your dependent spouse has the right to elect COBRA for up to 18 months for himself/herself and any children within the time period that you could have elected COBRA coverage.
5. A person who is already covered by another group health plan or Medicare may elect COBRA coverage. However, if a person becomes covered under another group health plan or Medicare after the date of the COBRA election, his or her COBRA coverage will terminate (unless the person has a preexisting condition that would cause the other plan to limit or exclude benefits).

   Note to Medicare-Eligible Participants: You MUST have Part B coverage before your COBRA starts. Although this Plan's active coverage is primary to Medicare while you are covered as an active employee, this Plan becomes secondary to Medicare when you elect COBRA. This Plan will not pay any charges that could have been paid by Medicare – even if you haven't elected it. If you do not elect Part B, you will be responsible for most of your non-hospital medical expenses.
6. You do not have to show proof that you and/or your dependents are insurable in order to be entitled to COBRA coverage.

Termination of COBRA Coverage

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

1. A correct and timely payment is not made to the Fund.
2. After an election of COBRA coverage, the person becomes entitled to Medicare benefits.
3. After an election of COBRA coverage, the person becomes covered under another group health care plan.
4. This Plan no longer provides group health coverage to any employees.
5. The person was receiving extended coverage for up to 29 months due to his/her or another family member's disability, and Social Security determines that he/she or the other family member is no longer disabled.

Other Coverage Options

There may be other coverage options for you and your family since you can buy coverage through the health insurance marketplace (exchange). On the exchange you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For More Information

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272 For more information about health insurance options available through a health insurance marketplace, visit www.healthcare.gov. For specific information about the Welfare Fund or how to elect COBRA through the Welfare Fund, call the Fund Office at 1-877-937-9602.

ELIGIBILITY FOR NON-BARGAINING UNIT EMPLOYEES

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

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

If your employer is contributing based on hours, the hour bank provisions, short-hours self-payment rules, and the eligibility during disability provisions do not apply to you. However, if you are an employee of a Local Union or NECA Chapter and your employer's contract with the Plan includes the hour bank benefit, 13 hours per month will be credited to your hour bank, up to 840 hours total. Also, if you are an employee of a Local Union or NECA Chapter, the eligibility during disability provisions will apply if you become totally disabled. For more information, please contact the Benefit Office.

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

In addition, you may participate in the Retiree Benefits program (if applicable) under the same terms and conditions as hourly bargaining unit participants.

RETIREE ELIGIBILITY (if applicable)

If your employer's contract with the Plan includes Retiree Benefits, you may have a choice of two types of continued Plan coverage for yourself and your dependents when you retire:

- **COBRA Coverage -** You may be entitled to make COBRA self-payments for up to 18 months; or
- **Retiree Benefits -** You can make self-payments for Retiree Benefits as long as you meet your employer's and/or the Plan's eligibility requirements.

If your employer's contract with the Plan does NOT include Retiree Benefits, you may still be able to elect COBRA coverage for up to 18 months.

COBRA Coverage for Retirees

Retirement is a *qualifying event* under COBRA coverage. When you retire, you may be entitled to make self-payments for up to 18 months for continued coverage under the COBRA coverage rules. If you are receiving pension benefits and elect COBRA coverage, you CANNOT get into the Retiree Benefits plan later, regardless of the length of your COBRA coverage period. For more information see *COBRA Coverage* starting on page 17.

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

Retiree Benefits

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

Eligibility Requirements for Retiree Benefits

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

Early and Normal Retirements

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

Disability Retirements

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

When You Retire

When you retire, if you qualify for Retiree Benefits, you must notify the Benefit Office within 90 days of the date of your retirement. Failure to do so may result in the loss of eligibility of Retiree Benefits under the Plan for you and your dependents.

Upon your retirement, your bank hours (if applicable) will be used to maintain your eligibility as an active employee until your hours are exhausted. When your bank hours have been exhausted, your coverage under the Retiree Benefits plan will start. Thereafter, if your employer contributed into the Special Fund, your Special Fund Account may be used to make your self-payments for Retiree Benefits (see page 55 for a description of the *Special Fund Program*). You need not use your Special Fund Account for this purpose, but you may hold it in reserve to cover eligible medical expenses not covered by the regular plan (see *What Your Account Can Be Used for* starting on page 55).

Retiree Benefits Coverage

There are two different types of benefits coverage for Retirees and their dependents:

- The benefits for retirees and dependents who are not eligible for Medicare are identical to Plan 17 medical benefits; and
- The benefits for Medicare-eligible retirees and dependents are provided under the UHC Medicare Advantage Plan.

Both plans include prescription drug coverage. A $7,500 retiree life insurance benefit is provided if those benefits are included with your employer's contract with the Plan. Dental and vision coverage, AD&D insurance and Weekly Disability Benefits are NOT provided for retirees or their dependents.

If you are a Medicare-eligible retiree or a dependent of a Medicare-eligible retiree and are covered under the UHC Medicare Advantage Plan, your benefits are different from the Major Medical Benefit provided under Plan 17, and your prescription drug coverage is administered jointly by UHC and Sav-Rx. UHC is the primary prescription drug plan and Sav-Rx is secondary, but your benefits will not change if both prescription drug programs are used. For a summary of benefits provided by UHC, please review your UHC Medicare Advantage Plan information packet or call UHC at 1-800-457-8506.

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

Dependent Eligibility

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

If your spouse is an eligible dependent on the date of your death, your spouse may continue making self-payments to continue her coverage (see *Benefits for Surviving Dependents of Retirees* starting on page 25).

Postponement or Suspension Due to Spousal Coverage

You can postpone Retiree Benefits coverage for your spouse if your spouse has employer-provided group health coverage. You can also suspend Retiree Benefits coverage for your spouse if, after you retire and elect spousal coverage, your spouse becomes eligible under another employer-provided plan. During the time your spouse has the other coverage, you will only need to pay the single rate for Retiree Benefits for yourself, provided you have no other eligible dependents. Then, when your spouse's coverage terminates (for example, when your spouse retires), you can start paying the higher rate for both you and your spouse.

To postpone or suspend coverage for your spouse, you must provide proof of your spouse's other coverage to the Benefit Office. To reinstate spousal coverage, you must submit proof that the other coverage has ended. Proof

must be submitted within one month after the other coverage terminates. There cannot be a coverage gap of more than one month. Your spouse's Retiree Benefits coverage cannot be reinstated unless and until her other coverage terminates.

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

Coordination of Benefits with Medicare Parts A and B

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

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

Other Medicare Part D Prescription Drug Coverage

This Plan's prescription drug plan for Medicare-eligible retirees and their Medicare-eligible spouses is a Medicare Part D plan, and federal rules prohibit anyone from having more than one Part D plan at a time. Therefore, Medicare-eligible retirees and their dependents have the option of dropping this Plan's prescription drug coverage and switching to their own Medicare Part D plan. However, doing so will not reduce the retiree's monthly self-payment amount.

Self-Payment Rules for Retiree Benefits

1. The total contribution rate required for you and your dependents to maintain retiree coverage through the Plan must be paid by either your employer or yourself. The Plan does not collect a portion of the contribution rate from any one party, but instead must receive the full amount from either you or your employer. Your employer may require you to pay a portion of that total contribution rate. If you have any questions about self-payment rules and contribution rates for Retiree Benefits, please contact your employer or the Benefit Office.
2. You (or your employer) must make your first retiree self-payment on or before the date on which a self-payment to maintain continuous coverage is due. There must be no lapse in coverage between active employee coverage and your Retiree Benefits coverage.
3. The amount of the monthly retiree self-payment is determined by the Trustees and may be changed at any time. Self-payment amounts for retirees are based on the retiree's dependent status and whether or not the retiree and/or his or her dependents are eligible for Medicare.
4. If you are making the full monthly self-payment, payments must be mailed directly to the Benefit Office. Each payment must be postmarked no later than the 15th day of the month preceding the benefit month for which you are paying in order to be accepted by the Benefit Office. For example, to be covered during the March benefit month, your self-payment must be postmarked no later than February 15th.
5. If you (or your employer on your behalf) fail to make a self-payment on or before the date it is due, your eligibility for Retiree Benefits will terminate at the end of the benefit month for which you have already paid. You will not be allowed to make any future self-payments.
6. Once a self-payment has been accepted by the Benefit Office, it will not be returned.
7. If you die while making self-payments for Retiree Benefits, your surviving spouse can continue coverage for himself/herself and any dependent children by making self-payments as explained in the Benefits for *Surviving Dependents of Retirees* section below.

If You Return to Work

If you return to active employment and have sufficient credited hours to reestablish your eligibility, you will be-

come covered as an active employee and your Retiree Benefits will be suspended. You will not have to make self-payments as long as your active coverage remains in effect. You can resume making retiree self-payments when you return to retired status.

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

Benefits for Surviving Dependents of Retirees

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

1. The self-payments must be made according to the same provisions that applied to the self-payments made by you.
2. Your surviving spouse can continue to make self-payments until the earlier of the date on which he/she re-marries or dies unless coverage terminates earlier according to the termination rules stated in the next section.
3. If there is no surviving spouse, or if your spouse dies while making self-payments for continued Retiree Benefits, your surviving dependent children or a legal guardian can make self-payments for continued Retiree Benefits on behalf of the children, subject to the following rules:
    a. Self-payments may be made on behalf of the children for up to a maximum of 36 months, minus any self-payments made by you before your death and/or any self-payments made by your surviving spouse before his/her death. If you and/or your spouse have already made a total of 36 self-payments for Retiree Benefits, no self-payments may be made by or on behalf of the children.
    b. The self-payments must be made according to the provisions of *Self-Payment Rules for Retiree Benefits* section above as though the self-payments were being made by you.
    c. Benefits for a surviving dependent child will terminate at the earlier of the end of the allowable maximum coverage period or the date the child fails to meet the Plan's definition of a dependent, unless coverage terminates earlier in accordance with the following termination rules.

Termination of Retiree Benefits

Retirees

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

1. The date the Trustees terminate Plan benefits.
2. The date the Trustees terminate Plan benefits for retirees.
3. The last day of the benefit month preceding the benefit month for which you fail to make a correct and on-time self-payment.
4. If you go to work for an employer in the electrical industry who is not required to make contributions on your behalf to an IBEW-NECA-sponsored health and welfare fund, on the last day of the month that precedes the month that your electrical industry employment begins.
5. The date of your death.

Your employer may have additional or different circumstances in which your retiree benefits are terminated. Please contact your employer or the Benefit Office for more information.

Dependents of Retirees

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

1. The date your eligibility for Plan coverage terminates for any reason other than your death.
2. The date the Trustees terminate Plan coverage for dependents of retirees.
3. The date on which the dependent ceases to meet this Plan's definition of a dependent unless the dependent is entitled to COBRA coverage and a correct and on-time election and self-payment is made by or on behalf of the dependent according to the rules governing COBRA coverage.
4. In the event of your death while you are making self-payments for Retiree Benefits:
    a. At the end of the last day of the last benefit month for which you had made a self-payment before your death unless self-payments are made by or on behalf of the dependent according to the rules governing benefits for surviving dependents of retirees; or
    b. If your surviving spouse is making self-payments to continue Retiree Benefits for himself/herself and any dependent children:
        - If a correct and on-time self-payment fails to be made by or on behalf of the dependent, at the end of the last day of the last benefit month for which a correct and on-time self-payment was made by or on behalf of the dependent;
        - The date the dependent fails to meet the definition of a dependent;
        - With respect to the surviving spouse, the date on which he or she remarries or dies, whichever occurs first; or
        - With respect to a dependent child in the event of the surviving spouse's death, at the end of the last day of the benefit month in which the spouse's death occurs unless self-payments are made by or on behalf of the child.
    c. If Retiree Benefits for a dependent child are being continued by self-payments by or on behalf of a dependent child because there is no surviving spouse or because of the surviving spouse's death:
        - If a correct and on-time self-payment fails to be made by or on behalf of the child, at the end of the last day of the last benefit month for which a correct and on-time self-payment was made by or on behalf of the child;
        - The date the child fails to meet the definition of a dependent; or
        - At the end of the last day of the last month of the allowable maximum coverage period to which the child was entitled and for which correct and timely self-payments have been made according to the rules governing benefits for surviving dependents of retirees.

Your employer may have additional or different circumstances in which you and your dependents' benefits are terminated. Please contact your employer or the Benefit Office for more information.

EMPLOYEE & RETIREE LIFE INSURANCE (if applicable)

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

You are only entitled to a life insurance benefit if it is included with your employer's contract with the Plan. Please contact the Benefit Office for more information.

$10,000 in life insurance is provided for active eligible employees. No insurance benefits are provided for dependents. $7,500 in life insurance is provided for eligible retirees.

If you die while eligible for life Insurance, your death benefit will be payable to the person you have named as your beneficiary regardless of the cause of your death. A certified copy of your death certificate must be submitted to the Benefit Office within twelve months after the date of your death in order for your beneficiary to receive the benefit.

Your Beneficiary

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

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

Continuation of Life Insurance During Total Disability

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

1. Your total disability must start before your 60th birthday.
2. You must be totally and completely unable to perform any and all work in any occupation or business for wage, compensation, or profit.
3. Your total disability must last for at least nine (9) months (or up to the date of your death if death occurs within 9 months from the date you become disabled).
4. You must provide the Trustees with acceptable medical proof that your disability has lasted for at least 9 months. The proof must be furnished after you have been disabled for at least 9 months and before your disability has lasted for twelve months. If the Trustees so request, you must agree to be examined periodically (but not more often than is reasonable) by a doctor chosen by the Trustees.
5. Annually thereafter, if requested by the Trustees, you must provide proof that you remain disabled.

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

Conversion Privilege

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

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

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

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (if applicable)

Accidental death and dismemberment (AD&D) insurance is provided for active eligible employees only and is only available if it is included with your employer's contract with the Plan. Please contact the Benefit Office for more information.

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

Amount of AD&D Benefit

The principal sum of your AD&D benefit is $10,000. The total amount payable for all losses resulting from any one accident cannot exceed this amount. If you suffer any combination of the losses on the *Table of Losses* as the result of one accident, only one amount (the largest) is payable for all losses. The amount paid for accidental death is in addition to your life insurance.

TABLE OF LOSSES	
	Amount Payable
Loss of Life	Principal sum* (paid to your beneficiary)
Loss of Limb(s):	
Two hands, two feet, or sight of two eyes	100% of principal sum
One foot and sight of one eye; or one hand and sight of one eye; or one hand and one foot	100% of principal sum
One hand, one foot, or sight of one eye	50% of principal sum
One thumb or index finger	50% of principal sum
Paralysis	
Quadriplegia, paraplegia, hemiplegia or uniplegia	100% of principal sum
Definitions	
Loss of a hand or foot means complete severance through or above the wrist or ankle joint. *Loss of sight* means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.	
Note	
**Two times the principal sum is payable if the loss of life is due to a workplace accidental death.*	

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

AD&D Exclusions and Limitations (Losses Not Covered)

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

1. Bodily or mental illness or disease of any kind.
2. Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound).
3. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane.

4. Participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion.
5. War or an act of war, whether or not declared, or any act related to war or insurrection.
6. Travel or flight as pilot or crew member in any kind of aircraft including, but not limited to a glider, a sea-plane or a hang kite.
7. Intake of any drug, medication or sedative unless prescribed by a doctor, or the intake of any alcohol in combination with any drug medication or sedative.
8. Use of alcohol, non-prescriptive drugs or controlled substances, such as PCP, LSD or any other hallucinogens, cocaine, heroin or any other narcotics, amphetamines or other stimulants, barbiturates or other sedatives or tranquilizers, or any combination of one or more of these substances.
9. Any poison or gas voluntarily taken, administered, absorbed or inhaled.

WEEKLY DISABILITY BENEFITS (if applicable)

Weekly Disability Benefits are designed to help replace lost wages when you are totally disabled and unable to work. You are only entitled to Weekly Disability Benefits if these benefits are included with your employer's contract with the Plan. Please contact the Benefit Office for more information.

No Weekly Disability Benefits are payable for any period of time during which you are able to work or while you are a COBRA continuee. Weekly Disability Benefits are NOT provided for non-bargaining unit employees, retirees or dependents.

Eligibility for Weekly Disability Benefits

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

1. You must be unable to work in the trade as a result of an accidental injury or sickness and be completely unable to perform each and every duty of your occupation or employment;
2. You must be covered under the Plan on the date your disability begins; and
3. You must be continuously under the care of a physician.

You may be required to submit additional medical information to be reviewed by an independent medical provider to verify you are eligible for Weekly Disability Benefits. Contact the Benefit Office for more information.

Amount of Benefit

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

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

Period of Payment / When Benefits Start

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

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

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

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

Benefits will be paid as long as you submit documentation of your continued disability or until 26 weeks of benefits have been paid. You are required to notify the Benefits Office when you return to work.

Successive Periods of Disability

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

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

Exclusions and Limitations

No Weekly Disability Benefits will be paid for:

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

Claims Procedures for Disability Benefits

The following claims procedures apply to Weekly Disability Benefits only, notwithstanding anything in the Plan or this booklet to the contrary.

How do I Submit a Claim for Plan Benefits?

You may file a claim for benefits by submitting a written request for benefits to the Benefit Office. Your written request must include sufficient evidence to enable the Benefit Office to determine whether you have met the Plan's definition of disability. You may be required to submit additional medical information to be reviewed by an independent medical provider to verify you are eligible for Weekly Disability Benefits from the Plan.

Initial Claims

A claim must be resolved, at the initial level, within 45 days of receipt by the Plan. The Plan may, however, extend this decision-making period for an additional 30 days for reasons beyond the control of the Plan. The Plan will notify you of the extension prior to the end of the 45-day period. If, after extending the time period for the first 30-day period, the Plan Administrator determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension period, the Plan may extend decision making for a second 30-day period.

The Plan will provide appropriate notice to you before the end of the first 45 days and again before the end of each succeeding 30-day period and will explain the circumstances requiring the extension and the date the Benefit Office expects to render a decision on your request for Weekly Disability Benefits. It will explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues. You will have 45 days from the date of receipt of the Benefit Office's notice to provide the information required.

What if my Benefits are Denied?

If the Benefit Office determines that all or part of the claim should be denied (an "adverse benefit determination"), it will provide a notice of its decision in written or electronic form explaining your appeal rights. An "adverse benefit determination" also includes a rescission, which is a retroactive cancellation or termination of entitlement to disability benefits. The notice will be provided in a culturally and linguistically appropriate manner and will state:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by you to the Plan of 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 your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
    - A disability determination made by the Social Security Administration regarding the claimant and presented by you to the Plan.
6. If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
7. Either the specific internal rules, guidelines, protocols or other similar criteria relied upon to make a determination, or a statement that such rules, guidelines, protocols or criteria do not exist.
8. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Review of Adverse Benefit Determinations

When you receive a notice of an adverse benefit determination, you may request a review of the decision. The request must be in writing and must be filed within 180 days following receipt of the notice. In the case of an adverse benefit determination regarding a rescission of coverage, you must request a review within 90 days of the notice. You may submit additional information relating to the claim, and if you so request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The review shall take into account all other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will be considered by the Board of Trustees of the Plan and will not afford deference to the initial adverse benefit determination.

If the initial adverse benefit determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees shall consult with a health care professional who was neither involved in or subordinate to the person who made the original benefit determination. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Plan considers, relies upon or creates any new or additional evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to you, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow you time to respond.

You will be notified of the determination on review of the claim no later than 45 days after the Plan's receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, you will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Benefit Office will notify you of the determination on review no later than 90 days after receipt of the request for review.

Notice of Adverse Benefit Determination on Review

The Plan shall provide written or electronic notification to you or your authorized representative in a culturally and linguistically appropriate manner. If the initial adverse benefit determination is upheld on review, the notice will include:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
4. A statement of your right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to your right to bring such an action, a statement to that effect which includes the calendar date on which such limitation expires on the claim.

   If the Plan offers voluntary appeal procedures, a description of those procedures and your right to obtain sufficient information about those procedures upon request to enable you to make an informed decision about whether to submit to such voluntary appeal. These procedures will include a description your right to representation, the process for selecting the decision maker and the circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on you as part of the voluntary appeal. Your decision whether to use the voluntary appeal process will have no effect on your rights to any other Plan benefits.

5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   - The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you;
   - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
   - A disability determination made by the Social Security Administration regarding you and presented by you to the Plan.
6. If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
7. Either the specific internal rules, guidelines, protocols or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols or criteria do not exist.

If it is determined that an overpayment of disability benefits was made to you, the Plan has the right to immediate repayment of those funds as a debt due and owing to the Plan. If you fail to return the disability overpayment funds to the Plan, the Plan has the right to withhold payments on behalf of you and/or your dependents to other providers of benefits through the Plan until the disability overpayment is recouped in full. Any overpayments otherwise received by the Plan from you and/or your dependents relating to other benefits provided by the Plan will

also be applied to your disability overpayment.

MAJOR MEDICAL BENEFITS

Utilization Review Program

Call 1-855-343-4852 for pre-certification.

The phone number to call for pre-certification is also on the back of your I.D. card.

Inpatient Treatment, Durable Medical Equipment and Home Health Care

Anthem/Blue Cross Blue Shield administers the Plan's Utilization Review Program by providing pre-certification and medical management services.

All inpatient treatment requires pre-certification. Durable medical equipment that costs $500 or more and home health care also requires pre-certification.

The hospital or physician will usually make the call for you, but it is your responsibility to see that the call is made. In case of an emergency admission, Anthem should be contacted within 48 hours of the admission.

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

Pre-certification is a requirement for both in-network and out-of-network hospitalization benefits, including inpatient treatment for mental health and/or substance abuse benefits.

Pre-certification is NOT a guarantee of payment.

Services are approved based on medical necessity and appropriateness. Actual payment is dependent upon that person meeting the Plan's eligibility rules and other provisions.

Diagnostic Imaging and Cardiovascular Procedures

You must also obtain pre-certification for all imaging procedures and specialized cardiovascular treatments in order for these benefits to be covered by the Plan. Pre-certification for these services is done by AIM Specialty Health, an affiliate of Anthem. You can access AIM through the same telephone number (1-855-343-4852) used for inpatient pre-certification. AIM will pre-certify services such as computed tomography (CT), magnetic resonance imaging and angiogram (MRI/MRA), positron emission tomography (PET), and myocardial perfusion imaging (MPI), stress echocardiography, transthoracic echocardiography, transesophageal echocardiography, arterial ultrasound, cardiac catheterization and percutaneous coronary intervention (PCI).

Deductibles and Benefit Reductions

Calendar Year Deductibles

- **PPO Deductible -** The first $500 of your in-network (PPO) covered medical expenses are paid out of your own pocket before benefits are payable for your remaining expenses. After two or more persons in your family have had amounts applied to their $500 PPO deductibles that together equal $1,000 for a particular calendar year, your PPO family deductible will have been satisfied for that year, and no further individual PPO deductibles will be required of you or your eligible dependents for the rest of that calendar year. No one family member can meet more than $500 of the PPO family deductible.
- **Non-PPO Deductible -** A separate $500 deductible applies to your out-of-network (non-PPO) covered medical expenses each year. After two or more persons in your family have had amounts applied to their $500 non-PPO deductibles that together equal $1,000 for a particular calendar year, your non-PPO family deductible will have been satisfied for that year, and no further individual non-PPO deductibles will be required of you

or your eligible dependents for the rest of that calendar year. No one family member can meet more than $500 of the non-PPO family deductible.

Amounts applied to your individual and family PPO deductibles do NOT apply to your individual and family non-PPO deductibles, or vice versa.

These deductibles are based on an accumulation period of a calendar year, and you must satisfy new deductibles each year. Only covered medical expenses can be used to satisfy a deductible. Prescription drug co-pays do not apply to Major Medical deductibles. Calendar year deductibles do not apply to office visits with a PPO provider.

Emergency Room Deductible

A $100 deductible applies to each occurrence of hospital emergency room treatment, whether the treatment is for an accident or illness, and whether the hospital is a PPO or non-PPO hospital. Emergency room deductibles apply to the facility fees and the emergency room physician's fees. No deductible will apply if the patient is admitted to the hospital as an inpatient directly from the emergency room.

Benefit Reduction for Failure to Pre-Certify

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

Office Visit Co-Pays

You must pay the first $10 toward the cost of an office visit with a PPO physician. The Plan pays the balance of the covered expenses at 100%. The office visit co-pay only applies to the physician's charge for the office visit. Charges for supplemental services, such as tests, x-rays, injections, etc. are paid under the regular coinsurance provisions (see the following section).

Coinsurance (Plan Payment Percentages)

The Plan pays the following percentages for covered medical expenses after satisfaction of the individual or family calendar year deductible each year:

	Plan Pays:
PPO expenses	90%
Out-of-network (Non-PPO) expenses:	
Emergency room treatment at an *out-of-network hospital* for an emergency medical condition. (If emergency room treatment results in admission to the out-of-network hospital, those charges will be paid by the Plan as traditional out-of-network expenses.)	90%
Professional charges by a radiologist, pathologist or anesthesiologist for services provided at a BCBS PPO hospital	90%
Other out-of-network expenses	70%

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

Out-of-Pocket Limits

- **PPO Out-of-Pocket Limit -** If your annual combined deductibles, co-payments and coinsurance amounts for covered PPO medical expenses total $2,100, the Plan payment percentage will be 100% for the covered PPO expenses you incur during the remainder of the calendar year.

If the combined deductibles, co-payments and coinsurance amounts of two or more of your eligible family members for covered PPO expenses total $4,200 in a calendar year, all covered PPO expenses incurred by your eligible family members will be paid at 100% during the remainder of that year.

- **Non-PPO Out-of-Pocket Limit -** If your annual combined deductibles, co-payments and coinsurance amounts for covered non-PPO medical expenses total $5,100, the Plan payment percentage will be 100% for the covered non-PPO expenses you incur during the remainder of the calendar year.

  If the combined deductibles, co-payments and coinsurance amounts of two or more of your eligible family members for covered non-PPO expenses total $5,100 in a calendar year, all covered non-PPO expenses incurred by your eligible family members will be paid at 100% during the remainder of that year.

Amounts applied to the PPO out-of-pocket limit do NOT apply to the non-PPO out-of-pocket limit, or vice versa.

Only covered medical expenses count toward out-of-pocket limits. Benefit reductions and any charges that are not payable due to the Plan's coverage limitations or exclusions do not apply toward meeting these limits.

Maximum Benefits

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

The Plan's maximums and limitations are shown on the *Schedule of Benefits*.

Covered Medical Expenses

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

1. **Hospital** services and supplies

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

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

Inpatient hospital services require pre-certification.

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

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

3. **Other freestanding medical facilities** - services provided by licensed urgent care centers, immediate care facilities and clinics.
4. **Surgery** by a physician. A surgical assistant's fees will also be covered when medically necessary.
5. **Anesthetics** and their administration by a physician.
6. **Doctors' professional services** rendered either in or out of a hospital for medical care and treatment.
7. **Chiropractic care** in accordance with the following provisions:

a. Covered chiropractic expenses include spinal and joint manipulations and adjustments, including X-rays and other services performed to diagnose or treat the condition for which the manipulations or adjustments are performed.

b. Benefits for chiropractic care are limited to 15 visits per person each calendar year.

8. **Professional services by other covered providers -** professional medical services provided by the following types of licensed providers when the services are within the Plan's normal covered expense provisions and are rendered within the scope of each such individual's license and specialty, and if payment would have been made under this Plan to a doctor for the same services:

   - An advanced practice nurse (a registered nurse) with a Master's or better degree who is licensed to practice in a clinical setting, for example, an N.P., L.N.P., C.N.P, C.N.S., or C.R.N.A.
   - For mental/nervous disorders and substance abuse treatment: a licensed clinical psychologist, a licensed Master's-level clinical social worker, a licensed Master's-level professional counselor, a licensed psychoanalyst, or a clinical specialist psychiatric nurse
   - A physician's assistant (P.A.)
   - A surgical assistant
   - A registered nurse first assistant
   - A licensed midwife (for pregnancy-related services only)
   - A doctor of dentistry (D.D.S.)
   - A podiatrist (D.P.M.)
   - A doctor of optometry (O.D.)
   - Other providers who are specifically stated as covered in the covered expense provisions of this booklet.

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

Diagnostic imaging and cardio procedures require pre-certification.

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

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

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

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

    c. *Cardiovascular rehabilitation therapy* that is rendered through a supervised medical cardiac rehabilitation program prescribed by a physician within six months after an acute cardiovascular incident for a patient with modifiable coronary risk factors or poor exercise tolerance.

The Plan only covers restorative therapy.
Habilitative services (which help a person develop a new skill or ability) are not covered.

12. **Speech therapy** to restore speech abilities lost due to stroke or trauma. Benefits are limited to 35 visits per person per calendar year.

Only rehabilitative speech therapy is covered by the Plan.

Speech therapy for development delays and learning disorders are excluded.

13. **Preventive care -** The Plan covers a wide variety of preventive services and supplies provided by PPO providers. For a complete list of covered preventive services and supplies, please see the Appendix starting on page 88.
14. **Breast reconstructive surgery** on the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.
15. **Dialysis** treatment.
16. **Diabetic treatment -** equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional counseling for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by the physician.
17. **Ambulance -** local service to a hospital in connection with care for a medical emergency or if otherwise medically necessary. The Plan also covers your transfer from one hospital to another, and air ambulance, if medically necessary.
18. **Mental or nervous disorders** treatment as follows:
    a. *Inpatient treatment* - When treatment is rendered as an inpatient at a hospital or covered residential treatment facility, covered expenses include the hospital's daily room and necessary miscellaneous charges.
    b. *Partial inpatient/intensive outpatient treatment* - Treatment provided at a hospital or covered residential treatment facility for at least three hours but less than twelve hours per day.
    c. *Outpatient or office treatment* - Individual treatment is rendered to a patient who is not hospital confined.

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

Inpatient/residential and partial inpatient treatment require pre-certification.

19. **Substance abuse** treatment as follows:
    a. *Inpatient treatment* - When treatment is rendered as an inpatient at a hospital or covered residential treatment facility, covered expenses include the hospital's daily room and necessary miscellaneous charges.
    b. *Partial inpatient/intensive outpatient treatment* - Treatment provided at a hospital or covered residential treatment facility for at least three hours but less than twelve hours per day.
    c. *Outpatient or office treatment* - Individual treatment is rendered to a patient who is not hospital confined.

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

Inpatient/residential and partial inpatient treatment require pre-certification.

20. **Dental treatment**, limited to:
    a. *Treatment of accidental injury to sound natural teeth*, including the initial replacement of such teeth and any necessary dental x-rays, provided the first treatment is received within twelve months of the accident causing the injury.
    b. *General anesthesia* and associated hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following, when medically necessary:
        - A patient who is age 7 or younger;

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

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

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

The Plan covers pregnancy-related expenses for employees and their dependent spouses only.

Note About Length of Maternity Confinements: An eligible female, and her newborn infant, are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarean section. (The attending provider may, however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section.) Benefits are payable for the covered medical expenses incurred by an eligible female during the prescribed time periods, subject to the applicable deductibles, coinsurance and maximum benefits shown on the Schedule of Benefits.

22. **Vasectomies** and other sterilization procedures for employees and dependent spouses.
23. **Certain infertility-related services -** diagnostic testing to determine the cause of a person's infertility, and surgical or medical treatment to treat the underlying medical cause of the infertility. Services to promote conception, including but not limited to the following, are NOT covered: a) hormone therapy; b) artificial intrauterine insemination; or c) the implanting of a fertilized egg, gamete or zygote by any means, including but not limited to in vitro fertilization, gamete intrafallopian transfer or zygote intrafallopian transfer.
24. **Obstructive sleep apnea treatment.** (Treatment of snoring without sleep apnea is not covered.)
25. **Hearing aids,** including their fitting by a licensed professional - one standard hearing aid per ear during the person's lifetime.
26. **Cochlear implants** when medically necessary and appropriate for a person with severe-to-profound sensorineural hearing impairment who can obtain limited benefit from a conventional hearing aid, up to one per person per lifetime.
27. **Organ/tissue/bone marrow transplants** as described in the *Benefits for Transplants* section starting on page 43.
28. **Home health care -** up to 120 visits per calendar year (a visit consists of up to four hours of care) for part-time or intermittent nursing care provided by a home health agency, subject to all the following requirements:

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

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

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

Home health care must be pre-certified.

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

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

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

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

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

e. Nutritional guidance when medically necessary.

f. Administration of prescribed drugs.

g. Oxygen and its administration.

Home health care requires pre-certification.

29. **Inpatient skilled nursing facility care,** including room and board and medically necessary services and supplies for up to 30 days per person per calendar year, subject to all the following requirements:

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

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

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

Skilled nursing facility care requires pre-certification.

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

31. **Durable medical equipment -** rental charge up to the purchase price of the equipment. The equipment must be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the patient's medical condition. The equipment must be ordered by a physician who certifies the medical necessity of the equipment and the length of time it will be required. The Plan may require proof at any time of the continuing medical necessity of any item.

Durable medical equipment costing $500 or more requires pre-certification.

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

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

    a. *Drugs and medicines* which may only be legally dispensed by a registered licensed pharmacist according to a doctor's written prescription which includes the name of the drug, and certain diabetic supplies not requiring a doctor's prescription. Refer to *Prescription Drug Program* on page 45 for more information about obtaining prescription drugs.

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

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

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

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

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

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

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

    c. Physical and occupational therapy and speech language pathology.

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

35. **Orthoptics** (vision training) when medically necessary, up to 20 visits per lifetime.

Benefits for Transplants

All transplants must be performed through the Anthem/BCBSGA transplant program.

Pre-Certification Requirement

All transplant procedures must: 1) be pre-certified by Anthem/BCBSGA for the type of transplant; 2) be medically appropriate per criteria established by the Plan; and 3) be performed through the Anthem human organ program.

Anthem/BCBSGA must be contacted BEFORE the transplant evaluation and/or work-up.

Contact the FMCP Benefits Office for more information on the pre-certification requirement.

Note that approval for HLA testing or donor search services performed by an authorized registry and/or harvest and storage is NOT an approval for the transplant procedure itself. Anthem/BCBSGA must also provide a final determination as to whether the transplant procedure itself meets the coverage criteria.

Covered Transplants

A covered transplant is a medically necessary human organ and stem cell/bone marrow transplant and infusion including necessary acquisition procedures, mobilization, harvest and storage, and including medically necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

Live Donor Charges

Medically necessary charges for the procurement of an organ from a live donor are covered, including complications for up to six weeks from the date of procurement. Unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry are also covered. Donor charges are only covered if the transplant procedure itself is covered. The donor's charges are also not covered if the donor has coverage through another plan or company.

Individual Case Management

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

other similar claims.

PRESCRIPTION DRUG PROGRAM

Sav-Rx administers the Plan's Prescription Drug Program. You can contact Sav-Rx for customer service at 1-866-233-IBEW (4239), or at www.savrx.com. Most of the major pharmacy chains are in the network.

Call 1-866-233-IBEW (4239) for Sav-Rx customer service.

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

You will save money when you use the mail-order pharmacy. You can receive up to a 90-day supply of each prescription or refill, and your medications will be delivered to your home, postage paid.

Additional information about the Prescription Drug Program is sent to all participants when they first become eligible for benefits.

Medicare-Eligible Retirees

If you are a Medicare-eligible retiree or a Medicare-eligible dependent of a retiree and are covered under the UHC Medicare Advantage Plan, UHC will send an additional packet containing UHC prescription drug cards and information about its prescription drug program to all participants when they first become eligible for benefits.

For more information, please contact UHC at 1-800-457-8506.

Your Prescription Drug Co-Pays

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

	You Pay
Generic	0%
Formulary brands	20%
Non-formulary brands	30% $40 minimum (30-day supply) $80 minimum (90-day supply)
Annual out-of-pocket limit	$1,000/person $2,000/family

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

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

Generics Required

If you decline a generic substitution, you must pay the cost difference between the brand and generic.

How the Out-of-Pocket Limit Works

If your co-pay amounts reach the out-of-pocket limit during a calendar year, your brand name co-pay will be $0 for the remainder of that calendar year.

The prescription drug out-of-pocket limit applies separately to each covered family member, and applies to all

covered retail and mail-order drugs purchased through the Prescription Drug Program.

Your cost share amounts for brand name drugs that have generic equivalents do not apply to your out-of-pocket limit and must be paid even after your out-of-pocket limit has been met.

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

90-Day Supply at Walk-In Pharmacies:

In addition to the Sav-Rx mail order pharmacy, you have the option to fill your long-term maintenance prescription drugs for a 90-day supply at most major chain pharmacies and many independent pharmacies. These 90-day supplies will be processed at the same rates as mail-order prescription drug requests. This means that you will pay the same co-pay percentages for these retail prescription drugs as you do for mail-order drugs.

Step Therapy Program

Under a step therapy program, certain medications are grouped into "steps." Generic medications, which are the most cost-effective, fall into the "first-step" category, and brand-name medications fall within the "second-step" category.

This Plan currently has step therapy programs for proton pump inhibitors (PPIs), which are for gastric acid, and statin drugs, which are for high cholesterol. Step therapy requires patients to try first step drugs – usually generics – before more expensive brand name drugs. Brand name PPIs and statins will not be covered unless your medication history shows that you've tried drugs in the first step category, unless you obtain prior authorization from the Sav-Rx clinical team. The following table shows the current first and second step drugs for these categories.

Drug Type	**1st Steps** Generics	**2nd Step** Brands
	No prior authorization	Need prior authorization
Proton pump inhibitors (for gastric acid)	esomeprazole lansoprazole omeprazole pantoprazole rabeprazole	Aciphex Dexilant Nexium Prevacid Prilosec Protonix
Statins (cholesterol-lowering)	atorvastatin fluvastatin fluvastatin ER lovastatin pravastatin rosuvastatin simvastatin simvastatin/ezetimibe	Altoprev ER Crestor Lescol Lescol XL Livalo Lipitor Mevacor Pravachol Vytorin Zocor
Subject to change as new drugs are released.		

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

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

Specialty Drugs

Specialty drugs are medications that are used to treat complex conditions, such as cancer, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. They are often self-injected or administered under profes-

sional supervision and require special handling by the pharmacy.

All specialty drugs require prior authorization and utilization review by Sav-Rx, whether the medication is purchased at a retail pharmacy or through the mail-order pharmacy. Each fill of a specialty drug will be limited to a 30-day supply. If you are prescribed a specialty drug, your physician should first call Sav-Rx at 1-866-233-4239 to request prior authorization.

When Your Spouse Has Other Coverage

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

Covered Prescription Drugs

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

If you are on the UHC Medicare Advantage Plan, please review the information packet provided by UHC about specific covered prescription drugs, exclusions, and limitations or call UHC at 1-800-457-8506.

DENTAL BENEFITS (if applicable)

The Plan's Dental Benefits are provided through **MetLife**. MetLife® handles all dental claims and administers a preferred provider network of dentists that provides negotiated fee discounts to Plan participants. Dental Benefits are not provided for retirees or their dependents. You are only entitled to Dental Benefits if dental coverage is included with your employer's contract with the Plan. Please contact your employer or the Plan for more information.

Your Dental PPO Network

This dental plan gives you access to dentists through the MetLife® Preferred Dentist Program (PDP). Dentists participating in the PDP have agreed to limit their charge for a dental service to MetLife's maximum allowed charge for such service. To find a participating dentist, go to www.metlife.com/mybenefits or call 1-800-942-0854.

Maximum allowed charge means the lesser of: 1) the amount charged by the dentist; or 2) the maximum amount which the in-network dentist has agreed with MetLife to accept as payment in full for the dental service. This means you may be able to reduce your out-of-pocket costs by using an in-network dentist.

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

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

Calendar Year Maximum Benefit

The Plan pays up to a maximum of $1,000 for all the covered dental expenses you incur in a calendar year. (The maximum does not apply to children under age 19.) Once you have received $1,000 for services and supplies performed during a calendar year, you will not be entitled to any further dental benefits for services and supplies obtained during the rest of that year. The maximum applies even if your eligibility is interrupted, or if your status changes – for example, when you retire.

Covered Dental Expenses

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

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

Preventive Care (80%)

1. Routine oral examinations and prophylaxis (scaling and cleaning of teeth, including periodontal maintenance prophylaxis), up to two per calendar year.
2. Emergency palliative treatment.
3. Dental x-rays, including full mouth x-rays (once in a period of 60 consecutive months), supplementary bitewing x-rays (one per calendar year), and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.
4. For dependent children under age 19 *(only)*:

a. Topical application of fluoride once per calendar year.

b. Space maintainers that replace prematurely lost teeth.

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

Basic Restorative Care (80%)

1. Extractions.
2. Oral surgery.
3. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.
4. General anesthetics when medically necessary and administered in connection with oral surgery.
5. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
6. Endodontic treatment, including root canal therapy.
7. Injection of antibiotic drugs by the attending dentist.
8. Repair or cementing of crowns, inlays, onlays, bridgework, implants or dentures, up to one repair per prosthetic every twelve months; or relining or rebasing of dentures.

Major Restorative Care (50%)

1. Inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration.
2. Initial installation of fixed bridgework (including inlays and crowns as abutments).
3. Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation).
4. Replacement of an existing partial or full removable denture, fixed bridgework, an inlay, an onlay or a single crown by a new denture, bridgework, inlay, onlay or crown, or the addition of teeth to an existing partial removable denture, but only if satisfactory evidence is presented that:
   a. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;
   b. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve months from the date of initial installation of the immediate temporary denture; or
   c. The existing denture, bridgework, inlay, onlay or single crown cannot be made serviceable and at least five years have elapsed prior to its replacement. Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, charges for such bridgework will be included as covered dental expenses.
5. Tooth implants, but no more than one per tooth position every five years (60 months).

Orthodontia Benefits (Dependent Children Only)

This benefit covers diagnostic procedures, including cephalometric x-rays and appliance therapy (braces). Benefits are only payable for dependent children under age 19 of active employees.

Covered orthodontia expenses are payable at 50% up to a maximum of $1,000 per child per lifetime. No deductible applies, and orthodontia benefits do not apply to the child's regular annual dental maximum. No benefits are payable for orthodontic therapy that was incurred when the patient was not eligible for orthodontia benefits. The initial treatment is considered incurred on the date the dentist takes the initial x-rays, impressions or other meas-

urements for the purpose of designing a corrective treatment plan. The Plan will not cover treatment (including scheduled monthly payments for treatment already in progress) rendered (or due) after the patient's eligibility for benefits has terminated. Replacement or repair of a lost or broken removable orthodontic device is also excluded.

Dental Exclusions and Limitations

No Dental Benefits are payable for:

1. Treatment by someone other than a dentist, except for: a) scaling or cleaning of teeth and topical application of fluoride by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a dentist; or services performed by a denturist who is licensed as a denturist in the state in which the services are performed.
2. Services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
3. Orthodontia-related services for an employee, retiree, or spouse of an employee or retiree.
4. The replacement of a lost, missing, or stolen removable prosthetic device unless no benefits were paid by this Plan for that prosthetic device.
5. Any duplicate prosthetic device or any other duplicate appliance.
6. Oral hygiene, dietary instruction, or a plaque control program.
7. Tooth re-implantation at the same tooth position unless the prior implant is more than five years (60 months) old.
8. Occlusal adjustments.
9. Splints or appliances (such as night guards) used to control harmful habits.
10. Treatment of conditions related to the temporomandibular jaw joint (TMJ).
11. Treatment incurred when the patient is not eligible for Dental Benefits.
    a. For full or partial dentures, treatment is considered incurred when the impression is taken for the appliances.
    b. Root canal therapy is considered incurred when the tooth is opened.
    c. Fixed bridgework, crowns, and other gold restorations are considered incurred when the tooth is first prepared.

Additional Provisions Governing Dental Benefits

Extension of Dental Benefits

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

1. Fillings, bridgework, crowns or gold restorations, provided the tooth was prepared while the person was eligible for Dental Benefits; or
2. Full or partial dentures, provided the impression for the appliance was taken while the person was eligible for Dental Benefits; or
3. Endodontic treatments, provided the tooth was opened for root canal therapy while the person was eligible for Dental Benefits.

Pre-Determination of Benefits Procedure

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

If you don't request a predetermination, you can just submit your claim after the dental work is done. However, you may be confronted with a large unexpected out-of-pocket cost. A predetermination of benefits does not guarantee payment of dental benefits. Coverage is valid only upon determination of eligibility.

Alternate Courses of Treatment

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

VISION BENEFITS (if applicable)

The Plan's Vision Benefits are provided through a contract with Vision Service Plan (VSP). VSP provides a preferred provider network and claims administration services. Vision Benefits are not provided for retirees or their dependents.

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

You are only entitled to Vision Benefits if vision coverage is included with your employer's contract with the Plan. Please contact your employer or the Plan for more information.

How the VSP Program Works

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

You Can Use a VSP Doctor

VSP has a large network of private practice doctors, and most participants will be able to find a VSP doctor in their area. If you use a VSP doctor, the covered vision services listed in the schedule below are provided at no cost to you. If you select lenses or a frame that costs more than the amount allowed by VSP, you pay an additional discounted charge directly to the VSP doctor.

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

Benefits for VSP Network Vision Care	
Vision exam	Provided in full
Lenses (per pair):	
Single	Provided in full
Lined bifocal	Provided in full
Lined trifocal	Provided in full
Lined lenticular	Provided in full
Contacts (elective)	Provided up to $150 allowance
Frame	Provided up to $180 allowance
Safety Glasses*	Provided up to $65 frame allowance.
** The safety glass benefit is for employees only. One pair is provided per calendar year in addition to regular eyeglasses.*	

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

You Can Use an Out-of-Network Provider

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

Benefits for Out-of-Network Care	
Vision exam	$35
Lenses (per pair):	
Single	$30
Lined bifocal	$40
Lined trifocal	$55
Lined lenticular	$55
Contacts (elective)	$120
Frame	$35
Safety Glasses:*	
Frame	$25
Lenses (per pair):	
Single vision	$30
Bifocal	$35
Trifocal	$45
Lenticular	$60
* *The safety glass benefit is for employees only. One pair is provided per calendar year in addition to regular eyeglasses.*	

Covered Vision Expenses

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

1. One vision examination per calendar year.
2. Either of the following per calendar year:
   a. *One frame* with a pair of corrective lenses; or
   b. *Contact lenses.* The contact lens allowance includes the lens fitting and evaluation fee. As long as your contact lenses contain a prescription, your allowance remains the same for all types of contact lenses ($150 for VSP providers, $120 for out-of-network providers). If the contact lenses, fitting and evaluation fees exceed the allowable amount, you are responsible for the payment of any remaining balance. VSP has guidelines and limitations regarding certain disposable contact lens materials. Please contact VSP at 1-800-877-7195 for more information.
3. *One pair of safety glasses per calendar year for active eligible employees.* VSP doctors will use materials certified as safe for a work environment by meeting the required test standards as set forth by the American National Standards Institute (ANSI).

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

Vision Benefit Limitations and Exclusions

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

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

In addition, Vision Benefits are not payable for any of the following:

1. Examinations or materials more frequently than once every calendar year (except for disposable contact lenses).
2. Vision analysis or examination that does not include refraction.
3. Lenses, frames or contact lenses which are lost or broken except at the normal interval when benefits are available.
4. Two pairs of glasses instead of bifocals.
5. Special procedures such as orthoptics or visual training.
6. Nonprescription lenses or frames that do not include prescription lenses.
7. Services or supplies related to medical or surgical treatment of the eyes.
8. Correction of refractive errors or astigmatism by laser or surgery (this is not payable under ANY Plan benefit).
9. Services or supplies furnished or billed by a person who is not a legally qualified or licensed ophthalmologist, optometrist or optician.

INDIVIDUAL SPECIAL FUND ACCOUNTS (if applicable)

You are only entitled to the Special Fund Account benefit if it is included with your employer's contract with the Plan. Please contact the Benefit Office for more information.

How the Special Fund Program Works

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

Your account can save you substantial amounts of money by allowing you to cover a wide range of expenses with pre-tax dollars rather than after-tax income.

- Contributions to your account and the reimbursements paid from it will not be considered taxable income to you. You should understand that tax law and regulations, as well as interpretations, change from time to time and you should contact your tax advisor concerning the taxation of Special Fund reimbursements.
- Your account balance can be carried forward from year to year – even after you retire.

What Your Account Can Be Used for

You can request reimbursement for the following expenses from your Special Fund Account. The expenses must have been incurred by you or a family member who is covered under the Plan as your dependent on or after the date your coverage under the NECA/IBEW Family Medical Care Plan first became effective.

1. Self-payments for active or retiree coverage
2. Deductibles and co-pays from the regular benefit plan
3. Medical, dental or vision expenses not covered by or in excess of the regular benefit plan
4. Surgery or laser treatments to correct vision
5. Hearing aids and examinations
6. Smoking cessation programs
7. Weight loss programs, but not food or dietary supplements
8. Certain transportation expenses for medical treatment
9. Christian Science practitioners
10. Acupuncture
11. Certain over-the-counter (OTC) products as follows, provided you have a written physician's prescription:

Allowed	Not Allowed
• Allergy medications • Antacids • Anti-diarrhea medicine • Antibiotic ointments • Calamine lotion • Cold medicine • Cough drops and throat lozenges • First aid creams • Motion sickness pills • Nicotine medications and nasal sprays • Pain relievers	• Acne treatments • Cosmetics • Dietary supplements • Fiber supplements • Herbs • Lip balm • Shampoos and soaps • Suntan lotion • Toiletries • Weight loss drugs • Vitamins

Allowed	Not Allowed
• Sinus medications and nasal sprays • Sleep aids • Suppositories/creams for hemorrhoids • Wart removal medication	• Expenses for which you have been reimbursed by some other source

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

Non-Covered Expenses

You cannot receive reimbursement from your account for the following:

1. Cosmetic surgery and treatments
2. Teeth whitening products or services
3. Non-prescription sunglasses
4. Health club memberships or expenses
5. Child and elder care
6. Household help
7. Maternity clothes
8. Non-prescription drugs, medicines and vitamins, unless specifically listed as a Special Fund covered expense
9. Premiums for long-term care insurance
10. Expenses for which you have been reimbursed by some other source
11. Benefit reductions because you failed to pre-certify a hospital admission

How to Use Your Special Fund Account

You will be provided with a prepaid benefits card to use as an easy way to access your Special Fund Account. Your prepaid benefits card will be loaded with the value of your account as it becomes available. You can use your pre-paid benefits card to pay for specified expenses not covered by the Plan, such as co-pays and deductibles. If you incur reimbursable expenses that are not paid with your prepaid benefits card, you must fill out a Special Fund claim form and return it to the Benefit Office along with copies of the bills. The form authorizes the Benefit Office to make a payment from your account.

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

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

You may submit a reimbursement request at any time, but **the minimum amount requested when you submit a paper claim should be $50.** If you accumulate less than $50 in a year, you may request reimbursement at the end of the year. **A reimbursement request will be honored only if it is submitted within two years of the date the expense was incurred.** Reimbursement requests can be submitted by you or your spouse. If you wish to use your account to make a self-payment, please write to the Benefit Office and direct them to subtract it from your account.

Claims for over-the-counter medications must include a copy of the physician's prescription, and store receipts on which the name of the product has been imprinted by the cash register, as well as the date of purchase and amount. Non-imprinted, or hand-annotated cash register receipts will NOT be accepted. It is your responsibility to purchase these products at stores that properly document the name of the product purchased.

In the Event of Your Death

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

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

Forfeiture of Special Fund Account Balance

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

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

If you enter employment in the electrical industry for an employer who is not signatory to an agreement which requires contributions either to this Plan or another IBEW-affiliated health and welfare trust fund, you shall forfeit the entire balance of your Special Fund Account. This provision does not apply to a member who is working as a SALT with the permission of an IBEW Local Union Business Manager pursuant to the provisions of an IBEW Salting Agreement

Qualifications and Limitations

1. You cannot make self-payments into your Special Fund Account. If you make self-payments under the Plan's regular eligibility or COBRA rules, no part of that self-payment will be credited to your Special Fund Account.
2. If you are entitled to the Plan's Special Fund Account through your employer's contract with the Plan, and you maintain a Flexible Spending Account (FSA) that is separate from the Plan, you must seek reimbursement of eligible medical expenses from your FSA first. You can only submit claims for reimbursement from your Special Fund Account once your FSA has been exhausted or if your FSA does not reimburse for those eligible medical expenses.
3. Non-bargaining unit employees may not participate in the Special Fund Account Program.
4. An Individual Special Fund Account is not a savings account from which you can withdraw at will. You are not "vested" in any part of the balance of your Special Fund Account. Any of the provisions of the Special Fund portions of the Plan, like all Plan provisions, may be altered or amended by the Trustees at any time and for any reason. In addition, the list of covered expenses and any of the Special Fund's rules and procedures can be changed at any time by the Board of Trustees. You do not have a present right to payment of any amount of the balance of the Special Fund Account, other than for reimbursement of covered expenses.

EXCLUSIONS AND LIMITATIONS

No payment will be made by this Plan for loss sustained as a result of, or for charges incurred for or as a result of, any of the services, supplies or conditions in the list below.

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

1. Treatments, care, services or supplies that are **not medically necessary** (as defined in the *Definitions* section).
2. Under the Major Medical Benefit, any amount in excess of the **allowable charge**; or with respect to the other benefits provided by the Plan, any charge or portion of a charge that is determined to be in excess of the **reasonable and customary** charge.
3. **Cosmetic treatment or surgery** on the body (including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue), or surgery to correct prior cosmetic surgery. This exclusion applies to breast reductions, reshapings and enhancements.

   Exceptions: This exclusion does not apply to:

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

   b. The correction of congenital defects; or

   c. Breast reconstruction following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance.
4. **Experimental or investigative** treatment, care, services, supplies, procedures or facilities.
5. **Obesity**, morbid obesity, any overweight condition, or any related complications thereof, unless otherwise listed as specifically covered in the Plan.

Obesity (bariatric) surgery is not covered.

6. **Developmental delays,** including charges for development and neuroeducational testing or treatment, hearing therapy, therapy for learning disability, communication delay, perceptual disorders, sensory deficit, developmental disability and related conditions, or for other special therapy not specifically included as a covered expense elsewhere in this booklet, whether or not such disorder is the result of an injury or sickness.
7. **Reversal** of, or attempts to reverse, a previous elective sterilization.
8. **Pregnancy** or a pregnancy-related condition of any person other than a female employee or the spouse of an employee.
9. **Infertility** treatment, including but not limited to hormone therapy, artificial insemination, or any other direct attempt to induce or facilitate fertility or conception. (The Plan does cover the initial diagnostic tests to determine the underlying cause of the infertility.)

Infertility treatment is not covered.

10. **Sex transformations** or transsexual surgery.
11. **Sexual dysfunction** or impotency of any kind, including any complications arising from such conditions or treatments. This exclusion applies to Viagra, Addyi and similar products, and penile implants, regardless of the person's physical or mental condition.
12. **Abortions** except when medically necessary to protect the life of the mother (employee or spouse only).
13. **Premenstrual syndrome** (P.M.S.)

14. **Marriage or family counseling.**
15. **LASIK surgery**, or any other surgical or laser procedures to correct nearsightedness, farsightedness or astigmatism.

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

16. **Over-the-counter drugs** or medicines which are drugs that are not legally required to be dispensed by a registered pharmacist according to the written prescription of a doctor (except that the Plan covers certain non-prescription diabetic supplies).
17. **Nutritional supplements,** food supplements, vitamins (other than prescription prenatal vitamins) or any other items of a like nature, whether or not prescribed by a physician, unless specifically listed as a covered preventive service.
18. **Growth hormone** therapy or any treatment for growth hormone deficiency or short stature.
19. **Snoring**.
20. **Contraceptive devices or medications** when not prescribed or performed by a PPO provider in accordance with Plan provisions.
21. **Excessive sweating**.
22. **Orthoptics** or vision training in excess of 20 sessions per lifetime.
23. **Corns, bunions** (except capsular or related surgery), calluses, toenail removal (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
24. **Travel or transportation**, whether or not recommended by a doctor, unless specifically listed as a covered medical expense.
25. **Physical therapy for chronic pain**.
26. Rehabilitative therapy or any other type of therapy if either the prognosis or history of the person receiving the treatment or therapy does not indicate to the Trustees that there is a **reasonable chance of improvement**.
27. **Organ and tissue transplants or services related to covered transplants that have not been preapproved** by Anthem/BCBSGA or that are not performed through the Anthem/BCBSGA human organ transplant program. Non-covered expenses include but are not limited to: transportation costs, mileage, lodging, child care, prepayments or deposits, services for a condition that is not directly related, or a direct result, of the transplant, telephone calls, laundry, postage, entertainment, travel expenses for donor companion/caregiver, and return visits for the donor for a treatment of a condition found during the evaluation.
28. **Artificial organs**.
29. **Individual or private nursing care** unless specifically listed as a covered medical expense.
30. **Rental or purchase of any durable medical equipment** other than as specifically provided under the Major Medical Benefit, including devices that do not meet the Plan's definition of durable medical equipment. For example, the following items are excluded:
    - Air conditioners, humidifiers, dehumidifiers, or purifiers
    - Arch supports and orthopedic or corrective shoes
    - Heating pads, hot water bottles, home enema equipment, or rubber gloves
    - Deluxe equipment, such as motor driven chairs or beds, when standard equipment is adequate
    - Rental or purchase of equipment if you are in a facility which provides such equipment
    - Electric stair chairs or elevator chairs
    - Physical fitness, exercise, or ultraviolet/tanning equipment
    - Residential structural modification to facilitate the use of equipment
31. **Any of the following items** or items of a similar nature or purpose, regardless of intended use:
    - Blankets, mattresses, pillows or covers for these items, even if orthopedic or hypo-allergenic

- Communication devices
- Continence aids (either anal or urethral)
- Devices or implants to simulate natural body contours
- Emergency alert equipment
- Exercise equipment
- Health club memberships
- Scales
- Sterile water
- Swimming pools
- Thermometers
- Whirlpools, saunas or Jacuzzis
- Wigs

32. **Smoking cessation** except as covered under the Plan's preventive benefits.

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

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

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

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

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

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

39. **Surrogacy or surrogate fees.** This exclusion applies to, but is not limited to, charges in connection with: a) the medical or other expenses of a surrogate who carries and delivers a child on behalf of a person covered under this Plan; or b) a female employee's or dependent's carrying and delivering a child for someone else. Any child born of a covered person acting as a surrogate mother will not be considered a dependent of the surrogate mother or her spouse. This exclusion does not apply to complications of pregnancy incurred by a surrogate who is an eligible employee or eligible dependent under this Plan.

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

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

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

    b. Accidental bodily injury, sickness or disease for which benefits are or may be payable in whole or in part

under any workers' compensation act or any occupational diseases act or any similar law.

42. **Education,** training or room and board while a person is confined in an institution which is primarily a school or institution of learning or training.
43. **Special education**, regardless of the type or purpose of the education, the recommendation of the attending doctor or the qualifications of the individual providing the education. This applies to special education or instruction for a learning disabled or handicapped child. (This exclusion does not apply to diabetic education for a person diagnosed with diabetes mellitus.)
44. **Custodial care**, which is care designed primarily to assist an individual in meeting the activities of daily living. This exclusion applies to all such care regardless of what the care is called (unless the care is provided to a person under an approved hospice care program).
45. Care or treatment rendered to you or a dependent which is provided by a person who is **a relative in any way to you** or to the dependent receiving the care or who ordinarily lives in your home or in the home of the dependent receiving the care.
46. Services or supplies provided while a person is confined in an institution which is primarily a **place of rest**, a place for the aged, or a nursing home (unless provided during an approved confinement in a facility that meets the definition of a skilled nursing facility).
47. Treatment, care, services, supplies or procedures provided while a person is confined in a hospital operated by the **U.S. Government** or its agencies, provided, however, that if charges are made by a Veterans Administration (V.A.) hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service-related disability, to the extent required by law such charges will be considered covered medical expenses to the extent that they would have been considered covered medical expenses had the V.A. not been involved.
48. Charges incurred by an eligible family member which you or the family member are **not legally required to pay**. This includes any portion of a provider's fee or charge which is ordinarily due from the patient but which has been waived. If a provider routinely waives (does not require the participant to pay) a deductible or an out-of-pocket amount, the claims administrator will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
49. The **replacement of a lost, missing, or stolen device** unless no benefits were paid by this Plan for the original item.
50. Completing of **claim forms** (or any forms required by the Plan for the processing of claims) by a doctor or other provider of medical services or supplies.
51. Bodily injury, disease or sickness caused by any act of **war,** whether war is declared or undeclared, any act of international armed conflict or any conflict involving the armed forces of any international body, or insurrection.
52. Services or supplies furnished, paid for or otherwise provided due to past or present service of any person in the **armed forces** of a government.
53. Treatments, care, services or supplies which are **not recommended, ordered or approved by the attending doctor**.
54. Unless specifically stated otherwise, any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection with, a **specific sickness,** illness or accidental bodily injury.
55. Any care or treatment of a person once the person has already received Plan benefits totaling the **maximum benefit** for that type of care and treatment as specified on the Schedule of Benefits.
56. Injury or sickness for which you or an eligible dependent, whether or not a minor, have a right to recover payment from a **third party**, except to the extent provided in the Plan's subrogation rules.
57. Injury or sickness resulting from or **occurring during a crime** committed by the patient.

58. Services or supplies provided to a **person who is not covered under the Plan**.
59. Charges which would not have been made **if this Plan did not exist**.
60. Services or supplies required by an employer as a **condition of employment,** or which an employer is required to provide under a labor agreement, or which are required by law.
61. Services, treatment or supplies which were ordered **before the person's effective date of coverage or** which are performed or provided **after the date a person's eligibility terminates.**
62. **Habilitative services**, which generally help you keep, learn, or improve skills and functioning for daily living, such as speech, physical, occupational, and cardiovascular therapies.

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

CLAIMS PROCEDURES

How to File Claims

Medical Claims

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

All BCBS PPO providers and most non-PPO providers will file your claims for you.

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

If you need to submit a claim yourself, send it to your local BCBS plan.
You can get the address of your local BCBS plan by going to www.anthem.com.

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

You may be required to complete claim forms in certain situations, including claims for injuries. Claim forms will also be available on www.nifmcp.com.

UHC Medicare Advantage Plan

If you are covered under the UHC Medicare Advantage Plan, your claims are filed though UHC. If you need to submit a claim yourself or have any questions, please contact UHC at 1-800-457-8506.

Prescription Drugs

There are no claims to file when you use the Plan's Prescription Drug Program (unless another group plan is the primary payor for the person's claims). You pay your co-pay shares directly to the participating retail or mail-order pharmacy. ***Co-pays are your responsibility. Do not submit claims for co-pays.***

Dental Claims (if applicable)

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

MetLife® Dental Claims
PO Box 981282
El Paso, TX 79998-1282

Be sure to include your Social Security number and your group account number (304133). You will receive your benefit payment explanations directly from MetLife and any questions you have about your claim should be directed to MetLife.

Vision Claims (if applicable)

Vision Service Plan (VSP) handles claims for vision care. You do not have to file a claim when you use a VSP doctor. When you use an out-of-network provider:

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

Send the itemized paid bill, along with the benefit form, to VSP at the address shown below. Please do not send vision bills to the Benefit Office. Vision claims should be filed within six months after the services or supplies are received.

Send out-of-network vision claims to:

Vision Service Plan
PO Box 385018
Birmingham, AL 35238-5018

Other Claims (if applicable)

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

NECA/IBEW Family Medical Care Plan
410 Chickamauga Avenue, Suite 301
Rossville, GA 30741

Claim Procedures

In order for the Plan to pay benefits, a claim must be filed with the Benefit Office in accordance with the procedures described below. A claim can be filed by you, your eligible dependent or by someone authorized to act on behalf of you or your eligible dependent.

1. A claim is considered to have been filed on the date it is received at the correct claims office, even if the claim is incomplete. Claims are received during regular business hours, Monday through Friday.
2. A "claim" is a request for Plan benefits, normally because the claimant has incurred a healthcare expense.

   A request for confirmation of Plan coverage is not a claim if you have not yet incurred the expense unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy.
3. **Claims must be filed within twelve (12) months from the date of service**.
4. You may designate another person as your authorized representative for purposes of filing a claim. Except in the case of an urgent care claim, such designations must be in writing. You and/or your representative can review materials in the Fund's files that are related to your claim and can submit written issues and comments to support your request for review. You and/or your representative may also make a written request for a personal appearance before the Trustees.
   - Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you.
   - A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as your authorized representative.
   - Designation of a person as an authorized representative does not grant that person the rights of a beneficiary under this Plan.

- Permission for you to utilize a representative does not provide the representative (particularly a health care provider) with an independent right to payment of benefits in the representative's name, to file or proceed with a review of a claim for benefits in the representative's name, or to obtain any rights as a "participant" or "beneficiary" under the Plan.
- Any appeal can only be brought in the name of yourself or your dependent who are the only entities permitted to be a "participant" or "beneficiary" under this Plan.

Initial Claims Processing Time Periods

The amount of time the Plan can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

1. A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested. Most claims are post-service claims.
2. A "disability claim" is a claim for Weekly Disability Benefits, including a retroactive termination of those benefits.
3. A "pre-service claim" is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining the care.
4. An "urgent care claim" is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function, or that could subject you to severe pain that cannot be adequately managed without the proposed treatment.
5. A "concurrent care claim" is also a type of pre-service claim. A claim is a concurrent care claim if a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved.

If all the information needed to process your claim is provided to the Benefit Office, your claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are as follows:

- Post-service claims – 30 days
- Disability claims – 45 days
- Pre-service claims – 15 days
- Urgent care claims – As soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim
- Concurrent care claims – 24 hours if the concurrent care is urgent and if the request for the extension is made within 24 hours prior to the end of the already authorized treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

When Additional Information Is Needed (Claimant Extension)

If additional information is needed from you, your doctor or the provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the normal time limits shown below, except that the additional information needed to decide an urgent care claim will be requested within 24 hours.

It is your responsibility to see that the missing information is provided to the Benefit Office. The normal processing period will be extended by the time it takes you to provide the information, and the time period will start to run once the Benefit Office has received a response to its request. If you do not provide the missing information within 45 days (48 hours for an urgent care claim), the Benefit Office will make a decision on your claim without it, and your claim could be denied as a result.

Plan Extension

The time periods above may be extended if the Benefit Office determines that an extension is necessary due to matters beyond its control (but not including situations where it needs to request additional information from you or the provider). You will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

- Post-service claims – 15 days
- Disability claims – 30 days (a second 30-day extension may be needed in special circumstances)
- Pre-service claims – 15 days

What if My Initial Claim Is Denied?

If all or a part of your claim is denied (including a rescission of coverage, which is a retroactive cancellation or termination of entitlement to benefits) after the Benefit Office has received all other necessary information from you, you will be sent a written notice giving you the reasons for the adverse benefit determination (denial). The notice will include sufficient information to identify the claim involved, including date of service, health care provider, and claim amount (if applicable) as well as the specific reason for the denial and reference to the Plan provisions on which the denial was based. The notice will also include the denial code and its meaning. It will include an explanation of the claim appeal procedure. If applicable, it will give a description of any additional material or information necessary for you to perfect the claim and the reason such information is necessary. The notice will provide a description of the appeal procedures and the applicable time limits for following the procedures. It will also include a statement concerning your right to bring a civil action under section 502(a) of ERISA. In cases where the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the notice will state that the specific internal rule, guideline, protocol or criterion will be provided to you free of charge upon request. If the decision was based on medical necessity or if the treatment was deemed experimental, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. For urgent claims, a description of the Plan's expedited review process will be provided. The notice will be provided in a culturally and linguistically appropriate manner and, if applicable, the denial will also include a statement indicating how to access language services provided by the Plan.

Internal Appeal Procedures – Review of Adverse Benefit Determination

Pre-Service Claims

If Anthem's clinical review department denies pre-certification for your prospective (pre-service) medical claim, in whole or in part, you can request a review by:

- Faxing your written appeal to 1-888-859-3046;
- Mailing your written appeal to:

  Anthem Blue Cross and Blue Shield
  Grievances and Appeals
  PO Box 105568
  Atlanta, GA 30348; or

- Calling or writing Anthem at the customer service number on your I.D. card; or
- Using the secure online website: www.anthem.com (individual login required).

Your provider can also appeal your pre-certification denial via the Anthem provider portal.

You have up to 180 days to file an appeal with Anthem, and Anthem's review should take no more than 30 days from the date your request is received. If Anthem denies your appeal, you may file a second level appeal to the FMCP Trustees (see *Internal Appeals* below). You have 60 days to file a second level appeal.

Urgent Care and Concurrent Care Medical Claims

You can request an expedited review of an urgent care or concurrent care claim by calling the customer service number on your I.D. card or faxing your request to 1-855-298-4264. Decisions are made on expedited appeals within 72 hours of receiving the request. You may ask for an expedited external review by an independent review organization at the same time as filing an expedited appeal with Anthem. You may not request an expedited appeal after the services have been rendered.

You may be notified of the decision of an appeal on a denied urgent care claim by telephone or facsimile.

All Other Medical and Vision Claims

If your medical or vision claim is denied in whole or in part, you can request a review by the Board of Trustees. Trustee appeals must be filed **within 180 days** of your receipt of the denial. (Pre-service medical claims should first be appealed to Anthem Blue Cross as explained above. If that appeal is unsuccessful, you may then appeal to the Trustees.) You can request a Trustee appeal by sending a letter, along with any additional information that you think will help a favorable decision to be made on your claim, to:

Board of Trustees
2400 Research Boulevard, Suite 500
Rockville, MD 20850

The Trustees will conduct a full and fair review of all the material submitted with your claim, the action taken by the Benefit Office, the additional information you have provided, and the reasons you believe the claim should be paid. The review will:

- Be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination nor the subordinate of such party;
- Not afford deference to the initial adverse benefit determination; and
- Take into account all comments, documents, records and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.

Additional Procedures Applicable to Internal Appeals

1. You have the right, upon request and free of charge, to receive copies of all documents, records and other information relevant to your claim for benefits.
2. If the Plan or Board of Trustees relies upon or generates new or additional evidence or rationale in connection with your appeal, the evidence will be provided to you as soon as possible and sufficiently in advance of the date on which the appeal shall be reviewed by the Trustees to give you an opportunity to address the new evidence.
3. Your claim review will be conducted by an individual who is neither the party who made the initial denial, nor the subordinate of such party. It will not afford deference to the initial determination, and will take into account all comments, documents, records and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.
4. With respect to a review of any determination based on a medical judgment, a health care professional with appropriate training and experience in the applicable field of medicine will be consulted. Such health care provider will be “independent,” which means the person consulted will be an individual different from, and not subordinate to, any individual who was consulted in connection with the initial decision.
5. If you submit your request for an appeal in a timely manner, and if you provide all the additional information necessary for a review of the original denial, you will be notified of the decision following review within the following time periods:
   - Urgent care claims – As soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of your request for review.
   - Pre-service claims – No later than 15 days per level of review.

- Post-service and disability claims – No later than 5 calendar days following the date of the Trustees meeting that immediately follows the Plan's receipt of a request for review, unless the request is filed within 30 days preceding the date of such meeting. In such case, a determination may be made by no later than the date of the second meeting. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a determination will be rendered not later than the third meeting of the Trustees. Before the start of the extension, you will be notified in writing of the extension, and that notice will include a description of the special circumstances and the date as of which the determination will be made.

6. All written appeal decisions will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based, including sufficient information to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; a statement of the claimant's right to bring an action under section 502(a) of ERISA; and a statement on the availability of a Consumer Assistance Program that can help you file an appeal or request a review of Plan's decision. If applicable, you will also be informed of the specific internal rule, guideline, protocol or similar criterion relied on to make the decision and your right to a copy, free of charge, upon request. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request. If applicable, the notice will also include a statement that language assistance programs may be available upon request by you.
7. If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, you may go to court to enforce your rights.

For more information on the handling of disability claims, see *Claims Procedures for Disability Benefits* starting on page 32.

External Review

If the review process described above still results in a denial of coverage or adverse benefit determination, you may, in certain cases, request an additional review by an Independent Review Organization (IRO). An independent external review is available for claims denied based on clinical or scientific judgments, such as decisions based on medical necessity, or for rescission of coverage (retroactive terminations of coverage). It does not apply to claim denials related to a person's eligibility for coverage or exclusion terms in the Plan.

You must apply for the external review within four months after the date of receipt of the written appeal decision you received from the Fund. To request an external review, call or write the Benefit Office. Benefit Office staff will provide you with the information you need to file your formal request for an external review and provide you with the information you need to complete the process. The Plan will determine within five days whether the request is eligible for an external review and will notify you within one business day after the review is complete.

The external review will be completed by an independent review organization ("IRO") that is accredited by URAC or a similar national organization to conduct the external review. The IRO will review the claim *de novo*, meaning it will not be bound by the previous decision of the Plan. However, the IRO will review the terms of the Plan so that its decision on your external review request is not contrary to the Plan. The IRO will make a final decision on your external review request within 45 days, and if the IRO reverses the Plan's benefit determination, then the Plan will immediately provide coverage or payment for the claim.

You may apply for an expedited external review if the claim involves a medical condition for which the regular timeframe for completion of an appeal would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not been discharged from a facility. The Plan will immediately determine

whether the request is eligible for an external review and assign it to an IRO, who will make a determination within 72 hours.

To request an external review, call or write the Benefit Office. Benefit Office staff will provide you with the information you need to complete the process.

Dental Claims

The Trustees have delegated MetLife® to be the final decision-maker with respect to dental claim reviews.

If MetLife denies all or part of your dental claim, you can request a review within 180 days of your receipt of the denial notice by sending a letter, along with any additional information that you think will help a favorable decision to be made on your claim, to:

MetLife Group Claims Review
PO Box 14589
Lexington, KY 40512

Your letter should refer to group account number 304133.

MetLife will conduct a full and fair review of all the material submitted with your claim, the prior action taken on the claim, the additional information you have provided, and the reasons you believe the claim should be paid. The review will be conducted by someone other than the person who made the initial decision.

Note that if your dental claim is denied due to your or your dependent's overall eligibility for benefits, you should appeal to the Board of Trustees, not MetLife. Follow the procedures described in *All Other Medical and Vision Claims* above.

Life/AD&D Insurance Claims

Life/AD&D insurance claims should be filed with the Benefit Office who will forward them to Union Labor Life Insurance Company, the insurer of these benefits. Since the Fund is the holder of the insurance contract, notices from Union Labor Life may be issued to the Fund instead of you.

Union Labor Life will normally issue an approval or denial of a life/AD&D claim within 90 days of the date it receives the claim. An extension of 90 days will be allowed if special circumstances are involved. The Benefit Office will notify you in writing of any extension the insurer requires to review your claim, and the notice will state the special circumstances involved and the date by which it expects to reach a decision.

If Union Labor Life denies your claim, the Benefit Office will issue you a notice written in an understandable manner explaining the reasons for the denial. The notice will also include an explanation of the claim appeal procedures.

Review of claim denials and final decisions on appeal are Union Labor Life's responsibility.

GENERAL PROVISIONS AND INFORMATION

Definitions

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

Ambulatory Surgical Center - A free-standing facility which is established, equipped and operated primarily for the purpose of performing surgical procedures. The Plan does not cover services by out-of-network ambulatory surgical centers except when Medicare is primary and covers that facility.

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

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

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

Chiropractic Care - Any service for spinal and joint manipulations and adjustments, including x-rays and other services performed to diagnose or treat the condition for which the manipulations or adjustments are performed.

Claims Administrator - The organization designated by the Trustees for handling claims. The Benefit Office is the claims administrator for medical claims and Special Fund claims (excluding prescription drugs). The dental claims administrator is MetLife Dental. Vision Service Plan (VSP) is the vision claims administrator. Sav-Rx is the claims administrator for prescription drug claims.

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

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

Cosmetic - Treatment or surgery to improve or preserve physical appearance. The fact that the patient may suffer psychological or behavioral consequences absent the treatment or procedure does not make it non-cosmetic or covered by the Plan.

Covered; Covered Under the Plan - A term used to indicate that a person is eligible to receive the benefits from this Fund which apply to his or her status as an employee, a retiree or a dependent under the Plan 17 Schedule of Benefits.

Dependent - For the purposes of the following definition, "your" means an eligible employee or eligible retiree. A dependent is one of the following:

1. Your legal spouse (from whom you are not divorced).
2. Your child who is less than 26 years old. (Your child will remain eligible through the end of the calendar month in which his or her 26th birthday occurs.)
3. Your unmarried child who is age 26 or older and who is permanently and totally disabled because of mental retardation, mental incapacity or physical disability as certified by a doctor. The child must have become disabled before becoming age 26; must remain disabled and be incapable of self-sustaining employment and be dependent upon you for the major portion of his/her financial support and maintenance, and specifically

not provide more than 50% of his/her own support during any calendar year. Within 31 days after the child's 26th birthday, you must furnish, at your own expense, initial proof of the child's disability and that he or she became disabled before he/she became age 26. Subsequent proof of the child's continued disability may be required by the Trustees, but not more often than once a year.

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

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

1. A child born of a valid marriage of yours, including a child legally adopted by you or placed in your home for adoption.
2. A child not born of a valid marriage of yours, of whom you have been determined to be the legal parent. Legal guardianship must be finalized and signed by a court of competent jurisdiction prior to the child's 18th birthday.
3. A stepchild of yours, meaning any child of your spouse who was born to your spouse or who was legally adopted by your spouse before your marriage to him or her.
4. A foster child, meaning an individual who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
5. A child who is determined to be an "alternate recipient" under the terms of a court order which the Trustees determine to be a Qualified Medical Child Support Order (QMCSO). The Trustees, in consultation with the Fund legal counsel, have adopted procedures for determining whether a particular court order qualifies as a QMCSO. If you would like a copy of the Plan's QMCSO procedures, please call or write the Benefit Office. If you are a responsible party in a court action involving a child, you should request a copy of the Plan's procedures BEFORE the final order is entered.

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

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

Durable Medical Equipment - Equipment that: 1) can withstand repeated use; 2) is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; 3) is not disposable or non-durable; 4) is used solely for therapeutic treatment of the patient's physical disorder; 5) is manufactured solely to serve a medical purpose; 6) is appropriate for in-home use.

Eligible Dependent - An individual who meets Plan's definition of a dependent and who is eligible to receive the Plan 17 benefits provided for dependents.

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

Eligible Family Member - You (the eligible employee or eligible retiree) and any person in your family or household who meets the definition of a dependent.

Eligible Retiree - A retired employee who has met the eligibility requirements established by the Trustees and who is entitled to receive the benefits provided for Plan 17 retirees.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part.

Employee - An "employee" is any of the following: 1) any person covered by a collective bargaining agreement between an employer and a Union who is engaged in employment with respect to which the employer is obligated to make contributions to the Fund; 2) any person employed by an employer who has a written agreement with

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

Employer - An "employer" is a person, firm, association, partnership or corporation that: 1) is bound by a collective bargaining agreement or other written agreement with a Union or the Trustees, or has a collective bargaining relationship with a Union or the Trustees that requires payment of contributions to the Fund on behalf of its eligible employees; 2) is a Union or local Association chapter that has agreed to make contributions to the Fund on behalf of its eligible employees; or 3) is the Board of Trustees, or the board of trustees of any jointly sponsored trust fund between a Union and a local Association chapter, who has agreed to make contributions to the Fund on behalf of its eligible employees.

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

1. It is not yet generally accepted among experts as accepted medical practice for the patient's medical condition.

1. It cannot be lawfully marketed or furnished without the approval of the U. S. Food and Drug Administration or other federal agency for the member's particular diagnosis, disease, illness or condition, and such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized.

2. It is the subject of ongoing Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses, or if the prevailing opinion among experts regarding any such treatment, procedure, facility, equipment, drug, device or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses.

Provided an individual's participation in a Phase I, Phase II, Phase III or Phase IV clinical trial is for the prevention, detection or treatment of cancer or other life-threatening condition or disease that is covered by the Plan, *Experimental or Investigative* does not include "routine patient costs" related to an individual's participation in a Phase I, II, III or IV clinical trial, such as items and services that are otherwise covered by the Plan. "Routine patient costs" do not include: 1) the investigational item, device or service itself that is the subject of the clinical trial; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

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

Fund - The NECA/IBEW Family Medical Care Trust Fund.

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

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

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

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

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

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

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

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

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

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

Physician; Doctor - A legally qualified doctor or surgeon who is a Doctor of Medicine (M.D.) a Doctor of Osteopathy (D.O.), or a Doctor of Chiropractic (D.C.), provided that any such individual renders treatment only within the scope of his or her license and specialty**.**

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

Plan 17 - The health and welfare benefits described in this booklet which are provided to Plan 17 participants based on the terms of the collective bargaining agreement under which contributions are paid to the Fund.

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

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

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

Residential Treatment Facility - An institution that is engaged primarily in providing mental health and substance abuse treatment on an inpatient basis and that meets the requirements set forth in 1 or 2 below, provided, however, that it is not a group home, halfway house, wilderness program or camp:

1. It is a facility in the Plan's PPO network; or
2. It is considered a duly-accredited psychiatric residential treatment facility by the Centers for Medicare and Medicaid Services (CMS). This means it is accredited by The Joint Commission, CARF International or another CMS-approved agency.

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

Skilled Nursing Facility - An institution, or a distinct part of an institution, which complies with all licensing and other legal requirements and which, to be approved for the purposes of this Plan, meets all of the following criteria: 1) it is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services for patients who are convalescing from injury or sickness and who require medical or nursing care to assist the patients to reach a degree of body functioning to permit self-care in essential daily living activities; 2) it provides 24-hour-per-day supervision by one or more doctors or one or more R.N.s responsible for the care of its inpatients, it provides 24-hour-per-day nursing services by licensed nurses under the supervision of an R.N., and it has an R.N. on duty at least eight hours a day; 3) every patient is under the supervision of a doctor, and it has available at all times the services of a doctor who is a staff member of a general hospital; 4) it maintains daily medical records on all patients, and it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; 5) it has a utilization review plan; 6) it has a transfer agreement with one or more hospitals; 7) it is eligible to participate under Medicare; and 8) it is not, other than incidentally, an institution which is a place for rest, for custodial care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or a similar institution.

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

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

Totally Disabled; Total Disability

1. An employee will be considered totally disabled if he or she is completely prevented from engaging in any occupation or employment for compensation, wages or profit solely as the result of accidental bodily injury or sickness.
2. A retiree or dependent is considered totally disabled if he/she is prevented from engaging in substantially all of the normal activities of a person of like age or sex in good health as a result of non-occupational accidental bodily injury or sickness.

If a person receives an award of disability benefits from the Social Security Administration, that person is auto-

matically considered to have met the definition of "totally disabled."

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

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

Subrogation

In the event the Fund pays or is obligated to pay benefits on behalf of a participant or his or her dependents for illness or injury to the participant or dependents and the participant or dependents have the right to recover the amounts of such benefits from any other person, corporation, insurance carrier or governmental agency, including uninsured or underinsured insurance coverage, or any other first-party or third-party contract or claim, the Fund shall be subrogated to all of the participant's or dependents' right of recovery against such person, corporation, insurance carrier, governmental agency or uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, to the full extent of payments made by the Fund.

The participant or his or her dependents or the participant acting on behalf of a minor dependent shall execute and deliver such documents and papers (including but not limited to an assignment of the claim against the other party or parties, assignment to the minor child of any parental claim to recover medical expenses of the minor child, and/or a Subrogation Agreement) to the Fund as the Fund may require. The participant or dependents shall do whatever else is necessary to secure the rights of the Fund including allowing the intervention by the Fund or the joinder of the Fund in any claim or action against the responsible party or parties or any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim. The participant or dependents may not release or discharge any claim or responsible party, effect any settlement, nor dismiss any legal action against another source who may be responsible for paying damages or providing compensation, nor will such person effect satisfaction of any judgment resulting from any legal action without first notifying the Fund's legal Co-Counsel and tendering to the Fund's attorneys the full amount of reimbursement due to the Fund.

If the participant or dependents do not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated, the Fund shall, if in the Fund's best interest and at its sole discretion, be entitled to institute legal action or claim against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all amounts paid to the participant or dependents or paid on their behalf.

In the event of any recovery by judgment or settlement against the responsible party or parties or by payment by any uninsured or under-insured insurance coverage or any other first-party or third-party contract or claim, the Fund's attorneys' fees expended in the collection of the subrogation lien, if any, shall first be deducted. The Fund's subrogation interest, to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, shall next be deducted. The remainder or balance of any recovery shall then be paid to the participant or dependents and their attorneys if applicable.

In the event of any failure or refusal by the participant or dependents to execute any document requested by the Fund or to take other action requested by the Fund to protect the interests of the Fund, the Fund may withhold payment of benefits or deduct the amount of any payments from future claims of the participants or dependents. After making a claim for benefits from the Fund, the participant or dependents shall take no action which might or could prejudice the rights of the Fund.

In the event the participant or dependents recover any amount by settlement or judgment from or against another party or by payment from any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, the Fund will request repayment of the full amount of benefits paid by the Fund. If the participant and/or dependents refuses or fails to repay such amount, then, in that event, the Fund shall be entitled to recover such amounts from the participant and/or dependents by instituting legal action against the participant and/or dependents and/or by deducting such amounts as may be due on future claims submitted by the

participant and dependents. Once a settlement or judgment is reached on the claim additional bills cannot be submitted with respect to the same injury.

The participant or dependent shall be required to pay their own legal fees and costs and to hire only attorneys who agree to waive the common fund doctrine and to remit the gross rather than the net proceeds from litigation. The Fund shall have a lien on any and all recoveries received by the participant or dependent from any responsible party, enforceable as a provision of this Fund, either before or after an adjudication of liens, for the full amount of benefits paid by the Fund. In the event a court awards the Fund less than the full amount of benefits, through an "adjudication of liens" or otherwise, the specific proceeds received by the participant or dependent shall be subject to a "constructive trust" or "equitable lien" in favor of the Fund in the amount of the difference between the full amount of benefits paid by the Fund and the amount paid the Fund pursuant to the court's award and this Plan provision establishing a "constructive trust" or "equitable lien" may be enforced through any available equitable remedy to ensure that the proceeds subject to the "constructive trust" or "equitable lien" are turned over to the Fund.

While not affecting the Fund's right to receive the full amount of benefits paid, the Fund may elect, in an appropriate case to pay a portion of the participant's or dependent's attorney's fees in exchange for the waiver of the terms of the common fund doctrine by the involved attorney and the participant or dependent. The Fund shall pay no legal costs or fees without receiving a recovery and then only within the terms of this provision. In the event that an attorney is hired by or on behalf of the participant or dependent and the Fund is given notice and an opportunity to pursue its own subrogation recovery, the Fund shall not be required to hire an attorney. If the attorney representing the participant or dependent nevertheless wishes to proceed and creates a common fund in which subrogated amounts are paid, the Fund may agree to pay up to 10% to include legal fees, provided that the participant or dependent and the attorney waive any other payment or agreement to reduce recovery from the Fund including, but not limited to, any rights under the common fund doctrine. Said 10% shall also include any prorated portion of the cost of recovery. If the attorney representing the participant or dependent receives either a payment or an agreement to reduce recovery from the Fund (whether in the form of cash payment or reduction of the Fund's right to the full amount of benefits paid by the Fund), the attorney and the participant or dependent will be considered to have waived the common fund doctrine.

The Fund's right of subrogation is from the first dollar received by the participant or dependent and takes effect before the whole debt is paid to the participant or dependent.

If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage (or should have been covered because of state law), including, but not limited to, no-fault or similar legislation, no-fault, no-fault-type, uninsured motorist, underinsured motorist or personal injury protection to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second, regardless of whether those laws or insurance policies preclude payment of medical benefits.

If motor vehicle coverage is required by state law but has lapsed or was not obtained by the eligible individual, this Plan would provide benefits less the amounts that would/should have been paid by the motor vehicle coverage had the eligible individual been covered by motor vehicle coverage.

If you want more information about subrogation, contact the Benefit Office.

Coordination of Benefits (COB)

The Coordination of Benefits provision is referred to as COB.

Benefits are coordinated when both you and your spouse (and/or your dependent children) are eligible for benefits from this Plan and another group health plan (usually your spouse's plan). Coordination allows benefits to be paid by two or more plans up to but not to exceed 100% of the allowable expenses on the claim.

This Plan has a separate but related rule, called the *Working Spouse Rule* (see page 4) that requires spouses to enroll in their employers' health plans. If a spouse fails to enroll in his/her employer's plan, this Plan will only pay 20% of the covered medical and prescription drug expenses he or she incurs. If your spouse does enroll in his or

her employer's plan, the COB rules described below govern the order and manner in which the two plans will pay their benefits.

General COB Rules

1. Benefits are coordinated on all employee, retiree and dependent claims. COB applies only to medical, prescription drug and dental benefits.
2. Benefits are coordinated with other group plans and Medicare. If you are covered under a personal individual plan for which you pay the full premiums, this Plan will not coordinate with that plan but will pay its normal benefits. Benefits are also not coordinated with Medicaid or, in most cases, TriCare (the health care program provided by the U.S. armed service).
3. You must file a claim for any benefits you are entitled to from any other source. Whether or not you file a claim with these other sources, the benefits payable by this Plan will be calculated as though you have received any benefits you are entitled to from the other source(s).
4. Benefits are coordinated based on "allowable expenses," which are expenses that are eligible to be considered for reimbursement.
5. If a person is covered by two or more plans that provide benefits on the basis of negotiated fees, any amount in excess of the primary plan's negotiated fees is not an allowable expense (unless the provider's contract with this Plan's PPO has a provision to the contrary).
6. A plan that pays "primary" benefits is the plan that is required to pay its benefits first. The plan that pays "secondary" benefits is the plan that pays its benefits after the other plan has paid its benefits.
7. This Plan will not pay benefits for expenses which would have been covered by another plan but which are either not paid or are subject to a reduction in benefits because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim on time or failure to provide missing information requested by the other plan.
8. If you and your spouse are both covered as employees under this Plan and one of you (or child who is a covered dependent of both of you) has a claim, the Plan will coordinate benefits on the claim (two claims must be submitted – one by you and one by your spouse).

Order of Benefit Payments

If all the plans providing benefits for the claim have a C.O.B. provision, benefits will be determined based on the first of the following rules that applies:

1. *Non-dependent or dependent* - The plan that covers the person other than as a dependent (for example as an employee) is primary, and the plan that covers the person as a dependent is secondary.

   (See *If There Is a Third Plan* on page 79 if the claimant is also covered by Medicare.)

2. *Children* - On claims for dependent children:
   a. When the natural parents are married (and not separated or divorced), or when they are not married but are living together, the plan covering the parent whose birthday comes first in the year will pay first and the plan covering the parent whose birthday comes later in the year will pay second (this is known as the "birthday rule").
   b. When the natural parents are separated or divorced, or are not married and not living together, benefits are payable according to any existing court decree. If there is no court decree stating who is responsible for a child's health care, the plan covering the parent with custody (if not remarried) pays first and the plan covering the parent without custody pays second. If the parent with custody has remarried, that

parent's plan pays first, the stepparent's plan pays second, and the plan covering the parent without custody pays third.

The birthday rule will apply if a court decree awards joint custody without specifying that one party has the responsibility to provide health coverage or in any other situation not addressed in the above rules.

If none of the rules of No. 2 above apply, and the two plans have the same effective date, then the allowable expenses will be split between the two plans.

3. *Active or inactive employee* - The plan that covers a person as an active employee is primary over a plan that covers the person as a laid-off or retired employee. The same order applies to the person's dependents. (See *If There Is a Third Plan* on page 79 if the claimant is also covered by Medicare.)
4. *Continuation (COBRA) coverage* - If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee or retiree (or as that person's dependent) is primary, and the continuation (COBRA) coverage is secondary. However, this rule will not apply if the person is covered as a dependent under one plan and as a non-dependent under the other plan. In that case, the plan covering him as a non-dependent is primary, even if the non-dependent coverage is COBRA coverage.
5. *Longer or shorter length of coverage* - The plan that covered the person as an employee or retiree longer is primary.
6. *Two Plan employees* - Claims for two married employees covered under the Plan and their dependent children will be coordinated, subject to rules in No. 2 above.
7. *Other situations* - If the preceding rules do not determine the primary plan, this plan will follow the guidelines established by the National Association of Insurance Commissioners (NAIC) to determine the order of payment. If the NAIC guidelines do not apply to a particular situation, the allowable expenses will be shared equally between the plans, but in no case will this plan will pay more than it would have paid had it been primary.

COB With Sub-Plans

If, under this Plan's C.O.B. rules, this Plan's coverage is secondary, and if the primary plan includes a provision that results in the primary plan paying a lesser benefit when there is secondary coverage, then this Plan's secondary benefits are limited as follows. This Plan will pay benefits as a secondary pay or, but not more than the lesser of the following calculations: 1) the difference between the amount that the covered person's primary plan would have paid if the primary plan had been the only plan providing coverage and the total amount of covered charges; or 2) the amount that this Plan would have paid had this Plan's coverage been primary. This rule takes precedence over any contrary provision in the primary plan and applies whether the coverage under the primary plan is provided through a "subplan," "wrap-around plan" or any other designation.

COB With Medicare

Employees Continuing to Work After Age 65

If you continue to work for a contributing employer who has 20 or more employees after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will be your primary provider of health care benefits unless it is legally permitted to pay second. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

If your dependent spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will usually pay its normal benefits for his or her before Medicare pays unless it is legally permitted to pay second. If he/she is covered under her own plan, her plan will pay first, this Plan will usually pay second, and Medicare will pay last.

Retirees (and Their Spouses) Eligible for Medicare

If you are an eligible retiree, and if you and/or your spouse are eligible for Medicare and have enrolled in both Medicare Part A and Part B, this Plan will coordinate benefits with Medicare on your claims. This means that Medicare will pay first, and this Plan will pay after Medicare pays, based on amounts not paid by Medicare. The Plan will determine its benefits as the secondary payor based on the amount of the charge allowed by Medicare – it will not pay any amount in excess of Medicare's allowable charge.

If you have not enrolled in Medicare Parts A *and* B, this Plan will calculate its benefits as if you had. This means that this Plan will only pay benefits equal to the benefits it would have paid if you were enrolled in both Parts, unless a different payment is required by law. You will have to pay the amount normally paid by Medicare.

Medicare-eligible retirees (and Medicare-eligible spouses of retirees) have the option of dropping this Plan's prescription drug coverage and switching to a Medicare Part D plan. See page 24 for more information.

Retirees and their spouses who are eligible for Medicare must be enrolled in Medicare Part A and Part B.

Medicare-Eligible Persons Under 65

If any covered person is entitled to Medicare for reasons other than being 65 or older (for example, because of disability or being an End Stage Renal Disease beneficiary), this Plan will usually pay its benefits on that person's claims before Medicare pays its benefits unless it is legally permitted to pay second. This provision doesn't apply to retirees or their dependents.

Declining This Plan's Coverage

Persons age 65 or older are also entitled to select Medicare as their only coverage. To do so, they must decline all coverage under this Plan. Contact your local Social Security Administration office if you have any questions about Medicare enrollment or eligibility.

If There Is a Third Plan

If a person who is eligible for age-65 Medicare is also covered under a plan as a retired worker and under a third plan as a dependent of an actively working spouse, the plan covering the person as a dependent will pay first, Medicare will pay second, and the plan covering the person as a retired worker will pay last. Similarly, if a person who is eligible for age-65 Medicare is covered as a retired worker under one plan and as an active worker under another plan, the plan covering the person as an active worker will pay first, Medicare will pay second, and the plan covering the person as a retired worker will pay last. The order will be different if the Small Employer Exception applies.

COB With Automobile Insurance Policies

In the event a covered person (you, your spouse and/or your dependent child) is eligible for benefits for allowable expenses under this Plan and one or more group or individual fault or no-fault automobile insurance policies, the benefits under this Plan will be coordinated with those under the automobile insurance policy or policies so that the total benefits be paid under this Plan and all automobile insurance policies will not exceed 100% of the total allowable expenses actually incurred. In all cases where a covered person is eligible for receipt of benefits under a no-fault automobile insurance policy, the automobile insurance carrier will be primary.

Trustee Interpretation, Authority and Right

The Board of Trustees has full authority to interpret the Plan, all Plan documents, rules and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. Parties to whom the Trustees have delegated the right of decision-making will also have the discretion to interpret the Plan. If a decision of the Trustees, or a party to whom the Trustees have delegated decision-making authority, is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them to make such

decisions, decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

The Trustees have the authority to amend the Plan, which includes the authority to change eligibility rules and other provisions of the Plan, and to increase, decrease or eliminate benefits. However, no amendment may be adopted which alters the basic principles of the Trust Agreement founding the Fund, is in conflict with collective bargaining agreement provisions applicable to contributions to the Fund, is contrary to laws governing multiemployer ERISA trust funds, or is contrary to agreements entered into by the Trustees. In addition, and as more fully explained in the *Plan Discontinuation or Termination* section, the Trustees may terminate the Trust and this Plan of Benefits at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. The Trustees may adopt such rules as they feel are necessary, desirable or appropriate, and they may change these rules and procedures at any time.

The Trustees specifically have the right and the authority to change the provisions relating to coverage for retirees and their dependents at any time and in their sole discretion, since the Retiree Benefits are not "accrued" or "vested" benefits. Any such change made by the Trustees will be effective even though an employee has already become a covered retiree.

The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participants and beneficiaries.

Non-Vested Benefits

All benefits described in this SPD are non-vested benefits. The Trustees may alter or change the provisions of the Plan at any time, which could result in the elimination of one or more benefits. Any savings that result from the reduction or termination of a benefit will revert to the general Trust Fund.

Plan Discontinuation or Termination

The Plan of Benefits and the Trust Agreement under which the Plan was founded may be terminated under certain conditions: if there is no longer a collective bargaining agreement or participation agreement requiring contributions to the Fund; or if it is determined that the Fund is inadequate to carry out the purposes for which the Fund was founded. The Plan may be terminated at any time by a vote of the Trustees or by a written mutual agreement of the Unions and the Association to terminate the Trust, if the action is taken in conformity with applicable law. In such a case, benefits for covered expenses incurred before the termination date will be paid on behalf of covered persons as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

Overpayments; Duty of Cooperation

Whenever a payment or payments are made in excess of the allowable amount payable under the Plan, the Fund has the right to recover such excess payments from any person(s), service plan or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of the employee or dependent, the Fund, at its option, may require immediate repayment in full; set-off the overpayment from current and future benefit payments, including benefit payments due on behalf of another covered family member; or institute legal action to collect the overpayment.

You and your covered dependents must provide the Fund with any information the Fund deems necessary to determine eligibility, process claims or implement Plan terms. Failure to provide any information requested by the Plan or its agents may result in the rejection of a claim for benefits.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Fund may also obtain reimbursement of interest, professional fees incurred and other damages related to that overpayment.

A claim for benefits will be rejected and the Fund will be entitled to recover money that you, your dependents or a service provider have received if a false statement or omission of a material fact was purposely made by any person in order to receive benefits. The Fund may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

HIPAA Privacy Rights

The Plan has responsibilities under the Health Insurance Portability and Accountability Act (HIPAA) regarding the use and disclosure of your Protected Health Information (PHI). Your PHI is any information that: 1) identifies you or may reasonably be used to identify you; 2) is created or received by a health care provider, health plan, employer or health care clearinghouse; and 3) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact:

NECA/IBEW Family Medical Care Plan
410 Chickamauga Avenue, Suite 301
Rossville, GA 30741

Examinations

The Trustees have the right to have a doctor examine a person for whom benefits are being claimed, to ask for an autopsy in the case of a death, and to examine any and all hospital or medical records relating to a claim.

Payment of Benefits

Health care benefits are payable individually for you and each of your dependents up to but not to exceed the maximum benefits stated on the Schedule of Benefits according to the following provisions:

1. Blue Card PPO providers and out-of-network providers should send their bills directly to the BCBS affiliate in their state which in turn forwards the claim to Anthem/Blue Cross Blue Shield of Georgia (Anthem). Anthem then sends the claims to the Benefit Office who processes medical claims on the Plan's behalf. The Plan's share of the expenses will be paid directly to the PPO provider or to the out-of-network provider. The provider will bill you for your share of the expenses, which you must pay directly to the provider. (If an out-of-network hospital requires payment from you, see No. 2 below for how benefits are paid.)
2. If an out-of-network provider or other non-doctor or non-hospital provider requires payment, you must pay the bill and file a claim for reimbursement. The Plan will reimburse you the Plan's share of the expenses.
3. In most other cases, benefit payments on claims for yourself and for your dependents will be made to you (employee or retiree) unless you assign benefits. Life insurance and loss of life benefits under the AD&D insurance proceeds will be paid to your beneficiary. Benefits are payable only when the required forms and information have been received by the Benefit Office.
4. The Trustees may, from time to time, enter into negotiated fee arrangements with health care providers under the terms of which the Plan will receive discounts on fees charged for such services. In such cases, any amount in excess of the negotiated (discounted) fee will not be considered a covered expense.
5. If the Trustees decide that a person isn't mentally, physically, or otherwise capable of handling his or her business affairs, the Plan may pay benefits to his/her guardian or, if there is no guardian, to the individual who has assumed his/her care and principal support. If the person dies before all due amounts have been

paid, the Trustees may make payment to the executor or administrator of his/her estate, to his/her surviving spouse, parent, child or children, or to any individual the Trustees believe is entitled to the benefits.

6. In determining the satisfaction of any deductible amounts and the amount of benefit payments, a charge for any service, treatment, or supply will be considered incurred on the date the service or treatment was rendered or on the date the supply was provided.

Any payments made by the Plan in accordance with these rules will fully discharge the Plan's liability to the extent of its payments.

Non-Assignability of Assets; Representations Regarding Coverage

No assignment of benefits or other agreement entered into by a covered person purporting to assign a right to collection of benefits to an assignee shall provide the assignee with any right to maintain an action in contract, tort, or as an ERISA benefit claim by the assignee against the Fund or as an ERISA claim by the assignee against the Fund or the Trustees for recovery of any amounts from the Plan. Any claim for payment of benefits must be brought in the name of the person upon whom services were performed.

Any oral or written representation made regarding coverage to any person or entity is made solely in the person or entity's capacity as a representative of a person covered under the Plan inquiring on the covered person's behalf concerning projected levels of Plan coverage. Any such representation provides no right to a person or entity independent of the rights of the covered person under the terms of the Plan. It does not provide the person or entity with an independent right to recover from the Plan or its representatives under any state or federal law, including state contract and tort law. Any rights a person or entity might have against the Plan or its representatives are solely those which derive from the rights of a participant or beneficiary under the terms of the Plan. No references to coverage and levels of benefits are binding upon the Plan or its representatives unless they have been provided by the full Board of Trustees following a construction of the governing Plan instruments. Any representation regarding coverage and benefit amounts may not be relied upon by any person or entity if it is any way contrary to the terms of governing written Plan instruments. Entitlements to payment under the Plan may only be obtained through action of the Trustees administering the Plan and these Trustee actions may only be appealed by a person covered under the Plan pursuant to the Plan's appeal procedures and by a benefits claim cause of action brought in a court of competent jurisdiction under ERISA.

In the event that the Plan, the claims administrator, or any third-party makes a direct payment to a person or entity or otherwise communicates to a person or entity on the Plan's behalf, such payment or communication shall in no way be construed or interpreted as a waiver of the Plan's prohibition on assignments.

Workers' Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any workers' compensation law, occupational diseases law or similar law. Benefits that would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.

Release of Information

You must provide the Benefit Office with any required authorization for release of necessary information relating to any claim you have filed.

Breast Cancer Rights

The Plan provides benefits for post-mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Your Rights Under ERISA

As a participant in the NECA/IBEW Family Medical Care Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

In certain cases you can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants, covered dependents and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you believe that Plan fiduciaries misuse the Plan's money, or if you believe you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Benefit Office, you should contact the nearest office of the Employee Benefits Security Administration, U.S. De-

partment of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions and a list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

How to Read or Get Plan Material

You can read the material listed in the previous section by making an appointment at the Benefit Office during normal business hours. This same information can be made available for your examination at certain locations other than the Benefit Office. The Benefit Office will inform you of these locations and tell you how to make an appointment to examine this material at these locations. Also, copies of the material will be mailed to you if you send a written request to the Benefit Office. There may be a small charge for copying some of the material. Before requesting material, call the Benefit Office to find out the cost. If a charge is made, your check must be attached to your written request for the material. The Benefit Office address and phone number are shown on the inside front cover of this booklet.

General Information About Your Plan

Name of Plan/Fund - The name of your Plan is the NECA/IBEW Family Medical Care Plan. The name of the trust fund through which your Plan is provided is the NECA/IBEW Family Medical Care Trust Fund.

Plan Sponsorship and Administration - Your Plan is sponsored by a joint labor-management Board of Trustees. The Board of Trustees is the Plan Administrator. The Board is divided equally between Trustees appointed by the Union membership and by Trustees appointed by the Employer Association. The names and addresses of the individual Trustees are shown on page 86.

A complete list of employers and the Unions sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Board of Trustees, and is available for examination by participants and beneficiaries, as required by DOL regulations 29 CFR §§ 2520.104b-1 and 2520.104b-30. This right includes a “superseded” collective bargaining agreement if such agreement controls any duties, rights or benefits under the Plan.

The Trustees are assisted in the administration of the Plan by the Benefit Office. For the contact information of the Benefit Office, please see the inside front cover of this booklet or page 86.

Service of Legal Process - Service of legal process may be made on the Board of Trustees or on any individual Trustee. Service may also be made on the Benefit Office.

Source of Financing/Plan Participation - The Fund receives contributions from employers under the terms of collective bargaining agreements and participation agreements and from the Union. The Fund also receives self-payments from employees, retirees and dependents for the purpose of continuing coverage under the Plan. It may also receive rebates from its prescription benefit manager.

Employees are entitled to participate in this Plan if they work under one of the collective bargaining agreements or participation agreements and if the required contributions are made to the Fund on their behalf. Administrative employees of the Union are also entitled to participate in the Plan.

Type of Plan/Accumulation of Assets/Payment of Benefits - The NECA/IBEW Family Medical Care Plan is classified as a health and welfare benefit plan, providing benefits of the type described in the following paragraph. Employer contributions and self-payments by employees, retirees and dependents are received and held in trust by the Trustees pending the payment of benefits, insurance premiums and administrative expenses.

The Plan provides medical (hospital and physician) and prescription drug benefits on a self-insured basis. When benefits are self-insured, the benefits are paid directly from the Fund to the claimant or beneficiary. The self-insured benefits payable by the Plan are limited to the Plan assets available for such purposes. Although, as described earlier in the Summary Plan Description, Anthem/Blue Cross Blue Shield of Georgia re-prices claims involving medical, surgical and hospital benefits. Its services are in the nature of limiting the amount the Plan must pay

providers, and all benefits paid remain self-insured.

This Plan is not an insurance policy and no benefits other than the life insurance and AD&D insurance are provided by or through an insurance company. The Plan provides life insurance and AD&D insurance benefits through Union Labor Life Insurance Company, 1625 Eye Street N.W., Washington, D.C., 20006.

Plan/Fund Year - The Plan's financial records are maintained on a twelve-month fiscal year basis, beginning January 1 of each year and ending December 31 of the same year.

Plan/Fund Identification Numbers - The Employer Identification Number (EIN) assigned to this Plan by the I.R.S. is 75-3198514. The Plan Number (PN) assigned to the Plan of Benefits is 501.

BOARD OF TRUSTEES

Union Trustees	Employer Trustees
Mr. Kenneth Cooper International Secretary-Treasurer International Brotherhood of Electrical Workers 900 Seventh Street, NW Washington, DC 20001	Mr. Geary Higgins Vice President, Labor Relations National Electrical Contractors Association 3 Bethesda Metro Center, Suite 1100 Bethesda, MD 20814
Mr. Paul Shaffer Business Manager IBEW Local Union 474 1870 Madison Avenue Memphis, TN 38104	Mr. Lawrence J. Moter, Jr. Chapter Manager Atlantic Coast Chapter NECA 2510 Grenoble Road Richmond, VA 23294
Mr. Gregory Lucero Business Manager IBEW Local Union 66 4345 Allen Genoa Road Pasadena, TX 77504	Mr. Kevin Tighe Executive Director Labor Relations & Workforce Development National Electrical Contractors Association 3 Bethesda Metro Center, Suite 1100 Bethesda, MD 20814
	Mr. Gregory Bowman Nabco Electric 2800 2nd Avenue Chattanooga, TN 37407

To Contact the Benefit Office	To Write to the Board of Trustees
To Call: 1-877 937-9602 or 1-706-841-7000 Fax: 1-706-841-7020 Write a letter to: NECA/IBEW Family Medical Care Plan 410 Chickamauga Avenue, Suite 301 Rossville, GA 30741	Address your letter as follows: Board of Trustees 2400 Research Boulevard, Suite 500 Rockville, MD 20850

FUND PROFESSIONALS

Executive Director	
Mr. Lawrence J. Bradley National Electrical Benefit Fund (NEBF) 2400 Research Boulevard, Suite 500 Rockville, MD 20850-3266	
Administrative Office	**Fund Legal Counsel**
NECA/IBEW Family Medical Care Plan 2400 Research Boulevard, Suite 500 Rockville, MD 20850-3266	Mr. David Potts-Dupre Potts-Dupre, Hawkins & Kramer, Chartered 900 7th Street, NW, Suite 1020 Washington, DC 20001
Fund Legal Counsel	**Fund Consultant**
Mr. Gary L. Lieber FordHarrison 1300 19th Street, NW, Suite 700 Washington, DC 20036	Foster & Foster, Inc. 184 Shuman Boulevard, Suite 305 Naperville, IL 60563

APPENDIX

PREVENTIVE CARE COVERAGE

The Plan covers a wide range of preventive and wellness services designed to keep participants and dependents healthy. The types of expenses covered are listed in the tables below. The Plan covers these services and supplies for eligible individuals at 100% of the **allowable charge** with no deductible or co-pay when the services are rendered by a PPO or Non-PPO provider. This list is subject to reasonable medical management techniques and may be revised in accordance with applicable law and regulatory guidance.

Covered Adult Preventative Services

Effective January 1, 2021

Professional Services & Supplies	Frequency	Plan Coverage
Ultrasound screening for abdominal aortic aneurysm (men ages 65 to 75 who smoke(d))	One per lifetime	100%
Counseling for unhealthy alcohol uses	One per lifetime	100%
Low-dose aspirin for the prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults ages 50 to 59 years who have a 10% or greater risk of CVD in the next 10 years, as prescribed by a physician (generic aspirin only)	N/A	100%
Screening for high blood pressure (adults age 18+)	One per calendar year	100%
Screening for cholesterol abnormalities (men age 35+ or age 20+ if increased risk; women age 45+ or age 20+ if increased risk)	One per calendar year	100%
Screening for colorectal cancer in accordance with the American Cancer Society's guidelines (currently recommend persons at average risk consult with their primary care provider to discuss colorectal screening with stool-based testing beginning at age 45, and from age 75 through 85, the primary care provider should advise on whether continued screening is beneficial (adults ages 45 to 85 years old) **Please Note:** The Plan will only cover generic bowel preps and bowel prep brands with no generic equivalent, subject to reasonable medical management techniques.	Tests and procedures within the age and frequency guidelines established by the American Cancer Society	100%
Screening for depression (adults)	One per lifetime	100%
Screening for diabetes, including an annual screening for pre-diabetes and T2DM with informal risk assessment in accordance with the American Diabetes Association's guidelines (adults ages 40 to 70 years old who are overweight or obese)	N/A	100%
Counseling for diet & physical activity (adults who are overweight or obese and at risk for CVD)	One per lifetime	100%

Professional Services & Supplies	Frequency	Plan Coverage
Screening and counseling for individuals whose BMI is 25 or greater, including pharmacotherapy for those individuals whose BMI is 27 or greater with comorbidities present or individuals whose BMI is 30 or greater. Please Note: Exercise and diet programs that are not supervised by a physician provider who is a medical practitioner in accordance with Plan provisions are excluded. This benefit is subject to reasonable medical management techniques.	26 face-to-face 15-minute behavioral counseling sessions per calendar year with a PPO provider and one (1) dietary assessment by a licensed nutritionist.	
Counseling for sexually transmitted infections (adults at increased risk)	One per lifetime	100%
Hepatitis C virus infection screening for persons at increased risk of infection and those born between 1945 and 1965	One per lifetime	100%
HIV screening for persons ages 15 to 65 years old and those at increased risk of infection	One per lifetime	100%
Syphillis screening for persons at increased risk	One per lifetime	100%
Tobacco use screening	One per lifetime	100%
Coverage for tobacco “cessation attempt” for those who use tobacco products	Two per calendar year	100%
Lung cancer screening with low-dose CT for adults ages 55 to 80 years old with a history of smoking within the last 15 years	One per calendar year	100%
Tuberculosis test for adults in at-risk populations	One per calendar year	100%
Statin prevention medication (generic only; subject to the Plan’s Step Therapy Program) for adults ages 40 to 75 years with no history of CVD, one or more CVD risk factors, and a calculated 10-year CVD event risk of >10%	N/A	100%
Screening and counseling for interpersonal and domestic violence or elder abuse	One per calendar year	100%
Counseling about the exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years old; Skin cancer risk assessment by a dermatologist for persons with family history of melanoma in two or more blood relatives, presence of multiple atypical moles	Once per calendar year	100%
Counseling related to fall prevention for community dwelling individuals (ages 65 years or older who are at increased risk for falls)	Once per lifetime	100%

Covered Women’s Preventive Services

(All women of reproductive capacity)

Effective January 1, 2021

Professional Services & Supplies	Frequency	In-Network	Out-of-Network
Annual well-woman visits	One per calendar year	100%	Excluded

Professional Services & Supplies	Frequency	In-Network	Out-of-Network
Prenatal care, meaning routine doctor visits (Delivery, prenatal lab work, ultrasounds, and high-risk pregnancy care services are covered under the regular major medical provisions of the Plan and are covered for female employees, retirees and spouses **ONLY –** not for dependent children.)	N/A	100%	Excluded
Screening for gestational diabetes (pregnant women after 24 weeks gestation)	One per pregnancy	100%	Excluded
Sexually transmitted disease counseling	One per calendar year	100%	Excluded
Contraception – All FDA-approved contraceptive methods and services related to follow-up and management for women (oral contraceptives, IUDs, Depo Provera, tubal ligation, sponges, spermicides, etc.) prescribed by a physician or covered facility. (Abortificacient drugs NOT covered.) **Please Note:** The Plan will only cover 1) generics; and 2) brands that are medically necessary and do not have generic equivalents, subject to reasonable medical management techniques.	N/A	100%	Excluded
Prenatal and postnatal breastfeeding support, supplies (including rental of breast pump), and counseling **Please Note:** All lactation services must be provided by a PPO provider. For a list of lactation services providers that are covered by the Plan in your area, contact the Benefit Office. Other supplies are covered as needed, subject to reasonable medical management techniques.	Up to five (5) lactation counseling sessions per pregnancy through the duration of breastfeeding; other supplies as needed, subject to reasonable medical management techniques	100%	Excluded
Screening and counseling for interpersonal and domestic violence	One per calendar year	100%	Excluded
Breast cancer mammography screenings (women ages 40 through 74 years old)	One per calendar year	100%	Excluded
Counseling and testing for BRCA gene (women with a family history of BRCA 1 or BRCA 2 risk factors)	One per lifetime	100%	Excluded
Screening for cervical cancer in accordance with the U.S. Preventive Services Task Force and the American Cancer Society	Once per calendar year	100%	Excluded
Folic acid supplements (women capable of pregnancy) (0.4 to 0.8 mg per day)	N/A	100%	Excluded
Counseling about chemoprevention of breast cancer (women at high risk)	One per lifetime	100%	Excluded
Screening and monitoring for prenatal preeclampsia, and low-dose aspirin to prevent preeclampsia in pregnant women at high risk	N/A	100%	Excluded
Screening for gonorrhea (women age < 25 or at increased risk)	One per calendar year	100%	Excluded
Screening for chlamydial infection (women age < 25 or at increased risk)	One per calendar year	100%	Excluded

Professional Services & Supplies	Frequency	In-Network	Out-of-Network
Screening for osteoperosis (women age 65 or post-menopausal women at increased risk of osteoporotic fractures)	One per lifetime	100%	Excluded
Anemia screening for pregnant women	N/A	100%	Excluded
Bacteriuria urinary tract or other infection screening for pregnant women	N/A	100%	Excluded
Hepatitis B screening for pregnant women at their first prenatal visit	One per pregnancy	100%	Excluded
Rh Incompatiability screening for pregnant women at first prenatal visit	One per pregnancy, unless follow up testing is required for women at higher risk	100%	Excluded
Syphillis screening for pregnant women	One per pregnancy	100%	Excluded
HIV screening for pregnant women	One per pregnancy	100%	Excluded
Tobacco use screening for pregnant women	One per pregnancy	100%	Excluded
Breast cancer risk-reducing medications for women who are increased risk for breast cancer and at low risk for adverse medication effects Please Note: The Plan will only cover 1) generics; and 2) brands with no generic equivalent, subject to reasonable medical management techniques.	N/A	100%	Excluded

Immunizations

Effective January 1, 2021

Professional Services & Supplies	Frequency	Coverage
Hepatitis B (HepB)	As recommended by the Advisory Committee on Immunization Practices (ACIP) and that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC), including: • Recommended immunization schedule for persons age 0 through 6 years; • Recommended immunization schedule for persons age 7 through 18 years; • Catch-up immunization schedule for persons age 4 months through 18 years who start later or who are more than one month behind; and • Recommended adult immunization schedule.	100%
Rotavirus (RV)		100%
Diphtheria, tetanus, and pertussis DTaP)		100%
Influenza type B (Hib)		100%
Pneumococcal (PCV/PPSV)		100%
Polio (IPV)		100%
Influenza (seasonal)		100%
Measles, mumps & rubella (MMR)		100%
Varicella		100%
Hepatitis A (HepA)		100%
Meningococcal (MCV)		100%
Human papillomavirus (HPV)		100%
Zoster (shingles)		100%
Other	As recommended by ACIP and the CDC or required by applicable law	100%

Covered Children's Preventative Services

Newborn to Age 21 years
Effective January 1, 2021

Professional Services & Supplies	Frequency	In-Network	Out-of-Network
Newborn screenings for hemoglobinopathies, hearing loss, hypothyroidism, phenylketonuria (PKU), and heritable disorders (as recommended by the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in newborns and Children that went into effect May 21, 2010)	One per lifetime	100%	Excluded
Prophylactic medication for gonorrhea	One per lifetime	100%	Excluded
Health history	As recommended by the American Academy of Pediatrics and Bright Futures	100%	Excluded
Measurements, including weight, heights, BMI, blood pressure, etc.		100%	Excluded
Sensory (vision and hearing) screening		100%	Excluded
Developmental screening		100%	Excluded
Autism screening		100%	Excluded
Behavioral screening		100%	Excluded
Alcohol/drug assessment		100%	Excluded
Physician examination		100%	Excluded
Metabolic screening		100%	Excluded
Hemoglobin screening		100%	Excluded
Lead screening		100%	Excluded
Tuberculin test		100%	Excluded
Dyslipidemia screening		100%	Excluded
STI screening		100%	Excluded
Cervical dysplasia screening		100%	Excluded
Oral health risk assessment		100%	Excluded
Anticipatory guidance		100%	Excluded
Iron supplements (children ages 6 to 12 months at increased risk for anemia)	As prescribed by child's physician*	100%	Excluded
Tobacco use counseling to school-aged children and adolescents to prevent initiation of tobacco use	One per lifetime	100%	Excluded
Skin cancer behavioral counseling for children and young adults ages 6 months to 24 years with fair skin about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer	One per lifetime	100%	Excluded
Vision screening for acuity and to detect amblyopia or its risk factors (children ages 3 to-5)	One per calendar year	100%	Excluded
Screening and counseling for obesity (children age 6+)	One per lifetime	100%	Excluded

Professional Services & Supplies	Frequency	In-Network	Out-of-Network
Oral fluoride (children 6 months+)	As prescribed through age 5*	100%	Excluded
Screening for depression (children ages 12 to 18)	One per lifetime	100%	Excluded
Counseling for sexually transmitted infections (children at increased risk)	One per lifetime	100%	Excluded
Screening for HIV (children ages 11 to-21 at increased risk)	One per lifetime	100%	Excluded

*** Itemized pharmacy bill required – cash register receipts not accepted.**

IMPORTANT NOTICE ABOUT YOUR BENEFIT PLAN

May 2020

To Participants in Plan:

This notice summarizes important changes to the NECA/IBEW Family Medical Care Plan. If you have any questions regarding the changes summarized in this Summary of Material Modifications ("SMM"), you should contact the Benefits Office. Please keep a copy of this SMM with your Summary Plan Description for future reference.

NEW COVERAGE OF PREVENTIVE SERVICES

Effective June 1, 2020, the Plan covers preventive and routine services as mandated by the Affordable Care Act at 100% of the allowable charge when prescribed or performed by in-network **and** out-of-network providers. The Plan may revise its list of covered preventive services pending future guidance from the federal government, but any change will apply prospectively. For a list of preventive and routine services covered by the Plan with no cost-sharing to you, please consult your Summary Plan Description or contact the Benefit Office for more information.

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Please keep this notice with your Summary Plan Description booklet for future reference.

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IMPORTANT NOTICE ABOUT YOUR BENEFIT PLAN

February 2021

To Participants in Plan:

This notice summarizes important changes to the NECA/IBEW Family Medical Care Plan. If you have any questions regarding the changes summarized in this Summary of Material Modifications ("SMM"), you should contact the Benefits Office. Please keep a copy of this SMM with your Summary Plan Description for future reference.

REMOVAL OF DEVELOPMENTAL DELAY EXCLUSION

Beginning April 1, 2021, the Plan will cover medically necessary treatment and services for developmental delays, including Autism Spectrum Disorder. The Plan will no longer apply the Developmental Delay Exclusion to exclude coverage for treatment and services for developmental delays. These benefits are subject to the same deductibles, copayments, coinsurance, out-of-pocket limits and visit limits and may also be subject to medical management, utilization review and other limitations, as outlined in your Summary Plan Description.

HABILITATIVE SERVICES & ABA THERAPY

Beginning April 1, 2021, the Plan will cover medically necessary habilitative services, including Physical Therapy, Occupational Therapy, and Speech Therapy, and Applied Behavioral Analysis ("ABA") Therapy. These benefits are subject to the same deductibles, copayments, coinsurance, out-of-pocket limits and visit limits and may also be subject to medical management, utilization review and other limitations, as outlined in your Summary Plan Description.

BEHAVIORAL HEALTH TELEVISIT SERVICES

Beginning March 24, 2021, the Plan will provide virtual behavioral health services for plan participants **ages 13 years and up** with licensed therapists through **Talkspace**. **Talkspace** is a convenient and affordable way to connect with a licensed therapist from the privacy of your mobile device. Through **Talkspace**, you can send your therapist text, audio, picture, and video messages at any time, and they will respond daily, up to five times per week. **TalkSpace** also offers live video sessions so you can utilize the "face-to-face" therapy experience. These benefits are provided with no cost-sharing to you. To get started on **Talkspace**, visit talkspace.com or download the app to your mobile device.

NEW ABA THERAPY VENDOR

Beginning April 1, 2021, Magellan Healthcare will assist in managing the Plan's coverage of ABA Therapy for individuals with confirmed diagnoses of Autism Spectrum Disorder ("ASD"). Once you receive an ASD diagnosis, you must contact Magellan to receive prior authorization before your ABA Therapy services are covered by the Plan. Magellan will also provide utilization management as treatment progresses and adjudicate claims. Magellan ABA Care Managers can work with your provider and anyone else involved in your child's treatment to develop a custom care plan tailored to your child that optimizes medically necessary treatment and services and ensures the best outcomes for you. For more information or to contact Magellan Healthcare for coverage of ABA Therapy, please contact:

Magellan Healthcare
1-800-424-1602

PREVENTIVE SERVICES

An updated list of preventive services can be found at www.nifmcp.com under "Plan Notices." These services are covered by the Plan at 100% of the allowable charge with no cost-sharing to you. You may also request a paper copy free of charge by contacting the Benefit Office at 877-937-9602.

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Please keep this notice with your Summary Plan Description booklet for future reference.

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