N.E.C.A. LOCAL UNION NO. 313 I.B.E.W. BENEFIT FUNDS

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February 2020

RE: Summary of Material Modifications Notice
NECA Local 313 IBEW Health & Welfare Fund
NECA Local 313 IBEW Pension Fund

Dear Participant:

This notice is to advise you of recent Plan changes adopted by the Trustees with regard to the NECA Local 313 IBEW Health & Welfare and Pension Funds.

Health & Welfare Fund

1. **Coverage for Colorectal Cancer Screenings**

   Effective August 1, 2019, colorectal cancer screenings using fecal occult blood testing, sigmoidoscopy or colonoscopy will be covered at 100% of the Plan's Allowed Charge, for adults beginning at age 45 (rather than 50) and continuing until age 75.

2. **Chiropractic Services**

   Effective August 1, 2019, the Fund will pay up to $25 per visit for up to 30 visits per calendar year (up from 10 visits per calendar year). The $10 co-pay per visit still applies.

3. **Pre-Medicare Retiree Self-Pay Rate**

   Effective December 1, 2019, the rate required to maintain coverage as a retiree for pre-Medicare retiree coverage increased to $1,338.00 per month, consistent with the increase in the hourly contribution rate for active members. There is no change in the monthly self-pay required for retirees eligible for Medicare.

4. **Dental Calendar Year Maximum**

   Effective January 1, 2020, non-orthodontic dental expenses will be subject to a $2,000 per individual maximum per calendar year. The $1,500 lifetime orthodontic maximum will remain unchanged.

5. **Medical Reimbursement Allowance (MRA)**

   The Trustees have voted to continue the $1,000 annual Medical Reimbursement Allowance (MRA) for 2020. In addition, beginning in 2020, the Fund will consider reimbursement from the MRA of any expense that is defined by the Internal Revenue Service as an allowable medical expense except for medical copayments. Prescription drug copayments remain reimbursable from the MRA.

(OVER)

6. **Blue Light Lens Coatings**

Effective January 1, 2020, you will have the option of adding blue light lens coatings through National Vision Administrators at a discounted price with in-network providers.

7 **Increase in Death and Accidental Death & Dismemberment Insurance Benefit**

Effective January 1, 2020, the self-funded active and retiree death and accidental death & dismemberment (AD&D) insurance benefits have been increased as shown in the table below.

Coverage	Plan Provision	Active Participants	Retired Participants
Death Benefit	For your death, paid to your beneficiary	$20,000	$10,000
Accidental Death and Dismemberment	For your accidental death, paid to your beneficiary	$15,000	$10,000
	For loss of two limbs, both eyes or loss of one limb and sight in one eye, paid to you	$15,000	$10,000
	For loss of one limb or sight in one eye, paid to you	$3,750	$2,500

Pension Fund

1. **Future Service Accrual Rate**

For pensions that begin on or after January 1, 2019, the Future Service Accrual Rate will be $100 per service credit. The existing Plan "rate break" provisions will still apply subject to the Plan modification noted below, including a minimum requirement of 200 work hours in Covered Employment in 2018 for this benefit rate to apply for benefit accruals earned prior to January 1, 2019.

If a Participant has a Separation from Service and subsequently returns to Covered Employment, the portion of his pension attributable to Covered Employment prior to the initial Separation from Service and the portion of his pension attributable to Covered Employment after the return to Covered Employment will be computed using the benefit rates in effect at the time of the Participant's subsequent Separation from Service if such Participant accrues at least 1,600 Hours of Service in each of three separate consecutive rolling twelve (12) month periods, with no overlap.

2. **Retiree Increase**

For pensioners and surviving spouses whose pension started before December 31, 2018 (and the pension is still in pay status as of November 1, 2019), monthly pension amounts increased by 5% effective with the check issued on November 1, 2019. For pensions that are still in pay status as of November 1, 2019, a retroactive, one-time payment representing the 5% increase was also made for the period January 1, 2019 through October 1, 2019.

If you have any questions about these changes, please don't hesitate to contact the Fund Office.

Sincerely,

THE BOARD OF TRUSTEES

Summary of Benefits Under the Health & Welfare Plan

Your Coverage

If you are an active employee, you and your eligible dependents are covered under the NECA Local 313 IBEW Health and Welfare Plan once you meet the initial eligibility rules. Plan coverage includes medical, prescription drug, dental and vision care services.

Additional benefits, like weekly disability income, a healthcare spending account, death benefit and accidental death and dismemberment (AD&D) insurance are also available to active participants.

Retiree Coverage

Retired participants are generally eligible for the same package of benefits as active participants except that weekly disability income benefits are excluded for retirees. Medicare-eligible retiree and dependent benefits are somewhat different since Medicare is customarily primary for their claims.

Participant-Only Benefits

The following benefits are available to active participants only. Dependents and retirees are not eligible.

ACTIVE PARTICIPANT BENEFITS

Benefit	Description	This Plan Pays
Weekly Disability Income Benefit	Non-occupational disability, payable from the first day of the accident or surgery or from the eighth day of illness	$250 per week for up to 26 weeks
	Occupational disability reduced by the amount of any state-provided benefit	Up to $450 per week for up to 26 weeks
Death Benefit	For your death, paid to your beneficiary	$10,000
Accidental Death and Dismemberment (AD&D)	For your accidental death, paid to your beneficiary	$10,000
	For loss of two limbs, both eyes or loss of one limb and sight in one eye, paid to you	$10,000
	For loss of one limb or sight in one eye, paid to you	$2,500

Retiree Benefits

The following benefits are available to retired participants. Dependents are not eligible. (NOTE: Dependents are included in the Health Care Spending Account.)

RETIRED PARTICIPANT BENEFITS

Death Benefit	For your death, paid to your beneficiary	$5,000
Accidental Death and Dismemberment (AD&D)	For your accidental death, paid to your beneficiary	$5,000
	For loss of two limbs, both eyes or loss of one limb and sight in one eye, paid to you	$2,500
	For loss of one limb or sight in one eye, paid to you	$1,250

Medical Benefits

All participants are encouraged to use doctors and other healthcare providers who participate in Aetna and its discount network. Doctors and other healthcare providers in the Aetna network are under contract to provide services at lower, contracted rates (the "allowable charge" or "AC") to Plan participants. They can't charge more than the agreed-upon rates, so it almost always saves you money to use them. There's never a balance bill if Plan coverage is 100%. If Plan coverage is 80%, when you use doctors in the network, you won't pay more than 20%.

When you use doctors who don't participate in the Aetna network, balance billing is in effect and you may incur additional out-of-pocket expenses.

The Plan has an Annual Out-of-Pocket Maximum (OOP) for medical services and prescription drugs. The OOP is the most you can pay out of your own pocket under the Plan before the Plan pays 100% of your expenses. Note also that under the plan of benefits, participants are reimbursed based on the AC. The AC is the fee or price Aetna determines to be reasonable for services.

Annual Medical Deductible	None
Annual Out-of-Pocket Maximum	**Medical:** $2,000 per person $4,000 per family **Prescription:** $4,600 per person $9,200 per family
Annual Outpatient Laboratory, Imaging & Machine Testing Deductible	$35 per family

Medical Benefits	Plan Pays
• Allergy Treatment • Allergy Testing	• 100% of AC • Not covered
Emergency Ambulance and Paramedic Service	80% of AC
Blood Bank Benefit	Plan pays annual membership fee in the Blood Bank of Delaware
Chemotherapy, Radiation, Speech, Occupational, Cognitive, Cardiac and Inhalation Therapy, Dialysis (at an outpatient facility)	100% of AC
Chiropractic Services (up to 10 visits per calendar year)	100% of AC up to $25 per visit after $10 copayment
Dental Care • Orthodontic Treatment (up to $1,500 lifetime maximum) • Other Services	 • 80% of charges • 100% of fee schedule
Emergency Outpatient Care (hospital or independent emergency facility)	**Emergency Room (ER):** If admitted to a hospital, $10 copay then no charge, up to allowable charge. If not admitted to hospital, $100 copay then no charge up to allowable charge. Subject to $35 family deductible per year for outpatient lab, imaging and machine tests. Applies to both in-network and out-of-network hospitals. **Urgent Care:** $10 copay then no charge, up to allowable charge. Subject to $35 family deductible per year. Out-of-network facilities subject to balance billing.
Hearing Exams	100% of AC after $10 copayment
Hearing Aid Benefit (once per 5-year period)	Up to $200
Home Health Care Services (up to 240 days)	100% of AC
Home Infusion Services	100% of AC
Hospice Program	100% of AC
Hospitalization (up to 120 days per confinement)	100% of AC
Medical Equipment	80% of AC
Inpatient Mental Health Care (up to 120 days per confinement)	100% of AC
Outpatient Mental Health Care	100% of AC
Nursing Services Inpatient Private Duty (up to 240 hours in 12-month period)	80% of AC
Outpatient Physician's Visits	100% of AC after $10 copayment
Physical Therapy (maximum 52 visits per course of treatment)	Visits 1–26—100% of AC Visits 27–52—80% of AC

Medical Benefits	Plan
Prescription Drugs	Preventive: See page 36 for information on preventive medications. Retail: • Generic drugs—You pay 20% of the cost with a minimum copay of $10 and maximum copay of $35 • Brand name drugs—You pay 20% of the cost with a minimum copay of $10 and a maximum copay of $35 Maintenance Medication Program: • Generic drugs—You pay 20% of the cost with a minimum copay of $20 and a maximum copay of $70 • Brand name drugs—You pay 20% of the cost with a minimum copay of $20 and a maximum copay of $70.
Skilled Nursing Facility Care (up to 120 days per confinement)	100% of AC
Surgical Facility Benefits	100% of AC
Surgical-Medical Benefits • Surgical Services • Anesthesia • Inpatient Medical and Consultation Services • Obstetrical Services • Newborn Care	100% of AC
Second Surgical Opinion	100% of AC
Therapeutic and Diagnostic Services (at an inpatient facility)	100% of AC
Vision Care Benefit	100% of AC of fee schedule
Well-Child Care (up to second birthday)	100% of AC
OB/GYN exams	100% of AC
Pap Labs (smears)	100% of AC
X-rays and Laboratory Services	100% of AC after $35 X-Ray and Lab Deductible

Eligibility for Coverage

FAST FACTS:

- When you meet the eligibility requirements, you and your eligible family participants are covered under the NECA Local 313 IBEW Health and Welfare Plan.
- Your eligibility for coverage depends on the hours you work for your contributing employers.
- If you don't work the required number of hours, you may be able to use banked hours in your Reserve Account to qualify for benefits.
- If you don't work the required number of hours and have insufficient banked hours in your Reserve Account to qualify for benefits you may be able to make up for the shortage in hours by self-paying to make up for the premium shortage.

Initial Eligibility

You are eligible for coverage under the NECA Local 313 IBEW Health and Welfare Plan on the first day of the Benefit Quarter after you've completed a total of 1,000 hours of work with one or more Contributing Employer during four consecutive Working Quarters. In other words, you have at least 12 consecutive months to work a minimum of 1,000 hours for Contributing Employers to establish Initial Eligibility.

Initial Eligibility allows you to receive benefits during the next upcoming Benefit Quarter, a three-month period that starts the first of March, June, September or December.

Once you become eligible, your family is also eligible for coverage under the Plan. To find out if your family participants are eligible, see "Eligibility for Your Dependents" on page 6.

Continuing Your Eligibility

To maintain your eligibility once you establish Initial Eligibility, you must work at least 360 hours during a Working Quarter. If you meet that requirement, you'll be eligible for benefits during the next
corresponding Benefit Quarter, which starts two months later, as the chart below shows. The two-month delay is due to processing your employment records to determine eligibility. Take note that if you're regularly working 360 hours during a Working Quarter your coverage will be continuous; there will be no lapse between Benefit Quarters.

If You Work 360 Hours During this Working	You'll Be Eligible for Coverage During this
January, February, March	June, July, August
April, May, June	September, October, November
July, August, September	December, January, February
October, November, December	March, April, May

Reserve Account Protects You

Hours you work in excess of 360 during a Working Quarter, up to 900, are credited to a Reserve Account in your name. This account helps you maintain eligibility. If you don't work 360 hours during a Working Quarter, hours that have been credited in your Reserve Account may be used to help you reach the 360-hour minimum, making you eligible for coverage during the next Benefit Quarter.

If your hours worked and Reserve Account don't total 360 hours, those hours will be used to reduce your cost to purchase continued coverage (see page 8) or they will be canceled.

What is a "Working Quarter?"

A Working Quarter is a three-month period (starting the first day of January, April, July and October) when you must work enough hours to satisfy requirements to be eligible for coverage during the upcoming Benefit Quarter.

What is a "Benefit Quarter?"

A Benefit Quarter is a three-month period (starting the first day of March, June, September and December) during which you're eligible for benefits, based on having met the requirements in the previous Working Quarter.

What is a "Contributing Employer?"

A Contributing Employer is one who has entered a collective bargaining agreement with IBEW Local 313 to contribute to the NECA Local 313 IBEW Health and Welfare Fund at the agreed-upon rate.

What You Need to Do:

You must complete and submit an enrollment form to receive benefits. Forms are available from the Fund Office or Union Hall. You will be required to provide birth and marriage certificates for dependent coverage.

Use of your Reserve Account is suspended temporarily if you are unavailable for work in covered employment for 30 or more consecutive days, unless it is due to circumstances beyond your control. Your Reserve Account is immediately canceled if you cease to be available to work in Covered Employment.

At retirement you may use hours in your Reserve Account to temporarily maintain your status as an active participant and continue to receive the benefits of coverage for active participants.

Disability Hours Credits

During periods of disability, you may be entitled to hours credits to help you maintain Plan eligibility, up to a maximum of 26 weeks. These credits may be available for both occupational and non-occupational disabilities. In the event of disability, you should contact the Fund Office accordingly.

Special Rules for Special Cases

Eligibility for Apprentices

If you are a first-year Apprentice, you are eligible for Plan coverage the beginning of the month in which your employment starts. Your coverage remains in effect for up to 12 months if you remain in the Apprentice Program. Coverage terminates immediately, however, when your term as an Apprentice ends. At the end of 12 months, you may participate in the Plan if you meet the Initial Eligibility requirements (see page 5). If you don't qualify, you may purchase Continuation Coverage under COBRA (see page 13).

If you are a pre-Apprentice, you do not qualify for this early coverage offered under the Apprentice Program. You must meet the same requirements for Initial Eligibility as other new employees.

Eligibility for Newly Organized Employees

If you are a newly organized employee, you become a participant of IBEW Local 313 on the first of the month during which you submit a completed enrollment form. After you have worked a full Working Quarter of 360 hours for a Contributing Employer, you and your dependents continue to be eligible for benefits the next Benefit Quarter.

Newly organized employees don't have to work 1,000 hours to establish Initial Eligibility as you would as a new employee. However, you must credit 1,000 hours back to the Plan in the following Working Quarters. This occurs automatically. Every hour you work during a Working Quarter in excess of 360 hours is credited back to the Plan until your total reaches 1,000 hours. Once you have repaid the Plan 1,000 hours, your excess hours go into your Reserve Account.

To continue to be eligible for benefits, you must work 360 hours each Working Quarter.

Eligibility for Your Dependents

When you become eligible for coverage, so do your eligible dependents, but you must complete and submit an enrollment form along with copies of your marriage certificate, birth certificates, etc. Dependents you acquire through marriage, birth, adoption or placement for adoption after you have become eligible are immediately eligible, provided you enroll them within 60 days.

Your dependents are:

- Your lawful opposite-sex spouse;
- Your Qualifying Children. A Qualifying Child is your child (including stepchildren, foster children and legally adopted children or children placed with you for adoption) who is under age 26; and

- Children incapable of self-sustaining employment because of a mental or physical disability that occurred before age 26, provided you gave the Plan written evidence of that fact before their coverage ended. Coverage for such children will continue as long as you have coverage and they remain disabled provided that you provide over one-half of such child's support during the calendar year; and the child is not a Qualifying Child of any other person for the year.

To request special enrollment or obtain more information, contact the Fund Administrator at the address and/or phone number on page ii of this booklet.

When Your Coverage Ends

Your coverage under the Plan will end on the earliest of the following dates:

- The date the Plan is discontinued;
- The last day of the Benefit Quarter in progress when you don't work the required number of hours to maintain eligibility;
- The day you stop making payments, if required; or
- The date of your death.

Self-pay is only available if the member is available for covered

employment. Benefits will not be paid for expenses you incur after

your coverage terminates.

In certain circumstances such as insufficient hours worked, Family and/or Medical Leave or military leave, you may be able to buy continuation coverage through the Plan (see page 8).

If your coverage ends and you are not eligible to extend your coverage through the self-payment option, you may be eligible to purchase continuation of coverage under the federal law known as COBRA, described on pages 13–16.

The Plan will not rescind coverage except to the extent it is attributable to a failure to timely pay required premiums or self-pay contributions, or it is the result of fraud or intentional misrepresentation. A rescission of coverage means a cancellation or discontinuance of coverage that has a retroactive effect.

When Coverage Ends for Your Dependents

Coverage for your dependents ends on the same date your coverage ends, or earlier under any of the following circumstances:

- On the last day of the month you and your spouse are divorced or legally separated or you lose custody of your children—unless you are legally obligated to provide healthcare for your children;
- On the last day of the month in which your child reaches age 26, unless he or she is medically or physically incapacitated; or
- On the last day of the Benefit Quarter in which a child incapacitated by physical or mental disability is either no longer incapacitated or proof of incapacity is not submitted as required.

If you die while covered under the Plan and you have had coverage for at least 15 consecutive Benefit Quarters prior to the current Benefit Quarter, your surviving spouse will continue to be covered under the Plan until such time as he or she remarries, provided premium payment is made as required. Your surviving dependent children will continue to be covered under the Plan until such time as they are no longer considered a dependent under the terms of the Plan, provided premium payment is made as required.

Required premiums may be deducted from your monthly pension benefit, if applicable, from the NECA Local 313 IBEW Pension Plan.

If you die while covered under the Plan and you did not have 15 consecutive Benefit Quarters prior to the Benefit Quarter in which your death occurred, coverage for your dependents will terminate at the end of the second Benefit Quarter following the Benefit Quarter in which your death occurred.

Self-Paying for Coverage

If you fail to accumulate enough hours for eligibility during a Working Quarter, you can self-pay to continue coverage under the Plan's provisions for continuation coverage.

Eligibility Requirements

You must meet all of the following requirements to be eligible for coverage under the self-payment option:

- You must have been eligible for coverage for at least three consecutive years;
- You must have been eligible for coverage in the immediately preceding Benefit Quarter; and
- You must be willing to and available for work.

If you have not been eligible for coverage for at least three consecutive years but meet the remaining requirements, you can self-pay to continue coverage for a maximum of two consecutive Benefit Quarters.

Notification Procedures

You will receive a "Work History" report from the Fund Office at least 15 days prior to the start of each Benefit Quarter. This report shows the number of hours you have worked during the applicable Working Quarter. If, after reviewing the report, it looks as though you are not eligible for coverage during the next Benefit Quarter, you must immediately send the appropriate self-payment to the Fund Office. Your self-payment must be received by the Fund Office within 10 days after you receive the "Work History" report for your coverage to continue. If you have any questions about the report, you should contact the Fund Office for more information.

NOTE: Even if you are not entitled to a monetary benefit for your disability, you may be entitled to eligibility hours credits to maintain Plan eligibility. Contact the Fund Office for any occurrence of disability.

How My Self-Pay Premium is Determined

Your employer makes self-pay contributions to the Fund on your behalf, so you generally don't have any monthly premiums. You may be required to make direct payments to the Fund Office for coverage if you:

- Don't work 360 hours during a Working Quarter; or
- Continue your coverage under COBRA (see page 13).

The amount you will pay in these cases is different based on the different circumstances. The premium cost for self-payment if you don't work 360 hour is $12.92 in early 2017 (this amount may be changed by the Trustees from time to time) multiplied by 360, or $4,651 per quarter for you and your eligibility dependents. However, you reduce the amount of the premium by every hour you work during the Working Quarter. **For example, if you work 200 hours, your premium would be based on 160 hours (360 hours required minus 200 hours worked) or 160 x $12.92, or $2,067.20.** This is the same cost you would pay to continue coverage if your eligibility for benefits terminates due to insufficient hours resulting from disability or for any other reason. In the event of short-term disability, you may be entitled to disability hours credits to maintain eligibility as described on page 6. In the event of permanent and total disability resulting in a disability benefit from the NECA Local 313 IBEW Pension Plan, your eligibility for benefits will be in accordance with rules for retirees on page 10.

The cost for Retiree Coverage (see page 12) and COBRA coverage (page 14) is described in those sections.

Reinstatement of Eligibility Within Two Years

If you lose eligibility because you stop working for a Contributing Employer but return to work within two years of the date your coverage terminated, you can reestablish coverage by working 360 hours during a Working Quarter. Coverage will begin on the first day of the following Working Quarter. If you return to work after this two-year period, you must meet the Plan's initial eligibility requirements to obtain coverage. Different rules apply if you terminated employment to enter military service (see page 19 if you enter active military service).

Reciprocal Agreements

This Plan also has reciprocal agreements with certain other employee welfare benefit plans. Under these agreements, your hours worked and contributions paid to such other plans based on your employment within their jurisdictions are transferred to this Plan on a one to one basis so long as the contribution rate is the same for each plan. In the event the two contribution rates are not the same, hours will be credited at the NECA Local Union No. 313 IBEW Health & Welfare Plan rate, which may cause your actual hours credited to be less than your actual hours worked.

For example, if you work 80 hours for an out-of-town employer and if the employer's contribution rate to the out-of-town health and welfare fund is 85% of the NECA Local Union No. 313 IBEW Health & Welfare Plan contribution rate, you will be credited with 68 hours worked in the NECA Local Union No. 313 IBEW Health & Welfare Plan (80 x .85).

When contributions are received by this Plan from a reciprocal welfare plan, hours worked under the collective bargaining agreements of the reciprocal welfare plan are credited at the appropriate percentage depending on the ratio of the contribution rate for the reciprocating plan to this Plan (but not greater than one) for eligibility purposes under this Plan. Contributions received by this Plan that are transferred to a reciprocal welfare plan are not counted for eligibility purposes under this Plan.

Eligibility for Retiree Benefits

FAST FACTS:

- As a retiree, you may maintain your Plan coverage if you meet all the required criteria.
- Plan health coverage for retirees is similar to what active participants have; some of the differences in the coverage are:
  - No Weekly Disability Income Benefits;
  - Half as much Death Benefit and Accidental Death & Dismemberment (AD&D) Insurance; and
  - If Medicare eligible, Medicare is primary for medical claims, and the Plan provides Medicare supplement benefits for medical claims.
- The Trustees determine if there's a cost for Retiree Coverage and if there is, this premium is generally deducted from your NECA Local 313 IBEW Pension benefit.
- If you don't qualify for Retiree Coverage under the Plan, you may be eligible to pay for coverage under the Federal program known as COBRA.
- After you become eligible for Medicare, if you continue Plan coverage, Medicare will pay claims first (primary plan) and this Plan will pay second. The Plan premium to continue eligibility may continue to be deducted from your pension benefit.
- Once you receive your Medicare card, you must provide a copy of your card to the Fund Office.
- You can temporarily waive Retiree Coverage (see section called "Temporary Waiver of Retiree Coverage" on page 11).

When you retire, you may be eligible for coverage similar to what's provided for active participants and their dependents. Your Weekly Disability Income Benefits will stop and coverage for Death Benefit and Accidental Death & Dismemberment (AD&D) Insurance are reduced to half the amount of active participants.

To be eligible for Retiree Coverage, you must meet all the following requirements:

- Retire at age 55 or later;
- Be receiving a pension from the NECA Local 313 IBEW Pension Plan;
- Be eligible for benefits from this Plan immediately prior to retirement; and
- Pay any required retiree premium, as determined by the Trustees.

If you are receiving a disability benefit from the NECA Local 313 IBEW Pension Plan, you qualify for Retiree Coverage, provided you meet the criteria above except for the age 55 requirement.

If you qualify, coverage begins on the first day of the Benefit Quarter following the Benefit Quarter in which your pre-retirement accrued work hours and the hours in your Reserve Account are exhausted or canceled.

Coverage for Dependents

Your dependents will be covered under your Retiree Coverage as long as you are covered and as long as they remain eligible. Dependent coverage ends when they no longer meet the Plan definition of an eligible dependent (see page 6).

There's an exception to this rule: If you die, your surviving spouse may continue Plan coverage if the following conditions are met:

- Your spouse is covered by the Plan at the time of your death;

- Your spouse continues to pay the required monthly premium; and
- Your spouse does not remarry.

Your spouse's request must be made in writing to the Fund Office.

Dependent children will have the opportunity to elect COBRA continuation coverage (see page 13).

If your surviving spouse continues coverage, the Plan will be secondary to all other group health plans, which cover dependents, except Medicare (see page 21).

When Retiree Coverage Ends

Your Retiree Coverage will end on the earliest of the following dates:

- The last day of the calendar month in which you are no longer a retired participant;
- The day you stop making required contributions or discontinue authorization for contributions to be deducted from your monthly pension;
- The day the Plan is discontinued;
- The day you qualify for benefits as an active participant because you have returned to work for a contributing employer; or
- The day you die.

Temporary Waiver of Retiree Coverage

If you meet the requirements for continued coverage as a Retiree under the Plan when you are initially eligible for Retiree Coverage, or if you are currently eligible for coverage as a Retiree, you may temporarily opt out of coverage.

To temporarily opt out of Retiree Coverage and reserve the option to enroll or re-enroll at a later date, you must notify the Fund Office in writing on the Opt Out Form For Temporary Waiver of Retiree Health & Welfare Plan Coverage, provided by the Fund Office.

You may temporarily opt out of and later return to Retiree Coverage within thirty (30) days of the following events, provided you complete the necessary forms and provide the necessary documentation:

1. the earlier of your Medicare eligibility or age 65 regardless of whether or not you have alternate coverage,
2. at any time, if you lose alternate coverage through no fault of your own.

Examples of "ceasing to have alternate coverage through no fault of your own" include, but are not limited to, loss of coverage under another employer's group health plan or your spouse's employer's health plan for reasons other than nonpayment of premiums; or the termination of COBRA coverage or coverage through the insurance exchange marketplace for other than nonpayment of premiums.

If you re-enroll when you become Medicare eligible, the Fund will provide coverage secondary to Medicare in accordance with the Plan's Medicare Supplemental Coverage schedule on pages 22 and 23.

If you do not re-enroll in Retiree Coverage at the earlier of Medicare eligibility or age 65, you may only re-enroll in the Retiree Coverage at a later date upon loss of alternative coverage through no fault of your own.

If you are not eligible for coverage as a retiree, you may be eligible for coverage under COBRA, explained on page 13.

To reinstate your Retiree Coverage at any time for any of the allowable reasons noted above, you must request re-enrollment and submit the necessary paperwork to the Fund Office within thirty (30) days of the loss of alternate coverage or the commencement of Medicare eligibility. If you do not timely re-enroll as required, you will never be able to enroll in Plan coverage at a later date.

By opting out of Retiree Coverage, you, your spouse and your dependents, if any, will NOT be eligible for ANY benefits provided under the Local 313 Health and Welfare Plan, including medical, pharmacy, dental, vision and life insurance. Upon opting out of Retiree Coverage, you will not receive notices from the Plan disclosing changes in Plan provisions, such as summaries of material modifications. Plan provisions, including changes to the requirements for re-enrollment, are subject to modification by the Board of Trustees at any time.

Cost of Retiree Coverage

The Trustees may, from time to time, determine to change the cost to continue Retiree Coverage under the Plan. Currently, that cost is $1,230 monthly (this may change from time to time as decided by the Trustees) for retirees under age 65. The current monthly cost of coverage for retirees who have attained age 65, for widows, for dependent children with both parents deceased and for participants receiving a disability benefit from the NECA Local 313 IBEW Pension Plan ranges from $230 to $250, depending on your classification. Any contribution will be deducted from your pension payment, unless you request self-payment.

Contributions received for work performed during a Working Quarter will be used to offset the self-payment requirements for the corresponding Benefit Quarter. See page 5 for more information on Working and Benefit Quarters.

Continuing Your Coverage Under COBRA

FAST FACTS:

- You and your eligible dependents may elect coverage under the federal law known as COBRA when your NECA Local 313 IBEW Health and Welfare Plan coverage ends due to a Qualifying Event.
- To continue this coverage, which is the same coverage you had before the Qualifying Event, you must elect COBRA coverage when it's offered and make timely monthly payments to the Fund Office.

The NECA Local 313 IBEW Health and Welfare Plan provides the opportunity for benefits to continue in certain situations when you don't work the required hours, such as when you are disabled, on Family and Medical Leave or when you are retired.

COBRA

If you're not eligible for extended coverage through the Plan when your coverage ends and you experience a "Qualifying Event," you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This federal law gives you the opportunity to temporarily purchase the health coverage you had prior to the Qualifying Event. By making monthly payments, you and/or your dependents may continue coverage up to 18, 29 or 36 months, depending on the Qualifying Event. To maintain your coverage under COBRA, you must make timely monthly payments to the Fund Office. You are fully responsible for the payment of your coverage under COBRA.

Qualifying Events

To be eligible for COBRA Continuation Coverage, you (as the participant) and/or your dependent(s) must lose coverage due to any one of the following Qualifying Events:

Qualifying Event	Who May Purchase	Maximum Period of
Participant loses eligibility due to termination (for any reason other than gross misconduct) or a reduction in hours of employment (including retirement and layoff)	Participant, spouse and/or dependent children	18 months
Termination or reduction in hours while you or your dependent is disabled	Participant, spouse and/or dependent children	29 months (18 months plus an additional 11)
Participant becomes entitled to Medicare and voluntarily drops Plan coverage	Spouse and/or dependent children	36 months
Participant dies	Spouse and/or dependent children	36 months
Participant is divorced or legally separated from spouse	Spouse and/or dependent children	36 months
Child is no longer considered a dependent child by this Plan's definition	Dependent child	36 months

Notify the Fund Office

You or a family participant should notify the Fund Office when any Qualifying Event occurs to avoid confusion over the status of your healthcare in case your employer does not provide prompt or correct information.

Qualified Beneficiaries

Under the law, only "qualified beneficiaries" are entitled to COBRA continuation coverage. Qualified beneficiaries are:

- You, as the participant;
- Your spouse; and
- Your dependent children.

One or more of your family members may elect COBRA even if you do not. However, in order to elect COBRA coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event. A child who becomes a dependent child by birth, adoption or placement for adoption with you while you are enrolled in COBRA coverage is also a qualified beneficiary. However, a person who becomes your spouse while you are enrolled in COBRA does not become a beneficiary. The individual must be your spouse prior to the continuation coverage starting to be a qualified beneficiary.

You or your spouse may elect or reject COBRA continuation coverage on behalf of dependent children living with him or her.

How to Elect COBRA Continuation Coverage

In some cases, your employer will notify the Fund Office. In other cases, you or your dependent must notify the Fund Office, as shown in the chart below.

In order to elect COBRA Continuation Coverage, the Fund Office must be notified when you have a Qualifying Event. You (or your employer) must notify the Fund Office at 800-223-7405 or 302-761-1080 within 60 days from the date that you lost coverage under the NECA Local 313 IBEW Health and Welfare Plan because of the Qualify- ing Event, or 60 days from the date that you received the election form and COBRA information, whichever is later.

When Your Employer Is	When You Are Responsible
Your employment terminates	You divorce
Your hours are reduced	You become legally separated
You retire	Your child no qualifies as a dependent under the plan
You become entitled to Medicare	You become entitled to Medicare
You die	You die (your family is responsible)

When the Fund Office receives notice of the Qualifying Event, they will mail you an election form, information about COBRA and the date on which your coverage will end.

Under the law, you and/or your covered dependents have 60 days to decide, from the later of the date:

- You would have lost coverage because of the Qualifying Event; or
- You and/or your covered dependents received the election form and COBRA information.

If you and/or any of your covered dependents do not elect COBRA within 60 days of the date you lose coverage because of a Qualifying Event (or, if later, within 60 days after receiving that notice), you and/or your covered dependents will not have any group health coverage from this Plan after your coverage ends.

Paying for COBRA Continuation Coverage

When you and/or your dependents become eligible for COBRA continuation coverage, the Fund Office will notify you of the COBRA premium amount that you must pay. You are responsible for the entire cost. Your COBRA premiums may be up to 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA Continuation Coverage for Disabled Participants.")

You must make payments so that your COBRA coverage is continuous. To prevent a lapse in coverage, you must send the first COBRA payment to the Fund Office within 45 days from the date on which you elect COBRA coverage. Payments for subsequent months are due on the first day of the month for which coverage is provided.

If you choose COBRA within the election period but after the date your eligibility ended, you must pay the required COBRA premiums retroactively to cover the elapsed period.

COBRA Continuation Coverage for Disabled Participants

If you are covered under COBRA for 18 months, and within the first 60 days of coverage you (or your covered dependent) become disabled, you (or your dependent) may be eligible to continue your COBRA coverage for an additional 11 months for a total of 29 months.

To be eligible, the Social Security Administration must make a formal determination that you (or your dependent) are disabled and therefore entitled to Social Security disability income benefits. You (or your dependent) must notify the Fund Office of the Social Security determination of disability within 60 days from the date you received the determination.

If you are eligible for the 11-month disability extension, your COBRA premiums may be up to 150% of the regular premiums for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- The last day of the month that occurs 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled;
- The end of the 29 months of COBRA coverage; or
- The date the disabled person becomes entitled to Medicare.

If you recover from your disability before the end of the initial 18 months of COBRA continuation, you will not have the right to purchase extended coverage. You must notify the Fund Office within 30 days of:

- The date that you receive a final Social Security determination that you and/or your dependent(s) are no longer disabled; or
- The date that the disabled person becomes entitled to Medicare.

Multiple Qualifying Events While Covered Under COBRA

The maximum period of coverage under COBRA is 36 months, even if you experience another Qualifying Event while you're already covered under COBRA. If you're covered under COBRA for 18 months because of your termination of employment or reduction in hours, your affected spouse or dependent may extend coverage for another 18 months if:

- You get divorced or legally separated;
- You become entitled to Medicare;
- Your child is no longer a dependent under the Plan's definition; or
- You die.

For example: Kevin stops working (the first COBRA-Qualifying Event), and enrolls himself and his family in COBRA Continuation Coverage for 18 months. Three months after his COBRA Continuation Coverage begins, Kevin's child turns 26 and no longer qualifies as a dependent child under the Plan's definition. Kevin's child can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA Continuation Coverage.

What You Need To Do:

If you lose coverage due to a Qualifying Event:

- Inform the Fund Office of the Qualifying Event and request a COBRA election form.
- Complete and mail back the election form within 60 days of the date you received it, or 60 days of the date you lost coverage because of the Qualifying Event, whichever is later.
- Make your first payment to the Fund Office within 45 days from the date elect COBRA coverage.

Need to Contact the Social Security Administration ?

Visit the Social Security Administration website at www.ssa.gov, or call 800-772-1213.

If you marry, have a newborn child, adopt a child or have a child placed with you for adoption while you are enrolled in COBRA, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage. You must enroll your new dependent within 31 days of the marriage, birth, adoption or placement for adoption.

You, as the participant, are not entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage because of a disability). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and you may not extend your coverage.

Coverage for Your Dependents if You're Enrolled in Medicare

If you are enrolled in Medicare and your hours are reduced or your employment is terminated, your eligible dependents would be entitled to COBRA for a period of 18 months (29 months if the 11-month Social Security Disability extension applies) from the date of your termination of employment or reduction in hours or 36 months from the date you became entitled to Medicare, whichever is longer.

Special COBRA Enrollment Rights

In addition, if you are enrolled for COBRA coverage and your spouse or dependent child loses coverage under another group health plan, you may enroll that spouse or child for coverage for the balance of the period of COBRA within 31 days after the termination of the other coverage.

To be eligible for this special enrollment right, your spouse or dependent child must have been eligible for coverage under the terms of the Plan but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage.

Adding a spouse or dependent child may cause an increase in the amount you must pay. To find out about COBRA rates, contact the Fund Office.

Confirmation of Coverage to Healthcare Providers

Under certain circumstances, federal rules require the Plan to inform your physician and healthcare providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule applies only in certain situations where the physician or provider is requesting confirmation of coverage and you are eligible for (but you have not yet elected) COBRA coverage, or you have elected COBRA coverage but have not yet paid for it.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- You do not make all required payments on time;
- The person receiving the coverage becomes covered by another group health plan;
- The person receiving the coverage becomes entitled to Medicare;
- The Plan terminates its group health plan and no longer provides group health coverage to its participants.

As an alternative to COBRA, when you lose coverage, you may want to look for a health insurance plan on your state or the federal health insurance marketplace. Visit www.healthcare.gov for more information and to see if you may qualify for a health insurance subsidy.

If you have questions about COBRA Continu-ation Coverage, contact the Fund Office at 800-223-7405.

Life Events That Affect Your Coverage

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when you experience certain "life events" and what you must do at those times to make sure you get the most from your Plan coverage.

FAST FACTS:

- You should notify the Fund Office as soon as possible if you experience a life event that may affect your coverage.
- You and/or your dependents may qualify to continue coverage under COBRA in the event you lose eligibility due to reduction of your work hours, termination of your employment or divorce from your spouse.
- Be sure to take any action required promptly when you experience these life events in order to get maximum benefit from your Plan coverage.

The following life events may affect your coverage:

- Moving to a new address
- Getting married or divorced
- Having a baby
- Adopting a child or having a child placed with you for adoption
- Experiencing a medical emergency
- Taking Family Medical Leave
- Loss of eligibility under another health plan
- Losing eligibility (dependents)
- Becoming laid-off
- Terminating employment
- Becoming disabled
- Retiring
- Becoming eligible for Medicare
- Death

If You Move

If you move, keep in touch! Notify the Fund Office in writing as soon as possible to make sure your records are up to date and to avoid a delay in the payment of your claims.

If You Get Married

If you legally marry, your spouse is eligible for dependent benefits under the Plan. You must enroll your spouse by completing an enrollment form available from the Fund Office within 60 days of the marriage.
If the enrollment form is received at the Fund Office more than 60 days after your marriage, your new spouse's coverage effective date will be the first of the month following receipt of the enrollment paperwork.

Once you provide the required information, your spouse is eligible for coverage under the Plan as of
the date of your marriage. If you wish to name your spouse as your beneficiary for your death benefit or accidental death and dismemberment benefit, contact the Fund Office for a "Change of Beneficiary" form.

If your spouse is covered under another group medical plan, you must report this other coverage to the Fund Office. The amount of benefits payable under the NECA Local 313 IBEW Health & Welfare Plan will be coordinated with your spouse's other coverage. For more information, see "Coordination of Benefits" on page 59.

If You Acquire a Stepchild through Marriage

Notify the Fund Office in writing if you are planning to cover a stepchild within 60 days of your marriage. If the enrollment form is received at the Fund Office more than 60 days after your marriage, your new stepchild's coverage effective date will be the first of the month following receipt of the enrollment paperwork. You will need to provide the following information:

- A completed Enrollment Form adding the stepchild;
- A copy of your divorce decree or custody orders for the stepchild;
- Your stepchild's birth certificate;
- A copy of your marriage certificate; and
- A copy of your child's other medical insurance information, if he or she is covered under another group insurance plan.

If You Have a Baby

What You Need To Do:

If you have a baby, you should timely provide the Fund Office with the fol- lowing information:

- A completed enrollment form adding your child as a dependent;
- The baby's birth date;
- A copy of the baby's birth certificate; and
- A copy of your baby's other medical insurance information if he or she is covered under another group insurance plan.

Once your child is born, notify the Fund Office in writing that you want your child covered under the Plan; then obtain, complete and submit an enrollment form within 60 days following the date of birth. As long as you are eligible for benefits, your child's coverage effective date will be as of the date of his or her birth. If the enrollment form is received at the Fund Office more than 60 days after the child's date of birth, the child's coverage effective date will be the first of the month following receipt of the enrollment paperwork.

If You Adopt a Child or a Child is Placed with You for Adoption

What You Need To Do:

If you need to add a child to your coverage, you should provide the Fund Office with the following information:

- A completed enrollment form adding your child as a dependent;
- A copy of the adoption certificate or documentation of the placement of adoption; and
- A copy of your child's other medical insurance information, if he or she is covered under another group insurance plan.

If you adopt a child or a child is placed with you for adoption, contact the Fund Office in writing that you want your child covered under the Plan; then obtain, complete and submit an enrollment form within 60 days following the date of adoption. If the enrollment form is received at the Fund Office more than 60 days after the date of adoption or placement for adoption, the child's coverage effective date will be the first of the month following receipt of the enrollment paperwork. Your child will be covered under the Plan as long as you are responsible for health care coverage, and your child meets the Plan's definition of a dependent child.

If You Take Family Medical Leave (FMLA)

If you take leave under FMLA, you can continue Plan coverage for yourself and your eligible dependents by paying contributions as they become due. If your coverage ends while you are on approved FMLA, your coverage will be reinstated on the day you return to active service if you return promptly. Your reinstated coverage will be subject to all accumulated maximum benefits that were incurred prior to the leave. FMLA leave is not counted as a break in coverage.

If Your Child's Eligibility for Benefits Changes

If your child is no longer eligible for benefits under the Plan because of loss of dependency, you or your child must notify the Fund Office in writing as soon as possible. If you do not notify the Fund Office in a timely manner, you will be responsible for reimbursing the Plan for all expenses that your child has incurred while he or she was ineligible for coverage and not covered under COBRA.

If You Divorce

If you divorce from your spouse, notify the Fund Office as soon as possible. Once you are divorced, your spouse's Plan coverage is terminated at the end of the month. He or she may enroll in COBRA Continua- tion Coverage if the Fund is notified of the divorce in a timely manner (see page 13).

If you do not notify the Fund Office in a timely manner when you divorce, you will be required to reimburse the Plan for any expenses paid by the Fund that your ex-spouse incurred during the period he or she was not eligible for coverage and not covered under COBRA.

Divorce Revokes Designation of Beneficiary

If you have designated your spouse as a Beneficiary of your benefits under this Plan, and you and the spouse that you have designated as Beneficiary are subsequently divorced, the divorce decree that relates to such spouse shall revoke your designation of that spouse as your Beneficiary unless a Qualified Domestic Relations Order provides otherwise or subsequent to such divorce decree, you re-designate your ex-spouse as a Beneficiary.

If your ex-spouse wants to continue coverage, he or she must:

- Contact the Fund Office; and
- Enroll in COBRA Continuation Coverage (see page 13).

What You Need To Do:

- Contact the Fund Office for an enrollment form to remove your former spouse as a dependent and to name a new beneficiary, if you'd like;
- Provide the Fund Office with a copy of your divorce decree; and
- If you have children and you do not have custody, provide the Fund Office with a copy of any Qualified Medical Child Support Order (QMCSO), if applicable.

If You Are Named in a Qualified Medical Child Support Order

As the result of federal legislation in 1993, healthcare plans can be required by an order to cover a participant's child(ren) regardless of whether or not the participant has enrolled him or her. These orders, called Qualified Medical Child Support Orders (QMCSO), generally result from orders requiring a non-custodial divorced or separated parent to provide coverage for a child under his or her employer's group health plan.

If you receive a support order, submit it promptly to the Fund Office so it can be determined if the order is a QMCSO according to federal law. Upon receiving the support order, the Plan Administrator will promptly notify you and the child that the support order was received and the Plan's procedures for determining if it is a **qualified** order. As required under the Employee Retirement Income Security Act (ERISA), this Plan will recognize a support order that:

- Provides for health coverage to the child(ren) under state domestic relations law (including a community property law); and
- Relates to benefits under this Plan.

If the support order is determined to be a qualified support order, the child will then be considered a dependent child and receive all Plan benefits for which he or she is eligible.

A copy of the procedures governing QMCSO determinations is available upon request and free of charge from the Plan Administrator.

Please contact the Fund Office at 800-223-7405 if your situation involves a medical child support order for information about how these orders are handled. You and/or your beneficiary(ies) can obtain, without charge, a copy of the Plan's QMCSO procedures from the Fund Office.

If You Enter Active Military Service

If you go into active military service duty in the U.S. Armed Forces or the National Guard for up to 31 days, you (and your eligible family participants) may continue coverage during that time.

If you go into active military service duty for **more than** 31 days, you may be able to continue coverage for up to 24 months at your own expense. Plan provisions that allow you to continue coverage comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility, as well as any hours remaining in your Hour Bank Account, will be reinstated on the day you return to Covered Employment, provided that you return to employment within:

- 90 days from the date of discharge if the period of your service was more than 180 days; or
- 14 days from the date of discharge if the period of your service was at least 31 days, but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of your service was less than 31 days.

What You Need To Do:

- Review the report of your hours worked sent to you by the Fund Office at least 10 days before each Benefit Quarter starts.
- If it shows you aren't eligible for coverage during the next Benefit Quarter, immediately send in the required self-payment premium to the Fund Office. Your payment must be received no later than 10 days after you receive your work history report for your coverage to continue.
- Call the Fund Office if you have questions about the report.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for a recovery of up to two years.

Contact the Fund Office for information if you are called to active military service. This Plan will coordinate coverage with Tricare/CHAMPUS (see page 61).

If You Are Laid Off or You Work Limited Hours

If you are temporarily laid off due to lack of work, or you are working occasionally but cannot meet the requirement of 360 hours in a Working Quarter, you may use banked hours in your Reserve Account to make up the difference. If you don't have enough working hours or banked hours, you may continue your coverage under the self-payment option. (See page 8 for more information.)

If You Stop Working

If you cease to be available to work in the bargaining unit, your coverage under the Plan will end on the day your employment ends. If your coverage ends because of a Qualifying Event, you may elect to purchase COBRA Continuation Coverage (see page 13). Be sure to notify the Fund Office promptly if your hours are reduced or terminated. You will lose your right to purchase COBRA Continuation Coverage if the Fund Office does not receive proper notification within 60 days.

If you return to work for a Contributing Employer within two years of the date coverage stops, you can reestablish coverage by working 360 hours during a Working Quarter. If you return to work after more than two years, you must again meet the Plan requirements for initial eligibility, described on page 5.

What You Need To Do:

If you stop working for any reason, you should:

- Inform the Fund Office promptly;
- Enroll in COBRA, if you are eligible and if you wish to continue your coverage; and
- Pay the required premiums promptly.

If You Become Disabled

If you are unable to work because of disability, you will be credited with 360 hours of employment each Working Quarter for the period you:

- Receive Weekly Disability Income benefits; or
- Receive Workers' Compensation benefits.

Initially, if you become Totally Disabled, Plan benefits will continue **for you and your dependents** until the earliest of the date:

- You recover from Total Disability;
- You meet the requirements for a retirement benefit;
- If you were eligible for coverage for less than 10 years at the time of disability, the end of the time period that's equal to the period covered by the Plan. If you have a Reserve Account, any banked hours may extend your coverage beyond that period; or
- 12 months after the onset of your disability.

Total disability means that you have qualified for Social Security benefits.

If you fail to obtain Social Security disability benefits within two years from the date of onset of the disability, your Plan benefits may be suspended.

If you return to work for a Contributing Employer after recovering from Total Disability, your Plan coverage will remain in effect until you can reestablish coverage by working 360 hours during a Working Quarter. The Trustees have the right to require periodic medical evidence of Total Disability during any period Plan benefits are continued.

What does it mean to be "Totally Disabled"?

Totally Disabled means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted (or can be expected to last) for a period of not less than 12 months.

If You Retire

When you retire, you may qualify for Retiree Coverage by meeting the following requirements:

- Retire at age 55 or later;
- Be receiving a pension from the NECA Local 313 IBEW Pension Plan;
- Be eligible for benefits from this Plan immediately prior to retirement; and
- Pay any required retiree premium, as determined by the Trustees.

If you retire before age 62, you may pay for Plan coverage until age 62, provided you meet all the other criteria above. The cost during the transitional Benefit Quarter when your accrued hours and reserve account have been exhausted is the same as the self-pay option for active participants (see page 8).

Retiree Coverage is different from active participant coverage in the following ways:

- Weekly Disability Income Benefits stops;
- Coverage amounts for Death Benefit and Accidental Death & Dismemberment (AD&D) Insurance are cut in half.

If you do not meet the requirements for Retiree Coverage, you can purchase COBRA continuation coverage (see page 13).

If You Become Eligible for Medicare

You or your covered spouse generally becomes eligible for Medicare when you each attain age 65. Medicare is the federally sponsored health care program consisting of hospital insurance benefits (Part A) and supplementary medical insurance (Part B).

You and/or your covered spouse should enroll in Medicare Part A and Part B as soon as eligible after retirement—three months before your 65th birthday or prior to that if you become disabled—in order to avoid a gap in coverage. If you don't apply for Medicare Part B within three months from the date you turn 65, it may cost you more to enroll later. **It is extremely important when you become Medicare- eligible that you enroll in Part B benefits to avoid paying higher premiums later on. You must be enrolled in Part A when you begin receiving benefits.**

Medicare Part A is free. Medicare Part B has a cost, so you must pay a monthly or quarterly premium for it. It's vital that you enroll as soon as you are eligible and pay for Part B in order to be eligible for the Plan's Medicare Supplement coverage. Once you are enrolled in Medicare, Medicare becomes your primary plan, so submit all medical claims to Medicare first, then to this Plan.

When you're eligible for Medicare, benefits available under Medicare are deducted from covered benefits payable under this Plan—regardless of whether you have enrolled for Medicare.

What You Need To Do:

- Promptly notify the Fund Office when you become disabled;
- Furnish appropriate proof of your medical disability, at the time of the occurrence and periodically, as required by the Trustees;
- Apply for Social Security disability benefits;
- Submit to a medical examination by a doctor named by the Trustees, if requested; and
- Document economic necessity for benefits, if requested by the Trustees.

What You Need To Do:

When you are ready to retire, you should:

- Contact the Fund Office.
- Request a pension application.
- Complete and submit the application and pay any required premium or complete the paperwork to have your premium deducted from your pension check.
- If you are not eligible for Retiree Coverage, enroll in COBRA continuation coverage by the deadline and pay the required premium when it's due.

Contact Medicare for an Explanation of How Medicare Works

You can contact the Medicare Service Center: 800-MEDICARE (800-633-4227).

To Enroll in Medicare:

- Visit your local Social Security Office;
- Call 800-MEDICARE (800-633-4227); or
- Go to the Medicare website at www.medicare.gov.

Medicare Supplemental Coverage

Inpatient Hospital Services	Medicare Covers	Medicare Supplement Covers
Acute Hospitals	For 60 days, Medicare pays all but the deductible.	The deductible
	For the next 30 days, Medicare covers all but the coinsurance.	Pays the coinsurance for the 61st through the 90th day
	There is a lifetime maximum of 60 days with all but the daily coinsurance covered. These days may be used at the patient's discretion.	Covers 91st through 120th day in a benefit period in a general hospital for non-mental illness. (Days may be used before Medicare's lifetime reserve. State your desire to substitute these days of coverage in writing to the hospital. Covers the coinsurance for 60 lifetime reserve days.)
Accommodations	a)Charged semi-private rate b)Average semi-private rate toward private room charge unless medically necessary when most prevalent private room charge is paid. c)Intensive Care covered	a) Charged semi-private rate
Ancillary Services	a) Coverage in full for the number of days approved	a) No coverage
	b) Whole blood covered after first 3 pints	b) Not covered
Nervous & Mental (Inpatient hospital)	190 lifetime days; Medicare pays all but the deductible for the first 60 days and pays all but coinsurance for following days	Pays the deductible and pays the coinsurance amount for the lifetime days approved under Medicare
Services in Skilled Nursing Facilities	All covered services for the first 20 days. For the next 80 days, Medicare pays all but the daily coinsurance. (Services covered only after a 3-day minimum hospital stay.)	Pays the coinsurance for the 21st through the 100th day
Inpatient Dental Surgery	Hospital services for surgery related to the jaw; reduction of fracture of the jaw or facial bone	Most-inpatient hospital admissions for dental surgery are not covered by Medicare
Coverage outside the United States	Benefits provided only in certain unusual emergency circumstances	Benefits equivalent to Medicare and hospital benefits in the U.S. with no reduction for deductible and coinsurance
Emergency Accident, Medical Emergency, Radiation Therapy, X-Ray, Laboratory, Anesthesia	80% of Medicare-approved amount	Pays the deductible and 20% coinsurance
Home Health Services	Covered in full	No coverage
Ambulance, Appliances, Supplies and Durable Medical Equipment	80% of Medicare-approved amount after deductible	Pays deductible and coinsurance

Inpatient Hospital Services	Medicare Covers	Medicare Supplement Covers
Physician Services Outpatient Psychiatric	80% of Medicare-approved amount, after deductible	Pays deductible and coinsurance
Home and Office Physician's Visits	80% of Medicare-approved amount	Pays deductible and coinsurance
Surgery, X-Ray, Anesthesia, Consultations, Inpatient Skilled Nursing Facility Medical visits, In-hospital medical visits, Medical Emergency in Outpatient Department of Hospital only, Laboratory, Machine Tests, Radiation Therapy	80% of Medicare-approved amount, after deductible	Pays deductible and coinsurance
Coverage outside the United States	Benefits provided only under certain unusual emergency circumstances	As provided in schedule
Physical Therapy, Clinical Services, Injections	80% of Medicare-approved amount, after deductible	Pays deductible and coinsurance
Inpatient Hospital Services extended 121st through 365th day in an acute hospital	No coverage	Beginning with the 121st day of each benefit period, while a bed patient in an acute hospital, inpatient hospital services equivalent to Medicare hospital benefits will be covered without the reduction for Medicare's deductible and coinsurance, and will continue through the 365th day of inpatient care in a benefit period. If a private room is occupied, an allowance of the most prevalent charge for semi-private accommodations will be made toward the charges for bed and board. Note: these benefits are not provided for hospitalization for tuberculosis, nervous or mental disorders including alcoholism or drug addiction.
Prescription Drugs	No coverage	Use the UHC/Sav-Rx Prescription Drug Card and/or the Mail-Order Drug Program
Private Duty Nursing	No coverage	This program covers the services of a Registered Professional Nurse at 80% or up to a maximum of 240 hours during any period of 12 months. If an R.N. is not available, at the discretion of the Plan, benefits limited to a maximum of $21 per 8-hour shift may be provided for a Licensed Practical Nurse.

*Medicare benefits are subject to change. If there is a discrepancy between the Medicare benefits described here and the Medicare benefits described in the official Medicare documents, the official Medicare documents will rule.

If You Die

If you are married and your death occurs while you're covered by the Plan, any continuing coverage for your dependents depends on your status at the time.

Active Participants

If you are an active participant and had been a Plan participant for at least 15 consecutive Benefit Quarters prior to your death, your surviving spouse will continue to be covered under the Plan until he or she remarries, as long as he/she meets the eligibility requirements for continuing coverage (see page 7). Your dependent children will continue to be covered until they are no longer considered dependents under the Plan, provided premium payment is made as required.

If you did not have 15 consecutive Benefit Quarters prior to your death, your dependents' coverage ends at the end of the second Benefit Quarter following the Benefit Quarter of your death.

Your death would be a Qualifying Event under COBRA, so the opportunity for your eligible survivors to purchase continuation coverage is available (see page 13).

What Your Spouse Needs To Do

In the event of your death, your spouse must:

- Notify the Fund Office;
- Provide the Fund Office with a copy of your death certificate.

Retired Participants

If you are retired and receiving Plan benefits at the time of your death, your surviving spouse will continue to receive coverage provided that:

- Your spouse is covered by the Plan at the time of your death;
- Your spouse continues to pay the monthly premium; and
- Your spouse does not remarry.

Note that your spouse's eligibility in this Plan will not be affected if Pension Plan benefits stop because of the pension payment option you selected.

If your surviving spouse continues coverage, the Plan will be secondary to all other group health plans that cover dependents. Coverage would switch from the active to the retired category on the first day of the Benefit Quarter immediately after the Benefit Quarter in which your pre-retirement accrued work hours and all hours in your Reserve Account are exhausted.

If your surviving spouse does not meet the criteria listed above, he or she may be eligible for COBRA continuation coverage.

Your Medical Benefits

FAST FACTS:

- The Plan covers a variety of medically necessary healthcare treatments and services.
- The chart on page 3 summarizes the medical services and treatments covered by the Plan. Eligible active participants, retired participants and dependents are covered for a variety of healthcare benefits.
- Note also that the Plan covers only medically necessary services, unless otherwise stated in the Plan. That means a service is not necessarily covered just because your doctor prescribes it.

Following is a brief explanation of these services. Contact the Fund Office for more information.

All participants are encouraged to use doctors and other healthcare providers who participate in the Aetna discount network. Doctors and other healthcare providers in the Aetna network are under contract to provide services at lower, contracted rates (the "allowable charge") to Plan participants. Therefore, when you use these providers and the Plan pays 100%, there's no additional cost to you after you pay any applicable copayments. When the Plan covers 80% of the charge, you pay only the remaining 20%.

When you use doctors and other providers who don't participate in the Aetna network, expenses are covered on the basis of the allowable charge. So, if the Plan pays 80% of the allowable charge, you're responsible for paying 20% coinsurance plus any amount that is in excess of the allowable charge.
If the out-of-network doctor you choose charges more than the Aetna allowable charge, you will also pay the difference between the allowable charge and the fee charged by the doctor, even if the Plan coverage is 100%.

To find a convenient doctor who participates in the Aetna discount network, refer to the Aetna website
www.aetna.com.

Notwithstanding provisions to the contrary, the Plan does not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.

The Plan pays for covered services from the first dollar of medical expense for active and retired participants. There is no deductible to meet. Participants also have an out-of-pocket maximum, which is a safety net to limit medical expenses.

There is no lifetime maximum for benefits under the Plan.

Plan ID Cards

When you become covered by the Plan, you will be sent an identification card for the NECA Local 313 IBEW Health and Welfare Plan and a separate ID card for the prescription drug coverage. Cards are sent shortly after enrollment from Aetna and Sav-Rx. If you need additional cards for your spouse or if you lose your card, contact Aetna or Sav-Rx.

Be sure to present your ID card when you receive healthcare services. The card contains all the information to confirm your benefit coverage.

If you or your spouse is Medicare-primary, you will receive two pharmacy-benefit ID cards: one from UnitedHealthcare and one from Sav-Rx.

What is "medically necessary?"

Medically necessary means treatments, services and supplies provided by a hospital, physician or other provider that is required to identify or treat an illness or injury. The services and supplies must be:

- Consistent with the symptom or diagnosis and treatment of the condition, disease or injury;
- Appropriate with the standards of accepted professional practice;
- Required for reason other than the convenience of the patient, physician or other provider; and
- The most appropriate supply or level of a service that can be provided safely for the patient in the most appropriate inpatient or outpatient setting.

Please contact the Fund Office Claims Department (800-242-8923) if you're unsure if a particular service is covered or for more details.

What is an "out-of- pocket maximum?"

The "out-of-pocket maximum" is a safeguard that limits what you have to pay each year for healthcare expenses covered by the Plan. The Plan will pay 100% of covered expenses for the remainder of the calendar year after you have spent your out-of-pocket amount on expenses covered by the Plan. See the annual out-of-pocket maximums for the Plan on page 2. There are two separate OOP maximums, one for medical services and another for pharmacy benefits.

Hospitalization

The Plan covers eligible expenses for inpatient hospitalization, including special diets and general nursing care, in a semi-private room or, if medically necessary, in an intensive care unit. If you prefer a private room, you pay the difference between the private room and board charge and the standard semi-private room rate. Hospitalization includes nursery care for a newborn while the mother is an inpatient receiving obstetrical benefits as well as continued medical treatment, if required, regardless of whether the mother remains hospitalized.

Coverage provides for 120 days per hospital confinement; a "confinement" is a continuous period of inpatient hospitalization. A subsequent hospitalization must be separated by a period of at least 90 days to be considered a separate confinement.

If you maintain eligibility for benefits, the 120-day period may be extended unless you're being treated for pulmonary tuberculosis or in a specialized care facility. Send any request for extension of hospital care to the Trustees at the Fund Office.

Newborns' and Mothers' Health Protection Act of 1996

By law, group health plans and health insurance issuers generally may not restrict benefits for the length of hospitalization in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending doctor, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

In accordance with the Women's Health and Cancer Rights Act of 1998, the Plan will provide the following coverage for a participant or eligible dependent who is receiving benefits in connection with a mastectomy and who elects breast reconstruction surgery in connection with the mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of the mastectomy, including lymphedemas.

Inpatient Care

The following hospital services that are covered while you're an inpatient include:

- Use of an operating room and recovery room;
- Medicines listed in the U.S. Pharmacopoeia or national formulary except white blood, blood plasma and plasma expanders;
- Surgical dressings;
- Administration of blood or blood plasma (but not blood itself);
- Machine testing
- Durable medical equipment;
- Diagnostic X-ray examinations;
- Laboratory examinations;
- Dialysis;

- Therapy:

- Chemotherapy (rendered by a physician);
- Occupational therapy that relates specifically to the physician's written treatment plan and either provides significant improvement to your condition in a reasonable and predictable period of time, or is necessary to the establishment of an effective maintenance program;
- Physical therapy (rendered by a physician or licensed physical therapist) that relates specifically to the physician's written treatment plan. Therapy must either provide significant improvement to your condition in a reasonable and predictable period of time, or be necessary to the establishment of an effective maintenance program;
- Radiation therapy for proven malignancies and neoplastic diseases;
- Inhalation therapy (rendered by a physician or registered inhalation therapist);
- Speech therapy that is rendered by a licensed or state certified speech therapist, referred by a physician, and limited to functional improvement in treatment of speech impairment resulting from disease, trauma, congenital anomaly (an anatomical structural defect resulting in speech pathology) or a recent surgical procedure;
- Cognitive therapy that is rendered by an approved provider. Diagnoses eligible for coverage are stroke with cognitive impairment or head injury or trauma; and
- Cardiac therapy.

Physician Services

Coverage includes the following physician services:

- Surgical services including pre-operative and post-operative care;
- Services while you are receiving hospital benefits for a condition not requiring surgery;
- Consulting physician services if you are receiving inpatient hospital benefits, provided the attending physician or operating surgeon certifies in writing that these services are medically necessary;
- On a case-by-case basis, services of a physician or consultant, necessitated by the critical condition of a patient;
- Second surgical opinions;
- Anesthesiologist services for the physician, other than the operating surgeon or assistant surgeon, who administers anesthesia for a covered surgical, dental surgical or obstetrical procedure; and
- Dental surgical services if medically necessary to repair an injury to solid natural teeth damaged in an accident.

Get more than one opinion

The Plan strongly encourages you to obtain a second opinion for any surgery. All associ- ated costs of the second opinion are paid in full by the Plan. If you need the name of a qualified surgeon for a second opinion, contact your local medical society.

Specialized Care

Specialized treatment facilities are covered under the Plan as follows:

- Skilled Convalescent Facility treatment for up to 120 days when it follows or replaces admission to hospitals, convalescent homes and rehabilitation centers approved by the Fund Office are covered. To obtain additional days of treatment, contact the Fund Office for application procedures.
- Home healthcare services, for up to 240 days upon referral by your attending physician. Benefits include dietary advice, dressings, drugs, laboratory services, medical supplies, nursing services, physical therapy, social service guidance and related services under the direction of a licensed physician. Services must be provided in place of and as an extension of inpatient hospital care, based on a treatment program administered by a hospital or other organization approved by the Claim Office.

Services must follow a treatment plan developed by your doctor and filed with the facility. Care may be obtained at any treatment facility and is covered at 80% of eligible charges.

What You Need to Do:

You must complete and submit an enrollment form to participate in the Blood Bank benefit. Contact the Fund Office for the form.

Additional Services

The following additional services are available to active and retired participants and their dependents in the Plan.

Ambulance Service

Coverage for an ambulance is covered if all the following conditions are met:

- An ambulance is required because of a sudden, serious and unexpected condition or illness that requires immediate transportation to a local hospital;
- No other emergency transportation is available; and
- The ambulance service normally charges.

Services performed by an emergency medical technician are also covered.

Chiropractic Services

The Plan pays up to $25 per visit for up to 10 visits per calendar year. You are responsible for a $10 copay for each visit.

Clinical Trials

If you are eligible to participate in an Approved Clinical Trial with respect to treatment of cancer or another life-threatening disease or condition, the Plan will:

- Not deny you participation in the trial;
- Not deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items and services otherwise covered by the Plan that are furnished in connection with participation in the trial; and
- Will not discriminate against you because of your participation in the trial.

The Plan will deem you eligible to participate in the trial if:

- Your health care provider is a participating provider in this Plan and that provider has concluded that your participation in the trial would be medically appropriate; or
- You provide medical and scientific information establishing that your participation would be medically appropriate.

Routine patient costs do not include the following:

- The investigational item, device or service itself;
- 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; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more of the Plan's participating providers is participating in a clinical trial, the Plan may require that you participate in the trial through such a participating provider if the provider will accept you as a participant in the trial.

An Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and that is funded or approved by the federal government, conducted under an investigational new drug application reviewed by the federal Food and Drug Administration, or a drug trial exempt from having such an investigational new drug application.

A life-threatening disease or condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Durable Medical Equipment

The Plan pays 80% of the cost of the following supplies if prescribed by your physician:

- Diabetic supplies such as needles and syringes (Sav-Rx-provided meters are available at no cost to you);
- Prosthetic devices;
- Orthopedic braces;
- Durable medical equipment, such as wheelchairs and hospital beds; and
- Rental charges for medical equipment up to the

purchase price. Comfort or convenience items are not

covered.

Emergency Outpatient Care

The Plan pays benefits for treatment in a hospital or emergency facility for:

- Accidental injury within 48 hours of the accident;
- Minor surgical procedures; and
- Services required as a result of a serious and unexpected illness that requires immediate medical care.

If you visit an emergency room (ER) there is a $10 copay, then no charge up to the allowable charge, if you are admitted to the hospital. If you are not admitted to the hospital, there is a $100 copay, then no charge up to the allowable charge. This is subject to a $35 family deductible per year for outpatient lab, imaging and machine testing, regardless of whether you are admitted. The benefit is the same for both in-network and out-of-network hospitals.

If you visit an urgent care center, there is a $10 copay, then no charge up to the allowable charge, subject to a $35 family deductible per year. If you go to an out-of-network provider, the benefit is the same, but if they charge you more than the allowable charge, you'll have to pay the difference between their charge and the allowable charge, plus your copay.

Hearing Aids

The Plan pays up to $200 toward the cost of purchasing and fitting a hearing aid (excluding batteries) once in any five-year period.

Nursing Services

The Plan covers the services of a private duty registered professional nurse while you are hospitalized provided that such services are:

- Available;
- Prescribed by the attending physician;
- Medically necessary;
- Required because of the condition for which hospital care and treatment are being rendered; and
- Approved by the hospital.

Nursing services are not covered in special care facilities of a hospital such as intensive care. If a registered nurse is not available, a licensed practical nurse may provide care.

The Plan covers 80% of eligible charges for a maximum of 240 hours in a 12-month period. Contact the Fund Office if an extension of additional hours of coverage is needed. The Trustees may authorize coverage in intervals of up to 80 hours for each hospital confinement.

Visiting home nurse services are covered if prescribed by your attending physician. Visits are limited to one per day and covered at 100% of allowable charges.

Physician Visits

The Plan covers physician visits (homes or office), including allergy shots or injections. You are responsible for a $10 copayment for each visit.

Psychiatric Services

The Plan covers services billed by a physician for psychotherapeutic treatment, psychiatric counseling in the physician's office or outpatient department of a hospital and psychological testing. The following related services are not covered:

- Aptitude testing;
- Treatment of a condition which the Plan does not classify as an emotional or personality illness; and
- Psychiatric services extending beyond the period required for an evaluation and diagnosis of mental deficiency or retardation.

Therapeutic and Diagnostic Services

The Plan covers the following therapeutic and diagnostic services obtained in a hospital, physician's office or independent lab. You must first meet the diagnostic X-ray and lab deductible ($35 per family per year):

- Radiation therapy;
- Physical therapy by a registered physical therapist. The first visit is subject to a $10 copayment:
  - Visits 1-26—Plan covers 100% of charges
  - Visits 27-52—Plan covers 80% of charges
  - The 52 visit-maximum is per course of treatment
- X-ray services;
- Laboratory diagnostic services excluding allergy testing; or
- Machine-based tests such as electrocardiogram, electroencephalogram and electromyogram.

Diagnostic services are not covered when tests are performed as part of a routine physical exam or hospital admission process, unless prescribed by a physician.

Preventive Medical Services

The Fund provides coverage for preventive services as required by the Affordable Care Act (ACA). Coverage is provided on an in-network basis with no cost sharing, which means that the following services are covered at 100% of the Plan's Allowed Charge, with no coinsurance, copayment or deductible (subject to applicable age and risk factor restrictions):

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations; and
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and Health Resources and Services Administration (HRSA) guidelines, including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

If preventive services are received from a non-network provider, they are not covered.

In some cases, federal guidelines are unclear about which preventive services must be covered under the ACA. In that case, the Plan will determine whether a particular benefit is covered under this preventive services benefit. If you receive a preventive service that is not recommended in the guidelines above, the Plan's normal cost-sharing rules apply, even if the treatment results from a recommended preventive service.

Covered Preventive Services for Adults

- Abdominal aortic aneurysm one-time screening for men ages 65-75 who have ever smoked.
- Alcohol misuse screening: Screening to reduce alcohol misuse by adults ages 18 and older, including pregnant women, in primary care settings.
- Aspirin to prevent cardiovascular disease when prescribed by a health care provider. A prescription must be submitted in accordance with plan rules.
- Blood pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
- Cholesterol screening (lipid disorders screening) for men aged 35 and older and women aged 45 and older; men aged 20-35 if they are at increased risk for coronary heart disease; and women aged 20-45 if they are at increased risk for coronary heart disease.
- Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. In addition, the Plan will not impose cost sharing with respect to anesthesia services performed in connection with a preventive colonoscopy when the attending provider determines such services to be medically appropriate for the individual.
- Depression screening for adults.
- Type 2 diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
- Diet counseling for adults at higher risk for chronic disease.
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.
- Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (BMI of 30 kg/m2 or higher). Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.

- Tobacco use screening for all adults and cessation interventions for tobacco users. Cessation interventions are limited to two tobacco cessation attempts per year. A cessation attempt includes coverage for: (i) four tobacco cessation counseling sessions of at least ten minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and (ii) all FDA-approved tobacco cessation medications (including both prescription and over-the- counter medications) for a 90-day treatment regimen without prior authorization when prescribed by a health care provider.
- Syphilis screening for all adults at increased risk of infection.
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.

Covered Preventive Services for Women, Including Pregnant Women

- Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care.
- Anemia screening on a routine basis for pregnant women.
- Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
- Screening for women who have family participants with breast, ovarian, tubal or peritoneal cancer to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). For women with positive screening results, the Plan will cover, without cost-sharing, genetic counseling and, if indicated after counseling, BRCA genetic testing. Only asymptomatic women who have not been diagnosed with BRCA-related cancer are eligible for this benefit.
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every one to two years for women aged 40 to 74.
- Breast cancer chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. In addition, for women at increased risk for breast cancer and at low risk for adverse medication effects, risk-reducing medications such as tamoxifene or raloxifene.
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. The plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the Plan Administrator.
- Cervical cancer screening for women ages 21 to 65 with Pap smear every three years.
- Human papillomavirus testing for women ages 30 and older with normal Pap smear results, once every three years as part of a well woman visit.
- Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.

- FDA-approved contraceptives methods, sterilization procedures and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, include barrier methods, hormonal methods and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence and device removal are also covered without cost sharing.
- Folic acid supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.
- Gonorrhea screening for all sexually active women, including those who are pregnant, if they are at increased risk for infection (i.e., young or have other individual or population risk factors), provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.
- Counseling for sexually transmitted infections, once per year as part of a well woman visit.
- Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year-old women. The Plan will pay for the most cost-effective test methodology only.
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
- Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
- Tobacco use screening and interventions for all women, as part of a well woman visit and expanded counseling for pregnant tobacco users. For those who use tobacco products, interventions are limited to two tobacco cessation attempts per year. A cessation attempt includes coverage for: (i) four tobacco cessation counseling sessions of at least ten minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and (ii) all FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen without prior authorization when prescribed by a health care provider.
- Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.
- Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.

Covered Preventive Services for Children

- Well baby and well child visits from birth through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following Age-Appropriate screenings and assessments:
  - Developmental screening for children under age three, and surveillance throughout childhood
  - Behavioral assessments for children of all ages
  - Medical history
  - Blood pressure screening
  - Depression screening for adolescents ages 11 and older

  - Vision screening
  - Hearing screening
  - Height, Weight and Body Mass Index measurements for children
  - Autism screening for children at 18 and 24 months
  - Alcohol and Drug Use assessments for adolescents
  - Critical congenital heart defect screening in newborns
  - Hematocrit or Hemoglobin screening for children
  - Lead screening for children at risk of exposure
  - Tuberculin testing for children at higher risk of tuberculosis
  - Dyslipidemia screening for children at higher risk of lipid disorders
  - Sexually Transmitted Infection (STI) screening and counseling for sexually active adolescents
  - Cervical Dysplasia screening at age 21
  - Oral Health risk assessment
- Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).
- Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
- Iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. Over-the-counter supplements are covered only with a prescription.
- Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.
- Counseling for children, adolescents and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

Covered Immunizations

Routine adult immunizations are covered for participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

- Immunization vaccines for adults—doses, recommended ages and recommended populations must be satisfied:
  - Diphtheria/tetanus/pertussis
  - Measles/mumps/rubella (MMR)
  - Influenza
  - Human papillomavirus (HPV)
  - Pneumococcal (polysaccharide)

- Zoster (shingles)
- Hepatitis A
- Hepatitis B
- Meningococcal
- Varicella

- Immunization vaccines for children from birth to age 18—doses, recommended ages and recommended populations must be satisfied:
  - Hepatitis B
  - Rotavirus
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Pneumococcal
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Varicella
  - Hepatitis A
  - Meningococcal
  - Human papillomavirus (HPV)

Office Visit Coverage

There may be limited situations in which an office visit is payable under the preventive services benefit.

The following apply to payment for in- or out-of-network office visits under the preventive services benefit:

- If a preventive item or service is billed separately from an office visit, then the Plan will impose cost sharing with respect to the office visit.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100% of the allowed charge, with no coinsurance, copayment or deductible for the in-network visit.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the preventive item or service, then the Plan will impose cost sharing for the office visit.

For example, if a person has a cholesterol screening test during an office visit and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will require a cost sharing for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as preventive services and paid at 100% in-network. Well woman visits are also treated as preventive services and paid at 100% in-network.

Covered Preventive Medication

The following are covered preventive medications:

- Aspirin to prevent cardiovascular disease for men age 45 to 79 years and for women age 55 to 79 years.
- Oral fluoride supplements for preschool children age six months to five years whose primary water source is deficient in fluoride.
- Folic acid supplements containing 0.4 to 0.8 mg for women planning or capable of pregnancy.
- Iron supplements for asymptomatic children aged six to 12 months who are at increased risk for iron deficiency anemia.

Over-the-counter preventive medications require a written prescription from your physician in order to be covered by the Plan.

Preventive Services Coverage Limitations and Exclusions

1. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the participant or dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment or other services.
2. Services covered under the Preventive Services benefit are not also payable under other portions of the Plan.
3. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.
4. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle or other indications). Travel immunizations, (e.g., typhoid, yellow fever, cholera, plague and Japanese encephalitis virus) are not covered.
5. Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan, except routine costs for approved clinical trials, as required under federal law. These services will be covered as preventive care or under the regular medical care services with cost sharing, depending on the nature of the clinical trial.
6. Examinations, screenings, tests, items or services are not covered when they are provided for the following purposes:
    a. When required for education, sports, camp, travel, insurance, marriage, adoption or other non-medical purposes;
    b. When related to judicial or administrative proceedings;
    c. When required to maintain employment or a license of any kind.
7. Drugs, medicines, vitamins and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.
8. Services related to a man's reproductive capacity, such as vasectomies and condoms are not covered.
9. Voluntary abortions are not covered.

Medical Benefit Exclusions

FAST FACTS:

- Many of the medical services the Plan doesn't pay for are listed below, though the list does not include everything.
- For questions whether the Plan covers a specific service, and to avoid unpleasant surprises, call the Fund Office before obtaining expensive medical care that may not be covered.

The following services and supplies are **excluded from coverage**:

1. Injury arising out of, or in the course of, employment for wage or profit, or from any injury or sickness for which any service or benefit is provided or available, to any extent, to the Insured under federal, state or local Workers' Compensation laws, occupational disease laws or other laws concerning job-related injuries or conditions.
2. Unless federal law requires otherwise, any services or supplies furnished by the Veterans' Administration or by any institution owned or operated by the United States, any corporation, agency or bureau thereof, or any state, county or municipal government; services of supplies available, in whole or in part under the laws of the United States, (including Medicare) or under the laws of any state or political subdivision thereof or furnished or available pursuant to any law hereinafter enacted.
3. Any service necessitated by an act of war declared or undeclared that occurs after the effective date of this health care plan, or by service in the armed forces of any country, or by any criminal act in which you conspired or took part.
4. Services rendered by any participant of your family or any person living with you. For purposes of this paragraph only, family includes parents, spouses, siblings and natural or adopted children of whatever age.
5. Services provided or available without charge to you or for which charges are not normally made in the absence of insurance.
6. Rest cures, custodial care or home-like care, whether or not prescribed by a physician.
7. Services as an inpatient for convenience or for observation, diagnostic examinations or diagnostic laboratory testing when these services could have been received as an outpatient.
8. Dental surgery, care or services, except certain dental surgical services as provided for in this section, regardless of the diagnosis for which the surgery, care or services is performed.
9. Unless otherwise specified, eyeglasses, contact lenses, the examination and prescription or fitting of same; all procedures for refractive correction.
10. Unless otherwise specified, hearing exams and the prescription or fitting of hearing aids.
11. Any expenses you incur for the treatment of Temporomandibular Joint Dysfunction (TMJ) Syndrome, including examination and fitting for the TMJ device, nutritional counseling and occlusal adjustment.
12. Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and corrective shoes, regardless of medical diagnosis.
13. Routine foot care.
14. Blood, including blood components or blood donor services.
15. Supplies or services for cosmetic purposes as determined by Aetna. Some examples of cosmetic services that are not covered are routine treatment of acne and treatment for hair loss restoration.

16. Services not directly related to or necessary for the diagnosis or treatment of an illness or injury. This means that Aetna covers only those services or supplies that are provided by a hospital, physician or other provider that are required to identify or treat an illness or injury and which, as determined by Aetna are:
    - Consistent with the symptom or diagnosis and treatment of the condition, disease or injury;
    - Appropriate with regard to standards of accepted professional practice;
    - Not solely for your convenience, the physician's convenience or any other provider's convenience; and
    - The most appropriate supply or level of service that can safely be provided. When applied to an inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an outpatient.
17. Services for routine physical examinations, or other examinations or treatments including procured by you to satisfy the requirements of any third party including those required or ordered by a potential employer, licensing authority, insurer, educational institution, court or legal representative. School, camp and pre-marital physicals are also excluded.
18. Computerized gait analysis or electrodynographic testing.
19. Services and supplies for or related to visual therapy or orthoptics.
20. Immunizations and inoculations, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle or other indications). Travel immunizations, (e.g., typhoid, yellow fever, cholera, plague and Japanese encephalitis virus) are not covered.
21. Services and drugs in any way related to weight reduction, whether or not recommended by a physician (unless provided in accordance with Aetna protocols).
22. Services by a medical department maintained by your employer.
23. Services and supplies that are deemed by Aetna to be experimental or investigational in nature. This includes any treatment, procedure, facility, equipment, drug, drug usage, devices or supplies not recognized as or deemed by Aetna to be accepted medical practice; or any of such items requiring federal or other governmental agency approval for use and for which such approval has not been granted at the time services were rendered.
24. When more than one service procedure or treatment modality is performed in a single day by a professional provider, Aetna will pay the allowance for whichever service has the greater allowable charge. Payment for more than one service, procedure or treatment modality per day will be solely at the discretion of Aetna.
25. Any room and board or professional charge by a school infirmary or student health center or the staff thereof.
26. Unless specifically provided for in this SPD, all services and supplies received for the treatment of alcohol and substance abuse, including inpatient rehabilitation services and outpatient services.
27. Unless specifically provided for in this SPD, services and supplies received for the treatment of mental health care.
28. Drugs obtained for the diagnosis of alcohol or substance abuse treatment, unless specified otherwise in this SPD.
29. Services, supplies or drugs obtained in violation of applicable law.
30. Services for speech therapy when rendered for the following conditions: attention disorders, behavior problems, conceptual handicaps, learning disabilities and developmental delays.

31. Transsexual surgery, except for correction of a congenital defect.

32. Unless specifically provided for in this SPD, services rendered or prescribed by a chiropractor including, but not limited to, X-rays, subluxation manual manipulation or any other manipulation for the treatment of musculoskeletal disorders.

33. Infertility procedures including, but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or artificial insemination (AI) procedures.

34. Voluntary sterilization, unless medically necessary.

35. Reversal of voluntary sterilization.

36. Personal convenience items such as telephone, televisions, radios and other personal care items.

37. Thermography services.

38. Acupuncture.

39. Nutritional counseling.

40. Occupational or physical therapy for developmental delay.

41. Allergy testing.

42. Unless specifically provided for in this SPD, outpatient physicians visits including, but not limited to, visits for illness and injury, allergy treatment, mental health care or substance abuse treatment.

43. Transcutaneous electrical nerve stimulation (TENS) units, replacement lead wires and other related supplies or batteries.

44. Enteral nutrition ingested or administered orally, even if it is the sole nutritional source. The only exceptions are certain medical foods prescribed for inherited metabolic disorders.

Prescription Drug Coverage

FAST FACTS:

- The Plan offers the opportunity to purchase prescriptions three ways — at a pharmacy that belongs to the Sav-Rx network; at any pharmacy you wish; or by mail through the Sav-Rx Mail Order Pharmacy.
- If you take a maintenance medication (one that you take on a regular basis for a chronic condition) it must be obtained through the mail-order pharmacy.
- You pay less for prescriptions if you use a Sav-Rx network pharmacy or the Sav-Rx Mail Order Pharmacy.
- You must present your Sav-Rx ID card to fill prescriptions at the discounted member rate.
- If you fill prescriptions at a pharmacy that's not in the Sav-Rx network, you pay more and must file a claim form for reimbursement. For covered persons who are Medicare-primary see section on page 43.
- The Plan covers medications in accordance with the Food and Drug Administration (FDA) guidelines for specific conditions.

You and your eligible dependents have prescription drug coverage. To obtain maximum plan benefits:

- For occasional, short-term needs, fill prescriptions at one of the pharmacies that belongs to the Sav-Rx Network; and
- For chronic conditions, such as high blood pressure, you must use the Sav-Rx Mail Order Pharmacy after the 3rd retail fill of each medication.

When you need to fill a prescription, such as antibiotics for an infection, you can go to either a network pharmacy that's part of the Sav-Rx network or any pharmacy you choose. Sav-Rx has a network of more than 64,000 providers, including both large chain and independent pharmacies. Call 866-233-IBEW (4239) to ask if your local pharmacy is a member.

When you use a network pharmacy, you need to show your Sav-Rx ID card. With your prescription card you pay **20% of the cost** (with a minimum copay of $10 and a maximum copay of $35) for both generic and brand name drugs.

Prescriptions are filled as prescribed up to 31 days. You pay the same copayment for prescription refills.

Generics Preferred

Generic drugs are "therapeutic equivalents" and, by law, must contain identical active chemical ingredients of the brand name drugs they replace. For most people, most of the time, a generic will give them the same results as a brand name drug. It is standard pharmacy practice to substitute generic equivalents for brand name drugs whenever possible.

Cost Share for Brand-Name Drugs when Generic is Available

If you receive a brand name when a generic is available, you are responsible for payment of the normal brand name copayment plus the cost difference between the generic and the brand name drug.

What You Need To Do:

Participating Pharmacy

- Take your prescription and your Sav-Rx ID card to the pharmacy.
- Pay the appropriate coinsurance to receive your prescription.

Non-Participating Pharmacy

- Take your prescription to the pharmacy.
- Pay the full retail cost of the medication.
- Complete and submit a claim form to Sav-Rx (the claim form can be obtained by contacting Sav-Rx).
- Wait for reimbursement.

**NOTE: You will be reimbursed at the negotiated rate, which in some cases may not include the entire out of pocket expense incurred.*

Maintenance Medication

- Obtain a prescription from your doctor for up to a 90-day supply of medication. The prescription must include:
  - Patient's full name;
  - Doctor's name, phone number and address;
  - Exact strength, quantity and dosage; and
  - Diagnosis, if required for that drug.
- Submit your prescription and the required copayment to the Sav-Rx Mail Order Pharmacy.
- Receive prescription by First-Class mail or UPS.
- For specialty medications contact Sav-Rx at 866-233-IBEW (4239).

Step Therapy Program

There are many medications within each drug category. Often times, the newest drug being marketed is also the most expensive option and not necessarily the most effective in treating a given condition. In fact, many times, a less costly drug in the same class of drugs can provide the same medical results.

Under the Step Therapy program, you may be required to try an alternative medication in the same class (either a generic or an alternative brand name) before the prescribed brand name drug is dispensed.

The first time you attempt to fill a new prescription that is not a "first-step" drug (either a generic or a less costly brand name), your pharmacist will tell you there's a note on the computer system indicating that your prescription requires prior authorization. If you would rather not pay full price for your prescription drug, your doctor needs to give you a prescription for a first-step drug. To get a first-step drug, you can ask your pharmacist to call your doctor and request a new prescription or you can contact your doctor directly. To avoid delays, we suggest that you make sure your doctor is aware of this program so that a first-step drug can be prescribed during your office visit.

Using Non-Participating Pharmacies

You will likely pay more, perhaps significantly more, if you fill your prescription at a pharmacy that's not part of the Sav-Rx network. The reimbursed amount is determined by the discounted network price so you may not receive the entire amount that was paid out of pocket. At non-participating pharmacies, you pay the full cost of the drug and then submit a claim form and receipt for reimbursement. Call 866-233-IBEW (4239) or visit www.savrx.com to see if your local pharmacy is in the network.

Avoid a Headache

If the pharmacy you use does not participate in the Sav-RX network, you must pay your pharmacy directly and file a claim. You will be reimbursed the allowable charge, minus your copayment. If you notify Sav-Rx that you use an out of network pharmacy they will be able to call the pharmacy to sign them up as a participating provider with the exception of Wal-Mart and its subsidiaries.

Maintenance Medication

You must use Sav-Rx's Mail Order service to purchase maintenance prescription drugs. Maintenance drugs are those medications that you take on a regular basis, such as medicine for high blood pressure and heart conditions. Specifically, this program should be used for medications that you will be taking for more than 31 days. This saves you and your Fund money.

After three fills of a maintenance medication locally, the Plan mandates that you use the mail order service for that medication. Your physician can fax (888-810-1394) or call (866-233-IBEW) your prescriptions to Sav-Rx. If you have a paper prescription, you may mail it to Sav-Rx.

When you obtain either generic or brand name drugs through Sav-Rx, you pay 20% of the cost with a minimum copay of $20 and a maximum copay of $70—for up to a 90-day supply. Prepayment is required with your order. To get pricing information prior to submitting your order, please call 866-233-IBEW (4239). All regular orders are processed within 24 hours, and mailed First Class.

Specialty Drugs

Specialty medications are powerful, expensive drugs used to treat certain serious medical conditions. They may be covered subject to certain limitations. Call 866-233-IBEW (4239) if you have any specialty drug coverage questions. They are generally considered high-cost injectable, oral, infused or inhaled drugs that typically require special storage or handling and close monitoring of your drug therapy. If you take specialty drugs, you must fill your prescription through the Sav-Rx Mail Order pharmacy.

What's Not Covered

What's a "non-legend drug?"

A non-legend drug is any drug that does not bear the label "Caution: Federal law prohibits dispensing without a prescription."

The Plan covers all medications that require a prescription by either state or federal law, other than the exclusions listed below and those covered under the Plan's General Exclusions (page 58).

Prescription drug benefits are not payable for:

- Any non-legend drug, except insulin;
- Administration charges for drugs or insulin;
- Vitamins, minerals, dietary supplements, cosmetics, beauty aids and blood or blood plasma;
- Unauthorized refills;
- Any medication which is to be taken or administered while in a hospital, rest home, sanitarium, extended-care facility, convalescent hospital, nursing home or similar institution;
- Drugs or medicines administered to a patient by a physician;
- Prescriptions covered without charge under federal, state or local programs including Workers' Compensation;
- Any drug labeled: "Caution: Limited by federal law to investigational use," or experimental drugs whether or not a charge is made to the patient;
- Devices or appliances, support garments or other non-medical substances, except for diabetic meters, which are provided free of charge from Sav-Rx; or
- Drugs administered for the treatment of erectile dysfunction (e.g., Viagra, Cialis) or hypoactive sexual desire disorder (e.g., Addyi).

Prescription Coverage for Medicare— Primary Retirees & Spouses

If you are Medicare eligible, you have automatically been enrolled in a Medicare Part D program with UnitedHealthcare. You will have the option to opt out of this prescription drug program but that is not advisable for most people. The NECA Local Union No. 313 IBEW Health & Welfare Fund will also provide a secondary prescription benefit through Sav-Rx that will "wrap around" the Medicare Part D drug program provided by UnitedHealthcare, known as a Medicare Part D Employer Group Waiver Plan ("EGWP").

Because your existing coverage under the prescription drug plan is at least as good as the standard Medicare prescription drug coverage, depending upon your individual situation, you may want to keep your current coverage under the Fund, and not enroll in a Medicare Part D prescription drug plan when you become eligible for it.

For Retirees:

- As long as you do not enroll for Medicare Part D and you maintain your retiree status as provided by the rules of the Fund, your prescription drug and other coverage will continue, provided you make the required self-payments to the Fund.
- Please note that if you sign up for any other coverage, including an individual Medicare Part D prescription drug plan, you will lose prescription drug coverage under this Fund. If your prescrip- tion drug coverage under this Fund terminates in favor of coverage under a Medicare prescription drug plan, you will not be able to get the Fund's prescription drug coverage back later. However, you can continue your other (non-prescription drug) medical coverage under the Fund, provided you meet the requirements set forth herein, regardless of whether you keep or drop prescription drug coverage under the Fund.

For Active Employees:

- You are not required to drop your coverage under the Fund in order to enroll in Medicare prescription drug coverage. As long as you maintain your eligibility status as provided by the rules of the Fund, your prescription drug and other coverage will continue. If you keep your coverage under the Fund and enroll in a Medicare prescription drug plan, the Fund will usually pay primary and Medicare will pay secondary (exceptions below).
- If you qualify for Medicare coverage because of end-stage renal disease, then the Fund will only act as the primary payer for the first 30 months. After 30 months, the Medicare Part D plan will act as the primary payer and the Fund will pay secondary.
- If you are not actively employed but are covered under the Fund through COBRA or other self-pay, and you are eligible for Medicare coverage because of age or disability, then the Fund will pay secondary and the Medicare prescription drug plan will pay primary.

Because your existing Fund Coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep your Fund coverage and not pay extra Medicare Part D premiums if you later decide to timely enroll in Medicare coverage.

The prescription drug coverage under this Fund qualifies as "creditable coverage." This means, as stated above, that the drug coverage the plan expects to pay on average for prescription drugs for individuals covered by the Fund is at least as good as or better than what standard Medicare prescription drug coverage would be expected to pay on average.

You should also know that if you drop or lose your coverage with the Fund and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. In particular, if you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, then if you later enroll in Medicare Part D, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, and then enroll in Medicare Part D, your Medicare Part D premium will always be at least 19% higher
than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

Please note that in addition to this SPD, you are entitled to receive an additional notice of creditable coverage from the Fund on at least three occasions: (i) annually, prior to October 15; (ii) if the Fund makes changes to your prescription drug coverage that changes whether it is as good as Medicare prescription drug coverage; and (iii) at your request.

More detailed information about "creditable coverage," the Medicare prescription drug plan enrollment period, and your prescription drug benefits and self-pay rates under the Fund are available from the Fund Office.

Vision Care Benefits

FAST FACTS:

- Vision benefits help reduce what you pay for vision care.
- You are encouraged to use an ophthalmologist or other vision care provider in the NVA network.
- The Plan pays benefits according to a schedule of benefits for each covered service or supply.

The Plan's vision coverage helps you pay for routine eye examinations and contacts or eyeglasses based on a benefit schedule. You receive a vision examination and one pair of lenses once every calendar year and a frame once every two calendar years or contact lenses once every calendar year. The Plan is administered through National Vision Administrators, LLC (NVA), and will pay the NVA allowable charge for covered services, up to the amount shown on the schedule. Any charges above that maximum scheduled allowance or the NVA allowable charge are your responsibility. The schedule indicates the frequency of Plan services.

Contact NVA

You can contact NVA at 800-672-7723 or service@e-nva.com.

Vision Care Fee Schedule

Service	Participating Provider	Non-Participating Provider	Frequency
Eye Examination	Covered 100%	Reimbursed up to $70	Once per calendar year
Lenses • Single Vision • Bifocal • Trifocal • Lenticular	Standard glass or plastic covered 100%	(Per Lens) • Up to $30 • Up to $44 • Up to $50 • N/A	Once per calendar year
Frame	Retail allowance* up to $70	Up to $70	Once every two (2) calendar years
Contact Lenses (in lieu of lenses and frame) Medically necessary***	Up to $130 retail allowance Covered 100%	Up to $130 Up to $150 (Per Lens)	Once per calendar year; elective contact lenses**

* Member is responsible for the difference between the wholesale cost and the plan allowance plus 20%.
** Providers will charge their U&C price less 25% on contact lenses up to allowance amount. Does not include contact lens fitting and follow up fees.
*** Pre-approval from NVA required.

Safety Glasses are available under the plan in and out-of-network for members only. The plan allowance for lenses and frames will be paid for the benefit. The safety glass benefits are in lieu of the lenses and frames. Lens options purchased from a participating NVA provider will be provided to you at the amounts listed in the fixed option pricing list below:

- $12 Solid Tint $50 Progressive Lenses Standard
- $12 Fashion / Gradient Tint $70 Transitions Single Vision Standard
- $10 Standard Scratch-Resistant Coating $70 Transitions Multi-Focal Standard
- $12 Ultraviolet Coating $30 Polycarbonate (Single Vision)
- $40 Standard Anti-Reflective $30 Polycarbonate (Multi-Focal)
- $30 Glass Photogrey (Single Vision) $30 Blended Bifocal (Segment)
- $30 Glass Photogrey (Multi-Focal) $55 High Index
- $75 Polarized

Options not listed will be priced by NVA providers at their wholesale price plus 25%.

How the Vision Benefit Works

- When scheduling your appointment, notify the NVA-participating provider that your vision coverage is administered by NVA.
- At the time of your appointment, present your NVA ID card to the provider or indicate clearly that your benefit is administered by NVA. A vision claim form is not required at an NVA participating provider.
- The provider will inform you of your eligibility status prior to rendering services.
- Be sure to inform the provider of your medical history and any prescription or over-the-counter medications you may be taking.

Choice of Providers

You are not limited to certain vision care providers to receive services. You can go to any provider you choose, however, you are encouraged to visit providers in the NVA network. If you visit a non-participating provider, you may be asked to pay for services when you receive them, and you may end up paying more money out of your own pocket. In this case, you must pay the charges, then file a claim for reimbursement from the Plan. Or, the provider may allow you to assign benefits (directing that the Plan pay them directly), and file the claim for you to obtain payment. It depends on the billing procedure the provider uses. For information on filing claims, see page 63.

Excluded Services

In addition to items listed under the Plan's General Exclusions (page 58), vision care benefits are not paid for:

- Prescription drugs or over-the-counter medications
- Non-prescription lenses
- Two pairs of glasses in lieu of bifocals
- Subnormal visual aids
- Vision examination or materials required for employment
- Replacement of lost, stolen, broken or damaged lenses/contact lenses or frames except at normal intervals when service would otherwise be available
- Services or materials provided by Federal, State, local government or Workers' Compensation
- Examination, procedures training or materials not listed as a covered service
- Industrial safety lenses and safety frames with or without side shields (except members—see safety lenses benefit)
- Parts or repair of frame/sunglasses

Health Care/Preventive Care Spending Account

FAST FACTS:

- The Health Care/Preventive Care Spending Account is provided by the Plan to cover a variety of out-of-pocket healthcare expenses that you and your dependents might have.
- The Trustees determine each year at what amount these accounts will be funded.
- Office visit copays are not reimbursable under this account.

The Health Care/Preventive Care Spending Account (the "Annual Account") is designed to help you pay for a variety of medically necessary services, treatments, equipment and supplies that would be
allowable as a medical expense under the Internal Revenue Code (IRC) that are not paid for by the Plan. For example, you could use the account to pay:

- The 20% coinsurance for services covered at 80%;
- Amounts exceeding the allowable charge when you obtain care outside the Aetna network;
- Deductibles;
- Any covered dental care benefit that exceeds the scheduled amount, such as the excess over $54 for teeth cleaning and scaling (prophylaxis);
- Preventive care benefits to the extent not fully covered, including associated testing;
- Any covered vision care benefit that exceeds the amounts paid under the schedule, such as the balance above $150 for contact lenses or vision services you receive more frequently than every two years;
- Treatments exceeding the scheduled maximums; or
- Prescription drug copays.

Eligibility

The Annual Account is available to all covered active and retired participants and their dependents. If you are eligible for an account, you may use it to pay for your own eligible health care expenses, as well as expenses of your dependents who are enrolled in the Plan. The amount of the account is the same for all eligible participants, regardless of how many dependents you have.

Spending Account Value

Annually, the Trustees decide whether to fund the Healthcare/Preventive Care Spending Account, and if so, to what level. The Trustees may decide to increase or decrease that amount, or not to provide the account at all in any given year.

Using Your Account

When you have an eligible out-of-pocket healthcare expense, simply pay it as you normally do. To receive reimbursement from your spending account, contact the Fund Office for the Medical Reimbursement Account Request for Reimbursement form and submit a copy of the Explanation of Benefits (EOB)— which is a detailed description of the services your were charged for—with a signed written request to use your account to pay the remaining balance. Mail your form, request and EOB to the Fund Office.

Based on what the EOB shows the Plan didn't pay, you will be reimbursed with funds in your account. It's up to you to pay your healthcare provider any outstanding expenses.

You can request reimbursements throughout the year, as long as you have an account balance remaining. If you have a balance remaining at the end of the year, it will be forfeited.

For Your Benefit

The Annual Account helps reduce your out-of-pocket costs for healthcare with an allowance you can use to cover services and treatments that aren't completely paid by the Plan.

Getting Reimbursement from Your Healthcare Account

Send a copy of the Explanation of Benefits form, along with a note to the Claim Office asking for reimbursement from your account for the charges the Plan didn't pay.