IMPORTANT NOTICE ABOUT YOUR BENEFIT PLAN

October 2016

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.

TERMINATION OF ELIGIBILITY

Effective January 1, 2017, 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 will 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-mandated continuation coverage. 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. This provision of the Plan is added as Paragraph 7 under "**TERMINATION OF ELIGIBILITY - Termination of Employee Benefits**" in your Summary Plan Description.

RESCISSION OF COVERAGE

Effective January 1, 2017, the Plan may rescind (retroactively revoke) your coverage if the Plan discovers that you and/or your Dependents (1) failed to make a required payment when it is due; or (2) 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. The Plan may demand repayment of all Benefits paid on behalf of the Employee and/or his 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. This provision of the Plan is added as Paragraph 8 under "**TERMINATION OF ELIGIBILITY - Termination of Employee Benefits**" in your Summary Plan Description.

ELIGIBILITY PROCEDURES

Effective January 1, 2017, 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 thirty (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:

(a) The nature of the claim (i.e., appeal of eligibility denial);
(b) The name of the individual(s) claiming eligibility and the relationship of such individual(s) to the actual plan participant;
(c) 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
(d) Any documentation that supports your claim for eligibility.

All claims or disputes submitted under these procedures must be submitted in writing to the FMCP Benefits Office. Within sixty (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 thirty (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 bank hour 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.

NEW COVERAGE FOR PREVENTIVE SERVICES

Below is a summary of newly added preventive services that are covered by the Plan beginning January 1, 2017. The Plan covers these services based on laws and regulations relating to provisions of the Patient Protection & Affordable Care Act. These services are covered at 100% of the cost when prescribed or performed by **in-network providers only**. The Plan may revise its list of covered preventive services pending any future guidance provided by the federal government. Any change to these covered services will apply prospectively.

Specifically, the Plan will cover the following preventive services beginning January 1, 2017:

- *Adult Preventive Services*: Weight management counseling for obese individuals, which includes up to 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, subject to reasonable medical management techniques. Coverage is limited to those individuals whose BMI is 30 or greater. Exercise or diet programs that are not directly supervised by a PPO provider who is a medical practitioner are excluded.

- *Women's Preventive Services*: Aspirin to prevent preeclampsia for pregnant women at high risk (duration of pregnancy only).

- *Women's Preventive Services*: Prenatal and postnatal breastfeeding support, supplies (including rental of a breast pump), and counseling (up to 5 lactation visits per pregnancy through the duration of breastfeeding). 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.

VISION BENEFIT

Beginning January 1, 2017, under the new VSP Choice Network Platform, your PPO (in-network) dollar allowances for glasses and contact lenses will increase to the following:

	Current Allowance	**Allowance eff. 1/1/17**
Retail Frame Value	$115.00	$180.00
Elective Contact Lenses	$120.00	$150.00

DENTAL BENEFIT

Beginning January 1, 2017, the frequency limits to the following dental benefits will become effective. The Plan is changing these limits based on the recommended guidelines published by the American Dental Association, which are intended to reduce patients' exposure to radiation.

	Allowance eff. 1/1/17
Bitewings (Children)	1 per calendar year
Bitewings (Adult)	1 per calendar year
Full Mouth X-Rays	1 per 60 months

DEPENDENT ELIGIBILITY

Please Note: If a Child under the age of 26 is an active employee in the Plan or is a full-time active member in the military for any country, he or she is still eligible for coverage as a Dependent under the Plan if his or her parent(s) is covered by the Plan as an Employee or Retiree. The plan will coordinate benefits on any claims submitted on behalf of the Child in accordance with the Plan's Coordination of Benefits provision.

A spouse who is an active Employee under the Plan is also eligible for coverage as a Dependent under the Plan if his or her spouse is covered by the Plan as an Employee or Retiree. The Plan will coordinate benefits on any claims submitted on behalf of your spouse in accordance with the Coordination of Benefits provisions.

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

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