Summary Plan Description
&
Benefit Plan

4th DISTRICT IBEW HEALTH FUND

June 1, 2008 Edition

Self-Funded Disability, Medical, Prescription Drug, Vision & Dental Benefits

GCC/IBT 619-M

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GOVERNING LAW

All questions pertaining to the validity or interpretation of the Trustee Agreement, the Plan, or any questions concerning the acts and transactions of the Trustees or any other matter that affects the Plan will be determined under federal law, where applicable federal law exists. If there is no applicable federal law, the laws of the state of Ohio will apply in all matters.

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CHANGE OF ELIGIBILITY RULES

The Trustees may, in their discretion, amend the Eligibility Provisions at any time; however, the Trustees shall make no change which, in their sole opinion, would render the Fund actuarially unsound.

ELIGIBLE EMPLOYEES

Classes for Eligible Employees	Dollar Bank?	HRA?
IBEW Members working under a Collective Bargaining Agreement (Inside, Outside, Residential, Teledata, CW or CE).	Yes	Yes
IBEW Memebers working under a Collective Bargaining Agreement* (Manufacturing or Utility)	Varies	Yes
IBEW Members employed by the IBEW or affiliated JATC** (Business Manager, Business Agent, Organizer or JATC Instructor)	Yes	Yes
Alumni IBEW Members employed by an affiliated NECA Chapter, a trade council affiliated with the IBEW or labor related governmental agency**	Yes	Yes
Non-IBEW Members employed by a Local Union, Contributing Employer, affiliated JATC, IBEW Federal Credidt Union, or affiliated NECA Chapter***	No	Yes
Non-IBEW or IBEW Members employed by a Contributing Employer who are owners (sole proprietor), or 5% or greater shareholders in an S-Corporation, Partnership or Limited Liability Company***	No	No****

*Hourly or monthly contribution rate, along with Dollar Bank eligibility, will be specified in the participation agreement. No contributions will be accepted prior to the date the Board of Trustees approves a written participation agreement.

**Hourly contribution rate will be the same as the member's home Local Union. A written participation agreement must be signed and approved by the Board of Trustees before contributions will be accepted.

***Monthly contribution rate and eligibility rules as herein after defined in "Salary Employees Qualifying Schedule." No contributions will be accepted prior to the date the Board of Trustees approves a written participation agreement. An IBEW Federal Credit Union will be accepted for participation only if membership in the Credit Union is restricted to IBEW members associated with that Local Union.

****IRS Regulations prohibit certain "owners" from participating in Health Reimbursement Accounts. The applicable participation agreement will establish the monthly contribution rate for such individuals.

ACTIVE PARTICIPANT ELIGIBILITY PROVISIONS

Contributions from Employers for each hour worked and reported will be credited to an individual's Dollar Bank upon receipt of the Employer's payment. Credit will only be granted for contributions actually paid to the Fund on an individual's behalf.

Participants will be come eligible for benefits following crediting of the amount determined by the Trustees to the Participant's Dollar Bank.

QUALIFYING SCHEDULE

Benefits will be effective on the first day of the Benefit Month if the Dollar Bank balance on the first day of the preceding month, the Eligibility Determination Date, is the amount determined by the Trustees, or more. For example, if contributions for a new Participant equal or exceed the amount determined by the Trustees are received in January, he will be eligible for March, which is the next Benefit Month following the next Eligibility Determination Date. Below are the Eligibility Determination Dates and the corresponding Benefit Months.

ELIGIBILITY DETERMINATION DATE	BENEFIT MONTH
January 1	February
February 1	March
March 1	April
April 1	May
May l	June
June 1	July
July 1	August
August 1	September
September 1	October
October 1	November
November 1	December
December 1	January

A Participant's eligibility will continue on a month-by-month basis in accordance with the schedule above. For each Benefit Month of eligibility, the Participant's Dollar Bank balance will be reduced by the amount determined by the Trustees. If a Participant's Dollar Bank balance is less than the required amount on an Eligibility Determination Date, a self-payment notice for the difference between the required amount and the Dollar Bank balance will be sent.

An ineligible member will be entitled to make a self-contribution to purchase coverage if the balance in his Dollar Bank is at least 40 times the current prevalent hourly contribution rate. If the member does not make the required self-contribution, the balance in his Dollar Bank is carried forward. Upon receipt of an additional contribution to the Dollar Bank, the member would be offered the opportunity to make a self-contribution for the difference between the required monthly amount determined by the Trustees and the balance in his Dollar Bank.

The balance in the Dollar Bank is "rolled-forward" until the earlier of 1) the month the member makes the required self-contribution to purchase coverage, 2) the month the Dollar Bank balance reaches the required minimum amount as determined by the Trustees for coverage without self-contribution and coverage is provided without self-payment or 3) the date twelve months elapse from the last Dollar Bank activity.

[If the balance in an ineligible member's Dollar Bank on any Eligibility Determination Date is less than 40 times the prevalent hourly rate, the balance in his Dollar Bank is carried forward.]

If an Eligibility Determination Date falls on a weekend or a holiday, eligibility for benefits will be determined on the next business day.

All Employer contributions received on a Participant's behalf will be credited to his Dollar Bank, subject to a maximum accumulation of $8,500. This maximum accumulation will be applied after the determination of eligibility at any Eligibility Determination Date.

The Trustees reserve the right to modify the amount required to purchase coverage from the Dollar Bank based upon advice of the Fund's professional advisors and to make any change in the required amount effective when deemed necessary.

NOTES:

IN ORDER TO ELECT CONTINUED COVERAGE UNDER THE REGULAR SELF-PAYMENT PROGRAM, A PARTICIPANT MUST REJECT THE COBRA CONTINUANCE OPTION IN WRITING.

A notice advising of the payment amount due will be sent to the participant. This notice will advise the date payment is due.

Failure to make the required payment when due will result in termination of coverage. **Late payments will not be accepted**. Once coverage terminates reinstatement is only possible by requalifying as an active participant.

The Fund has entered into reciprocal agreements permitting transfer of contributions earned in the jurisdiction of another fund. Contributions received from reciprocal funds will be posted in the month received. It is the participant's responsibility to request and execute the required authorization form for transfer of contribution and to contact the other fund in the event contributions are not transferred on a timely basis. Questions concerning reciprocal agreements should be directed to the Administration Office.

The participant is responsible for advising the Administration Office of changes of address, beneficiary or dependents.

SELF-PAYMENT PROVISIONS
FOR ACTIVE PARTICIPANTS

1. A covered participant who has a Dollar Bank balance on an Eligibility Determination Date but does not have a sufficient balance in his/her Dollar Bank to purchase a month's coverage may make a payment to continue coverage equal to the difference between the required amount and the balance in his/her Dollar Bank. There is no limit to the number of months of coverage a participant may purchase in this manner.

2. A covered participant who has no balance in his/her Dollar Bank on an Eligibility Determination Date may make a payment to continue coverage equal to the required monthly amount. A participant may make up to fifteen (15) consecutive payments to purchase coverage in this manner. An additional three (3) months of coverage may be purchased under the COBRA Benefits Continuation Provisions described on pages 1.9 through 1.11. The total number of consecutive months allowed under this Self-Payment and COBRA Benefit Continuation Provisions is eighteen (18).

If a covered participant has appealed the denial of Social Security Disability benefits and in the interim the maximum period of full self-contribution described above has expired, upon submission of proof of appeal of that denial to Social Security Administration (in the form of documentation from the attorney representing the participant) the participant will be entitled to make self-contributions for an additional period of six (6) months. Additional six (6) month extensions may be granted upon submission of status reports from the participant's attorney.

Any covered participant who has exhausted the maximum period of full self-contribution while unable to work due to an occupational injury may continue to make self-contributions for additional six (6) month increments until he/she is able to regain eligibility through active employment. The participant must submit a written request for the additional periods of coverage and provide evidence of an occupational injury recognized by a state Workers' Compensation agency, as well as any other evidence requested by the administrator. Once the participant is released to return to work he must sign his Local Union's referral book and actively seek employment with a contributing employer.

3. A covered participant who becomes totally and permanently disabled, as evidenced by receipt of a Social Security Disability Award or a Worker's Compensation Total and Permanent Disability Award, while eligible for benefits may make a payment to continue coverage equal to the required monthly amount. A participant may continue to purchase coverage in this manner until the Participant either recovers and is able to return to work or until the participant retires under a qualified pension plan.

Reduced Benefit Plan Self-Payment Election Option

A covered participant who has no balance in his/her Dollar Bank on an Eligibility Determination Date will be permitted to select the Flexible Choice benefit program in lieu of continuation of the benefits provided by this plan (Building Trades benefit plan), either through self contribution or COBRA. In making this election the participant will be required to reject continuation of the Building Trades benefit plan in writing.

Once the Flexible Choice plan is selected:

1. Contributions received from employer(s) will be applied to the participant's Dollar Bank and will not be available to reduce the self contribution required for the Flexible Choice plan nor be used to allow reinstatement of the Building Trades benefit plan through self-contribution.

2. The participant will not be allowed to reinstate the coverage formerly available under the Building Trades benefit plan until such time as the balance in his/her Dollar Bank equals the amount necessary to purchase coverage under the Building Trades benefit plan for one month. (i.e. Contributions received will continue to roll-forward until such time as the amount is sufficient to purchase a months' coverage.)

The self contribution amount payable by the participant for the Flexible Choice benefit program will be that required of participants in that Class FR. This amount will not include any allocation to the participant's HRA account.

The maximum period of full self-contribution remains fifteen consecutive months. Following the expiration of this fifteen month period, the participant will be permitted three additional months of coverage under the COBRA continuation provisions.

Calendar year deductible and out–of–pocket amounts applied while covered under the Building Trades benefit plan will be credited to satisfy the calendar year deductible and out-of-pocket amounts of the Flexible Choice plan. Likewise, if a participant would requalify for the Building Trades benefit plan during a calendar year, amounts applied to the deductible and out-of-pocket maximum under the Flexible Choice plan would also apply to the Building Trades benefit plan.

FOR RETIRED PARTICIPANTS

1. A disabled participant who retired under a qualified pension plan may continue eligibility for benefits through self-contribution for him or herself and all eligible dependents.

2. A covered participant who (a) retires from the industry under a qualified pension plan; (b) is at least age fifty-seven and one-half (57 1/2); (c) has been eligible for benefits for at least forty-eight (48) of the most recent sixty (60) months or for ninety-six (96) of the most recent one-hundred and twenty (120) months and (d) is eligible for Plan benefits at the time of retirement may make a payment to continue coverage for him or herself and all eligible dependents in the amount determined by the Trustees as appropriate.

3. A covered non-Medicare dependent of a deceased participant or a retiree who becomes eligible for Medicare may purchase coverage. The amount required is established by the Trustees from time to time.

4. When you retire and become eligible for Medicare due to age and have maintained eligibility through the Fund from your retirement (and for forty-eight (48) of the sixty (60) Benefit Months or for ninety-six (96) of the most recent one-hundred and twenty (120) months immediately preceding retirement, if you were eligible for Medicare at retirement), you will be eligible to purchase the Supplemental Medicare Retiree Benefit Plan F for yourself and your spouse, provided you and your spouse are covered under Medicare Hospital and Medical Benefits (Parts A & B). All claims, along with your Medicare Explanation of Benefits Statements and completed Claim Form, should be submitted directly to the administration address listed on the Claim Form from the Insurance Company. All premiums for the policy will be billed by the Fund. Information including your policy, I.D. Cards, and Claim Forms will be provided after enrollment.

Prescription drug coverage will be provided by the Fund subject to the copayment factors described in the Prescription Drug Benefit.

Disabled participants entitled to Medicare will also be permitted to purchase Plan F benefits to supplement Medicare and coverage for prescription drug expenses. These benefits are administered by the Fund and the Prescription Benefit Manager, SAV-RX.

NOTES:

1. A notice of the required self-contribution amount will be sent from the Fund Office monthly. A due date for receipt of the self-contributions will be provided. LATE SELF-CONTRIBUTIONS WILL NOT BE ACCEPTED.

2. Weekly Disability Benefits are not provided to retired participants.

3. Life Insurance, Accidental Death and Dismemberment Benefits, Vision Benefits and Dental Benefits are not provided to retirees with Medicare supplement benefits.

4. The Trustees reserve the right to terminate the continuance of eligibility for a class of retirees at their discretion. In addition, coverage for retirees and dependents under the Fund will terminate:

a. the date the Fund is terminated;
b. the date the retiree requalifies as an active participant;
c. the date the ending the last period for which the required self-contribution is paid;
d. the date the spouse of a deceased participant remarries;
e. for retirees or spouses with Medicare benefits, the date coverage under both Part A (hospital) and B (medical) of Medicare ends; or
f. for withdrawal of a participating Local Union effective on or after September 1, 2004, the benefit eligibility for retired and other non-active participants will terminate on the last day of the month for which contributions are required to the Fund under the terms of the applicable Collective Bargaining Agreement.

5. Direct (debit) payment of self-contributions is available to permit you to pay your self-contribution directly from your checking or savings account. If you elect this option, your bank account will be debited for the payment and you will no longer have to issue a check. The required amount will be deducted from your account on the 15th day of each month and will continue until you notify the Fund, in writing, that you wish to terminate the authorization.

When there is a change to the self-contribution amount, you will be provided at least thirty (30) days notice of the new amount that will be deducted. It will not be necessary to complete a new authorization form when the amount to be deducted monthly is changed.

Contact the Fund Administration Office to secure the necessary form for completion.

RETIREE SUSPENSION/REINSTATEMENT OF BENEFIT ELIGIBILITY PROVISIONS

A retiree has the option to waive (decline) Fund coverage for both himself/herself and his/her spouse if he/she is covered as a dependent under his/her spouse's plan. Proof of the coverage under the spouse's employer-sponsored group health plan is required and the retiree and spouse would be required to complete and sign an Election to Decline Coverage form.

The retiree would then be permitted to reinstate coverage at a later date upon certain conditions. The conditions which would allow reenrollment for the retiree and spouse are:

1. The other employer-sponsored group health coverage ends;

2. The retiree acquires a dependent; or

3. The retiree becomes entitled to Medicare benefits due to age or disability.

Likewise, if the spouse of the retiree is covered under a separate employer-sponsored group health plan, the retiree can elect coverage on his/her behalf only through the Fund and the spouse is permitted to defer Fund coverage until the spouse's employer-sponsored group health coverage terminates. The spouse must reinstate coverage through the Fund immediately upon termination of the separate employer-sponsored group health coverage.

Reinstatement of Fund coverage must, for the retiree, be effective no later than the date the retiree becomes entitled to Medicare benefits or, for the spouse, be effective no later than the date the spouse becomes entitled to Medicare benefits.

Failure of the retiree and/or spouse to reinstate coverage through the Fund within thirty (30) days of the earliest of the reinstatement conditions detailed above will result in the permanent termination of eligibility and reinstatement of coverage will not be permitted at a later date.

A retiree and/or spouse will be provided only one opportunity to waive Fund coverage and request reinstatement of Fund coverage. Once Fund coverage has been reinstated under the terms of this provision, a retiree and/or spouse will not be allowed again to waive coverage with the option of reinstatement at some future date. The second waiver of Fund coverage will constitute a permanent termination of participation.

SALARIED EMPLOYEES QUALIFYING SCHEDULE

Payroll Month If a salaried employee is credited with the required contribution for:	**Benefit Month** Such employee will be eligible for benefits for:
January	February
February	March
March	April
April	May
May	June
June	July
July	August
August	September
September	October
October	November
November	December
December	January

The contribution for salaried employees is due on the 15th day of the Payroll Month for coverage in the following Benefit Month.

If a salaried employee becomes ineligible for benefits due to inadequate contribution for a Payroll Month, such employee will be permitted to purchase continuance of benefits in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). It is the employer's responsibility to notify the Administration Office of the termination of employment.

RESERVE BANK

No Dollar Bank credits will be posted for salaried employees.

The Trustees retain the absolute authority to reject any employer application for participation in the Plan or terminate the participation of any salaried employee group with or without cause upon thirty (30) days written notice.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Benefits Continuation Provisions

You may elect to continue certain benefits provided by the Plan in the event your coverage, or that of your dependents, would otherwise terminate. You may continue your medical, prescription drug, dental, vision, and Life Insurance benefits. The length of the time for which the benefits elected may be continued is based upon the qualifying event which would have caused the loss of benefit eligibility.

1. You may elect to continue benefits for yourself and your eligible dependents (or your dependents may make the election) for up to eighteen (18) months from the date your eligibility ends as the result of:
   a. termination of employment (other than due to gross misconduct) or
   b. you do not earn sufficient credits to qualify for benefits
2. You may elect to continue benefits for an additional eleven (11) month period beyond the basic eighteen (18) months provided for in 1. above if you are awarded Social Security Disability Benefits as the result of a disability which commenced prior to the qualifying event or within sixty (60) days of the commencement of the COBRA continuance. Proof of the total disability must be provided to the Fund Office prior to the end of the basic eighteen (18) month period.
3. Your eligible spouse and/or any eligible dependents may elect to continue benefits for as long as thirty-six (36) months from the date their eligibility ends because:
   a. you die;
   b. you become eligible for Medicare benefits and elect that coverage as primary;
   c. you and your spouse are legally separated or divorced; or
   d. a child is no longer eligible as a dependent.

When the qualifying event is the end of employment or reduction of the participant's hours of employment and the participant became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered participant becomes entitled to Medicare eight (8) months before the date on which his eligibility lapses, COBRA continuation coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months).

You are responsible for notifying the Fund Office in writing when medical benefits end in accordance with 3(b), 3(c), 3(d) above. This notice must be received by the Fund Office within sixty (60) days after the divorce, legal separation, or dependent's loss of eligibility. You will need to provide a copy of any court order, birth certificate, or other information the Plan may deem relevant. Additionally, if you are already receiving COBRA continuation coverage, you must notify the Fund Office, in writing, of any qualifying event that may extend your COBRA eligibility period.

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B or both), gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred

Upon recognition of the occurrence of a qualifying event, the Fund Office will send you and your spouse a notice describing your rights to purchase continued benefits. (The notice will be sent to a former dependent if the qualifying event resulted in the loss of dependent eligibility.) You or your dependents have sixty (60) days to return the written application for COBRA continuation coverage. This sixty (60) day period begins the latter of:

a. the date benefits would otherwise end (the last day of the Benefit Month) or
b. the date the notice is received. (If the notice is sent after the last day of the Benefit Month.)

The required contribution for purchase of the continued coverage must be paid to the Fund within forty-five (45) days from the date the COBRA continuation is elected. The notice of your rights to COBRA will provide the costs associated with the options available. This initial payment must include the current month's premium plus any premium due for the months which have elapsed since the end of the last Benefit Quarter for which you or your dependents were eligible. Subsequent payments are due monthly on the first day of the month. A thirty (30) day grace period is granted for payment of the amount due.

The COBRA continuance will end at the earliest of the following to occur:

a. the date the Fund ceases to provide any group health plan;
b. the last day of the month through which you or your dependent have paid the required premium;
c. the date the individual becomes covered under any other group benefit plan which does not contain a pre-existing conditions clause or such clause is not applicable to the individual due to the absence of a pre-existing condition; (A plan's pre-existing conditions limitation period will be reduced for each month that you or your dependents had continuous health coverage (including COBRA) with no break in coverage greater than sixty-three (63) days. When your coverage ends you will receive certification of the duration of your coverage. This provision applies to each individual with COBRA coverage.)
d. the date you again become eligible for benefits as the result of contributions credited;
e. the date the individual becomes covered for benefits under Medicare; or
f. the end of the maximum periods described in paragraphs 1., 2. or 3. above.

NOTES:

1. Continued coverage begins after the expiration of previously earned eligibility. You cannot purchase double coverage for the same period of time.
2. You or your dependents are not permitted to continue COBRA if you and/or they become eligible for other group coverage on or after the date the COBRA coverage becomes effective.
3. In the event more than one continuation provision applies, the periods of continued coverage will run concurrently.
4. The continuation of eligibility through self-contribution as described on page 1.4 will be counted to reduce the maximum eighteen (18) month continuation period described above.
5. The continuation of eligibility at no cost for the surviving dependents of an active participant who dies while eligible for benefits will be counted to reduce the maximum thirty-six (36) month continuation period described above.
6. You, or your dependents, WILL NOT receive monthly reminder notices concerning payment of the required premium to keep coverage in effect. It is the responsibility of the covered individuals to pay the premium when due.
7. The COBRA premium amount due to purchase continued coverage WILL NOT be affected by contributions made to the Fund by your employer.
8. It is important all addresses for participants and dependents be kept up to date. In the event the Fund Office does not have a valid address on file, you may jeopardize your right, or a dependent's right, to elect continuation coverage.
9. This is not a complete description of your COBRA rights. For more information contact the Fund Office at 888-466-9094, or consult the Department of Labor website at www.dol.gov/ebsa.

BENEFIT CREDIT BANK PROVISIONS

Introduction

A new apprentice or a newly organized employee will be permitted to request a deposit to a Benefit Credit Bank upon employment in the industry under a Collective Bargaining Agreement associated with his/her Local Union. The purpose of the deposit to the Benefit Credit Bank is to purchase initial eligibility for benefits through the Fund.

In order to participate in this program, the individual must:

1. Have never been eligible under the Fund;
2. Be associated with a Local Union affiliated with the Fund;

3. Begin working or be available for work under a Collective Bargaining Agreement covering members of the Local Union to which the individual belongs; and

4. Complete and execute an agreement providing for the repayment of the credit extended from contributions posted to the individual's Dollar Bank as the result of covered employment.

The amount of the deposit to the Benefit Credit Bank will be equal to the amount required to purchase coverage through the Fund for three (3) months.

Administration

Upon receipt of the executed agreement from the individual's Local Union, two accounts would be created. The first is the Benefit Credit Bank, which would receive the initial deposit, and the second is the Dollar Bank for the deposit of employer contributions. An amount equal to the cost to purchase one months' coverage would immediately be transferred from the individual's Benefit Credit Bank to the individual's Dollar Bank to purchase coverage for the next calendar month.

On the first day of the month (Eligibility Determination Date) following the employment date a second transfer from the Benefit Credit Bank to the Dollar Bank equal to the cost of one months' coverage will occur. The Dollar Bank will then be charged the required amount to purchase coverage for the ensuing Benefit Month, in accordance with the qualifying schedule applicable to active employees.

If sufficient contributions are not received during the month following the month of employment, a third transfer from the Benefit Credit Bank to the Dollar Bank will occur. The amount will be equal to the difference between the balance in the Dollar Bank and the amount on the Eligibility Determination Date to purchase a month of coverage.

This procedure will continue until the individual exhausts the balance in the Benefit Credit Bank or until the individual earns sufficient contributions to qualify for coverage without further transfers from the Benefit Credit Bank to the Dollar Bank. Transfers from the Benefit Credit Bank to the Dollar Bank will no longer be possible once repayment of the Benefit Credit Bank begins. (A self-payment notice will be provided any time the

balance in the Dollar Bank is not sufficient.)

Repayment of Initial Deposit
Transfers from the Benefit Credit Bank will be recouped from the individual's Dollar Bank as follows:

1. If on any Eligibility Determination Date, after the deduction for the ensuing Benefit month, there is a balance in the individual's Dollar Bank, that balance will be transferred from the Dollar Bank to the Benefit Credit Bank.
2. Excess balances will be transferred in such a manner each month (as described in 1. above) until the value of the Benefit Credit Bank equals the beginning balance, i.e. an amount equal to the cost of coverage for three (3) months.
3. If the Benefit Credit Bank is not completely replenished by the second anniversary of the date the individual's Benefit Credit Bank was created, all deposits to the individual's Dollar Bank from that second anniversary forward will be transferred to the Benefit Credit Bank until the beginning balance in the Benefit Credit Bank is repaid. (In this situation the individual will be required to make self-payments to continue eligibility for Fund benefits.)

AMENDMENT OR TERMINATION

THE TRUSTEES RESERVE THE RIGHT TO MODIFY THE TERMS OF THIS PROGRAM AT ANY TIME AS NECESSARY OR TO TERMINATE THIS PROGRAM WITHOUT PRIOR NOTICE. THE TRUSTEES MAY ALSO USE AND/OR MODIFY THIS PROGRAM TO FACILITATE THE ADDITION OF ANY UNION THAT WISHES TO HAVE ITS MEMBERS PARTICIPATE IN THE FUND.

REINSTATEMENT OF ELIGIBILITY

Generally, eligibility for benefits ceases on the date you enter full-time service in the Armed Forces. The Fund will reinstate your benefits without waiting period or initial eligibility periods or other exclusions, upon your reemployment with any employer under this Fund.

The Fund will provide you with the ability to retain coverage in the Fund during the time you are in qualified military service. If you are in qualified military service for less than thirty-one (31) days, the cost of continuation coverage will be the responsibility of the Fund, provided you meet the conditions for reemployment. If you are in qualified military service for more than thirty-one (31) days, the cost of continuation coverage will be your responsibility.

If you are in qualified military service for more than thirty-one (31) days, you will be entitled to continue coverage for a maximum period of twenty-four (24) months. See the COBRA coverage section of this booklet for a full explanation of how and when these circumstances may apply to your medical coverage.

If you served more than thirty-one (31) days, your coverage will be reinstated on your reemployment with any Employer under this Fund if you apply for reemployment within fourteen (14) days after honorable discharge. Coverage for the first three (3) months following discharge from active duty and reemployment with a contributing Employer will be provided at no cost to you.

Any questions about the effect of military service on your eligibility should be addressed to the Benefit Administration Office.

EFFECTIVE DATE OF BENEFITS

Benefits with respect to you and your eligible dependents will become effective on the date you become eligible for benefits in accordance with the Qualifying Schedule.

DISCONTINUANCE OF BENEFITS

Your coverage under each type of benefit will cease on the earliest to occur of the following dates:

1. The date the Plan is discontinued;
2. The date you are no longer eligible for the type of benefit either because of an amendment to the Plan or because you have become a member of an ineligible group of employees;
3. The date that any required contribution on your part is due and unpaid;
4. The date you enter the Armed Forces on full-time active duty; or
5. The date a group of participants elect to withdraw from the Fund by amending the applicable Collective Bargaining Agreement to terminate contributions from the signatory employers. No benefits will be provided on behalf of participants who would otherwise be eligible for benefits for claim expenses incurred more than ninety (90) days after the end of the work month for which contributions were last required to be paid.

Your benefits with respect to any individual dependent will not be continued beyond the date he or she no longer meets the definition of “dependent” in the Definitions Section of this booklet, except as provided in the next paragraphs.

A. Incapacitated Children - If you covered dependent child is mentally or physically incapable of earning a living upon attaining the limiting age for covered children, you may continued dependent benefits for the child during such incapacity, provided that (a) proof of such incapacity and its continuance is given to the Plan within thirty-one days after the child attains the limiting age and whenever thereafter required by the Plan, (b) the Plan may have the child examined by designated doctors from time to time, but no more often than once a year after the second year of continuance under this paragraph and (c) no dependent benefits will be continued beyond the cessation date of such coverage as provided in the first paragraph of this Discontinuance of Benefits Section.

B. Surviving Spouse and Children - If your death should occur while eligible, benefits for your eligible dependents will continue without payment until the end of the Benefit Month during which the second anniversary of your death falls or until your spouse's remarriage, whichever occurs first. This survivor benefits continuance applies only to active participants and covers dependents covered on the date of death and any of your then unborn children when they meet the definition of "dependents" herein. An individual dependent's coverage under this survivor benefit continuance will cease at the end of the Benefit Month described above, when the individual no longer meets the definition of a "dependent", or when he or she becomes eligible for Medicare, whichever occurs first.

C. Qualified Medical Child Support Orders - In certain circumstances a court may order a non-custodial parent to provide health care coverage on behalf of his/her child. This is accomplished through the use of qualified medical child support order (QMCSO). The Plan has adopted procedures to determine whether a medical child support order meets all of the elements required by law. Any participant or beneficiary may obtain, without charge, a copy of the procedures by contacting the Benefit Administration Office.

SELF-FUNDED SCHEDULE OF BENEFITS

Weekly Disability Benefit .... $250 for 26 weeks maximum*

Accident Benefit $300

Comprehensive Major Medical Benefit

1. Calendar Year Deductible
   a. In-Network Provider Charges
      Per Individual $350
      Per Family $1,050
   b. Out-of-Network Provider Charges
      Per Individual $700
      Per Family $2,100

   (Charges applied to the in-network deductible will also apply to the out-of-network deductible and vice versa)
2. Plan Payment Factors
   a. For all covered charges:
      In-Network Charges and All Emergency Care 80%
      Out-of-Network Charges 60%
      (Charges for chiropractic manipulations and treatments are subject to a maximum benefit of $500 per calendar year per individual.)
3. Family Calendar Year Out-Of-Pocket Maximums**
      In-Network Charges $3,750
      Out-of-Network Charges $7,500

   (The Out-Of-Pocket Maximum includes the deductible expense and amounts applied to the in-network out-of-pocket maximum will also apply to the out-of-network out-of-pocket maximum, and vice versa.)
4. Maximum Benefits Per Individual
      Lifetime benefit for attendance of a registered graduate nurse in the individual's home $50,000
5. Organ Transplant Benefit (Blue Distinction Centers for Transplants (BDCT) Program)
   a. In Network (BDCT facility) 100%
      [The calendar year deductible does not apply to this benefit. This benefit includes a $10,000 allowance for transportation and lodging prior to, during and after the transplant procedure for the patient and one family member or companion.]
   b. Out-Of-Network (non-BDCT facility) .... Not Covered

* Offset by Social Security Disability and Pension Disability monthly benefits

** For non-Medicare retirees and spouses, the Calendar Year Out-Of-Pocket Maximums are $2,000 per person for In-Network charges and $4,000 per person for Out-Of-Network charges.

Prescription Drug Benefit

Co-Payments Factors (amount you pay per fill)

a. Retail Pharmacy

i. Generic Drug..10% (minimum $10 maximum $100)

ii. Formulary Brand Name Drug..20% (minimum $15 maximum $100)

iii. Non-Formulary Brand Name Drug..30% (minimum $30 maximum $100)

Mail Service Program Co-Pay Amounts

i. Generic Drug.. $15

ii. Formulary (preferred) Brand Drug................20% (minimum $40 ....maximum $200)

iii. Non-Formulary (non-preferred) Brand Drug....30% (minimum $60 ....maximum $200)

Preventive Care Benefit............ 100% of the stated benefit amount in the description of benefits and 80% of the balance, for the services of an In-Network provider.

Smoking Cessation Program..100%

Quit For Life® interventions per individual's lifetime..5

[Participants and Dependents will be entitled to telephone and on-line support, and one course of a predetermined dosage of non-prescription Nicotine Replacement Therapy upon recommendation of a Quit Coach. Prescription smoking cessation products will be subject to the co-payments and limitations outlines in the Schedule of Benefits.]

Outpatient Laboratory Services Benefit

In-Network Provider..100%

(Not subject to calendar year deductible.)

Out-of-Network Provider..60%

(Subject to calendar year deductible.)

(Laboratory services received when confined in a hospital are treated the same as any other hospital expenses.)

Vision Exam..

One per calendar year

[Participants will be entitled to discount pricing for lenses, including contact lenses, and frames under the contract between the Fund and National Vision Administrators.]

Dental Benefit

1. Deductible Per Calendar Year
   a. Preventive..None
   b. Other
      i. Per Individual.. $75
      ii. Per Family.. $225
2. Payment Factors
   a. Preventive..100%
   b. Other Services..75%
3. Calendar Year Maximum Per Individual
   a. In-Network..$900**
   b. Out-of-Network..$750**

** The Calendar Year Maximum does not apply to pediatric oral services provided to dependent children less than age 18.

Refer to the following pages for additional information concerning these benefits.

GENERAL PROVISIONS

The following General Provisions are applicable to all of the Health Benefits described in this section which provide reimbursement of expenses for medical care or treatment. Until such time as regulations are issued by the appropriate federal agencies, the Plan will use good faith efforts to define and interpret the term "essential health benefits" in a reasonable and consistent manner to comply with the restrictions against lifetime and annual limits under the federal health care reform law (Patient Protection and Affordable Care Act of 2010).

PRE-EXISTING CONDITION LIMITATION

PRE-EXISTING CONDITION–is an injury or illness, including a pregnancy, for which you or your dependent receives medical care, advice, diagnosis or treatment, including the prescribing of prescription drugs, or for which a diagnosis was made in the six (6) month period prior to the effective date of your coverage or the effective date of your dependent's coverage. The Plan will pay up to $2,000 for covered expenses related to a pre-existing condition. No further benefits will be provided for that pre-existing condition until you or your dependent have gone six (6) months without treatment of the pre-existing condition or until you or your dependent have been continuously covered by the Plan for twelve (12) months.

The Plan's pre-existing condition limitations do not apply to individuals who are under 19 years of age. This pre-existing conditions limitation will apply to all Plan participants and their dependents, subject to the foregoing age limitation, upon their initial eligibility date for Plan benefits and will reapply to all Plan participants and dependents upon reinstatement of their eligibility for Plan benefits following a break of eligibility of more than six (6) consecutive months.

This pre-existing conditions limitation does not apply to the Life Insurance, Accidental Death and Dismemberment, Weekly Disability, Vision Care, or Dental Care Benefits. Further, this provision will **not** apply to covered maternity expenses incurred by an employee or spouse or to covered expenses of a newborn or newly adopted child under age eighteen (18) if enrolled within thirty (30) days of birth or adoption. This provision will also not apply to individuals who present a Certificate of Creditable Coverage from a prior plan reflecting continuous coverage for a minimum of twelve (12) months and a period of less than sixty-three (63) days separated the termination date of the prior plan's coverage and the effective date of coverage under this plan.

HOSPITAL PRE-ADMISSION CERTIFICATION PROGRAM

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

If you do not follow the Pre-Admission Certification Program for any admission, a penalty of $250 will be applied.

Precertification is a review process where physicians, nurses and/or

pharmacists work with your physician to determine whether a procedure, treatment or service is a covered benefit. The precertification process provides information to your physician on what your benefits will be for a procedure, treatment or service.

The Plan requires precertification for hospital admissions for mental health and substance abuse treatment. When a request for precertification comes in from your provider, a nurse evaluates the request using a nationally recognized guidelines to assist with the review. These guidelines are consistent with sound clinical principals and processes, and have been developed with involvement from actively practicing health care providers. Nurses determine which services are covered based on the benefit plan, and using these guidelines. When guidelines do not exist, clinical resource tools based on clinical evidence are used.

Anytime a nurse is unable to approve coverage for clinical reasons; the case is referred to a physician who considers each case individually. The physician may speak with your physician to obtain additional information. Your physician will be notified in writing if a request for precertification cannot be approved based on the information that received, and your plan benefits.

Your provider or you must call the toll-free number listed on your ID card to precertify designated services. In an emergency, seek care immediately, then call your primary care doctor as soon as possible for further assistance and directions on follow-up care within the number of hours noted on your ID card.

Failure to make contact within seventy-two (72) hours of an emergency admission will result in application of the $250 penalty described above.

Failure to make contact prior to an elective admission for mental health and substance abuse treatment will result in application of the $250 penalty described above.

GENERAL LIMITATIONS

Benefits are not payable for expenses due to any of the following:

1. medical care or treatment given by or in any facility owned or operated by the Federal Government, unless a charge is made to the claimant;
2. medical care or treatment given by or in any facility owned or operated by a State or its political subdivision, unless there is an unconditional requirement to pay without regard to rights against others, contractual or otherwise;
3. disease for which you or your dependent are entitled to benefits under any Workers' Compensation Law or Act, or an accidental injury arising out of or in the course of employment;
4. maternity services of any type on or for a dependent child; however the Plan will pay for Complications of Pregnancy which are conditions of the dependent pregnant child caused or contributed to by pregnancy, childbirth, or related medical conditions;
5. any confinement, treatment, care, service or supply which is not recommended or approved by a Physician, or periods of disability when not under the regular care of a Physician;
6. bodily injury, disease or sickness caused by any act of war, whether war is declared or undeclared, any act of international

armed conflict or any conflict involving the armed forces of any international body, or insurrection or any military service-connected injury or sickness;

7. treatment or services not deemed by the Plan to be medically necessary, unless otherwise provided herein;
8. treatment or services for a non-accidental, self-inflicted injury or condition sustained by you or your dependent, unless due to a physical or mental condition;
9. any loss, expense, or charge resulting from participation in a riot or in the commission of a felony, whether charges are filed or not;
10. any loss, expense, or charge which the individual is not responsible, in the absence of coverage under this Plan;
11. any part of the expense for medical services and supplies for which benefits are payable under any other benefit provision for the Plan or for which case or service benefits are provided by any other Group Plan of Medical Care Benefits;
12. any part of the expense for medical services and supplies which exceeds the usual and customary charge or fair and reasonable value of such services and supplies, as determined by the Fund by comparing the charge with charges made to other individuals of similar age and sex for the same type of illness in the locality where furnished;
13. dental treatment, except for the necessary repair of natural teeth as a consequence of an accidental injury;
14. cosmetic surgery performed on other than a child to correct a deformity present at birth or other than to repair disfigurement as the result of an accidental injury;
15. any loss, expense or charge which results from appetite control or any treatment of obesity (except for surgery to treat morbid obesity);
16. any expense or charge for services or supplies which are:
    a. not provided in accord with generally accepted medical standards within the U.S. of America,
    b. for experimental treatment,
    c. investigative and not proven safe and effective;
17. any operation or treatment in connection with sex transformations or treatment of sexual dysfunction that is not organic in nature;
18. in vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT) embryo transplant, surrogate parenting, donor semen, or similar type procedures, all expenses related to any of the foregoing, and fertility treatments;
19. reversal of sterilization;
20. vision therapy, unless treatment is required in treatment of strabismus, estrophia, or exotrophia;
21. health examinations, normal eye and ear examinations, and the purchase of fitting of glasses and hearing aids, except as provided for herein;

22. radial keratotomy, lasik, lasek, or similar surgery;
23. high dose chemotherapy with autologous transplantation (HDC/ABMT) for solid type tumors, including, but not limited to, cancerous breast tumors;
24. personal hygiene and convenience items such as, but not limited to: air conditioners, air purifiers, whirlpools, swimming pools, humidifiers, de-humidifiers, allergy-free pillow, blankets or mattress covers, electric heating units, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, cliical thermometers, scales, elastic bandages, or wigs, devices or surgical implantation for simulating natural body contours, breast pumps, or health club memberships;
25. contraceptive devices or any other method of contraception, other than covered surgical sterilization or birth control pills (Prescription Drug Benefit);
26. telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
27. travel and accommodations, even if prescribed by a Physician, unless otherwise noted specified in the Schedule of Benefits;
28. services rendered to you or your dependent by a member of your immediate family or anyone residing with you;
29. physical therapy, or any other type of therapy if either the prognosis or history of the person receiving the treatment or therapy does not indicate there is a reasonable chance of improvement;
30. rental or purchase of any durable medical equipment or other equipment that is not necessary solely for therapeutic treatment of a single individual's injury or sickness;
31. in-hospital items such as telephones, TV's, cosmetics, newspapers, magazines, laundry, guest trays, or beds or cots for guests or other family members, or any other personal comfort items or items that are not medically necessary;
32. educational services and devices;
33. "over-the-counter" drugs or medicines and drugs or medicines not legally dispensed by a registered pharmacist or physician according to the written prescription of a doctor, or more than a 90-day supply of a drug or medicine obtained at one time.
34. any transplant services performed at a non-Blue Distinction Centers for Transplants Program facility; and
35. the additional costs associated with the following preventable medical errors: 1) surgery on the wrong patient, 2) surgery on the wrong body part, 3) the performance of the wrong surgical procedure and 4) foreign objects inadvertently left in a patient following surgery.
36. The Plan will provide coverage for the screening and evaluation necessary to diagnose an individual with an autism spectrum disorder, which includes autism disorder, Asperger's Syndrome, Rett's Syndrome, Childhood Disintegrative Disorder and pervasive developemental disorder not otherwise specified. This coverage will not extend to treatment of the autism spectrum disorder, regardless of whether the treatment is prescribed by a physician and provided by qualified providers. The Plan will not cover Applied Behavioral Analysis, intervention and modifications for the disorders.

37. psychotherapy, counseling, or other services in connection with marital problems, developemental disorders, learning disabilities or mental retardation.
38. hypnotherapy, bio feedback and other forms of self-care or self-help training, and related diagnostic testing.
39. expenses associated with confinement and services in a halfway house or group home.

Any additional limitations applicable to specific types of benefits appear in the provisions describing the benefits payable.

COORDINATION OF BENEFITS PROVISION

The Coordination of Benefits Provision is applied to individuals who are covered under another Group Plan. When a dependent spouse is also eligible as an employee, the total amount payable for all benefits (except Life, Accidental Death & Dismemberment and Weekly Disability Benefits) shall not exceed the lesser of the Reasonable and Customary charges for expenses incurred or the total benefits allowable under the benefit program on behalf of the employee and spouse.

These definitions are provided so that you will have a better understanding of this provision.

"Coordination of Benefits " means if you or your eligible dependent are covered under more than one Group Plan, the total benefits payable under such plans for care, services or supplies shall not exceed one hundred percent (100%) of the total allowable expenses.

"Plan" means any Plan providing benefits or services for or by reason of medical or dental care or treatment if such benefits or services are provided by (a) group, or blanket coverage; (b) group hospital service prepayment plans, group medical service prepayment plans, or group practice; (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans, and (d) any coverage under governmental programs (including Medicare) and any coverage required or provided by any statute.

The term "Plan" will be considered separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to any portion of the policy, contract or other arrangement which reserves the right to consider benefits or services of other Plans in order to determine its benefits and that portion which does not reserve that right.

"Plan" means the following listed benefits of this summary: All benefits are affected except the Weekly Disability Benefits and Vision Care Expense Benefits.

"Allowable Expense" means any necessary, reasonable and customary expense which is covered at least partially under one or more of the Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered both and Allowable Expense and a benefit paid.

"Claim Determination Period" means a calendar year (January 1 through December 31).

The rules for determining which Plan is the primary carrier Plan are (in order of their application) as follows:

1. A Plan without a Coordination of Benefits clause always pays first.
2. The Plan covering the patient as employee (rather than as dependent) pays first.

3. The Plan covering a child as dependent of the parent whose birthday occurs first during the calendar year pays first.
4. The Plan covering a child as dependent of a male (rather than a female) employee pays first.

In the case of divorced parents, the following line of benefit determination is applied:

a. A dependent of the (natural) mother, if the mother has custody.
b. A dependent of the stepfather, if the mother has custody.
c. A dependent of the (natural) father.

5. The Plan covering the patient as an active member, or dependent, (rather than a retiree or laid-off employee) pays first.
6. The Plan not covering the patient under a COBRA continuance pays before the Plan with the COBRA continuance.

Medicare benefits will provide secondary coverage for an eligible active participant entitled to Medicare and for the Medicare eligible spouse of an eligible active participant.

Except insofar as the above may apply first, when a participant is covered as employee under two (2) plans, or as dependent under two (2) plans, the Plan under which the patient has been covered the longer time pays first. In determining the length of time the individual has been covered under a given plan, we will consider two (2) successive plans covering a given group to be one continuous plan so long as the claimant concerned was eligible for coverage within twenty-four (24) hours after the prior plan terminated.

If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

In applying the rules for determining which plan is the primary carrier, the provisions of any plan which would: 1) attempt to shift the status of this Plan from secondary to primary by excluding from coverage under such other plan any participant or dependent eligible under this Plan; or 2) limit the amount or type of coverage available to a participant or dependent as a result of eligibility under this plan, shall not be considered.

In the event another plan is determined to be primary and such other plan is either not financially able or refuses to discharge its responsibility, such action shall not cause this Plan to assume primary status.

In the event an employee or dependent fails or refuses to comply with the terms and conditions of another plan, thereby resulting in that plan reducing or denying benefits, this Plan will only provide benefits under the Coordination of Benefits provision based upon the benefit which the other

plan would have provided if the employee or dependent had fully and properly complied with the terms and conditions of the other plan.

The Fund may exchange benefit information with other insurance companies, organizations and individuals, and has the right to recover any overpayment made to you if you neglect to report coverage under any Plan.

In order to obtain all benefits available to you, a claim should be filed under each Plan.

SUBROGATION, REIMBURSEMENT, & THIRD PARTY RESPONSIBILITY

Subrogation and Reimbursement allows the Fund to recover the full value of any benefits (medical, disability, etc.) it pays on behalf of a person covered by this Plan who is injured or suffers an illness through the act or omission of another person or persons (herein-after called “third party or parties”). In such event the Fund is subrogated to all rights of recovery that the covered person may have for injury or illness caused by third party or parties. The fund’s subrogation/reimbursement rights apply even though the covered person may not have been “made whole” or fully compensated for his physical, psychological, or financial damages. Additionally, the subrogation/reimbursement rights apply to any recovery made by the Participant/Dependent regardless of whether classified as medical/disability, pain and suffering, etc. The Participant/Dependent has the right to reject the payment of benefits by the Plan and may choose to attempt to recover such costs from the third party who caused the illness or injury. However, by accepting benefits, the covered person shall be deemed to have conclusively agreed to the terms and conditions set forth in this section. Any recovery, whether by settlement or judgement, and from any source, including your own insurance, must be held in trust for the benefit of the Plan. If necessary, the Plan may file a lien or constructive trust action to enforce its subrogation/reimbursement rights.

Payment of benefits are also CONDITIONAL upon the covered person’s agreement (including forms required by the Fund to sustain the operation of this provision) to reimburse the Fund for any benefits paid, should the covered person recover monies or damages or be compensated for that same injury or illness, either directly by the third party or parties or through insurance. And, in such event, the Fund shall have the right to recover against any source which makes payment, or to be reimbursed by the covered person who receives benefits from the Fund, 100% of the benefits paid. If the 100% reimbursement provided above exceeds the amount recovered by the covered person, less attorney fees incurred by the covered person in obtaining such recovery (the covered person’s “Net Recovery”), the covered person shall reimburse the Fund the entire amount of the Net Recovery.

In addition, the Fund may file a lien for such a return of benefits.

Each covered person shall be deemed to have conclusively agreed to and accepted the terms and conditions of the Fund when he or she becomes a covered person.

If (1) the Fund pays benefits on a claim and payments are received from a third party who is responsible for the expenses incurred and the recipient of benefits does not repay the Fund as agreed upon under the Subrogation Provisions, or (2) if the Fund pays benefits based upon misrepresentations and were not otherwise covered under the Plan; then the Trustees have the right to withhold any future benefits such person may be entitled to on claims for that person or his/her dependents until the proper amount has been satisfied.

DEFINITIONS

The words and phrases have the following meanings when used in this booklet:

Complication of Pregnancy–non-obstetrical treatment of a definable medical condition or disability occurring to the mother during the pregnancy, delivery, or after termination of pregnancy that is related to the pregnancy, and that is classified as a medical condition under the following ICD-9 codes: V23, V28, 630-649.6, 651-677. Complications of pregnancy does not include common symptoms/discomforts associated with pregnancy such as spotting, false labor, morning sickness, skin changes, backache, headache, leg cramps, indigestion, constipation, hemorrhoids, or the usual lab/ultrasound tests to monitor status and progression of the pregnancy.

Dependent–The term “dependent” means your spouse provided you are not legally separated or divorced. Your “dependent” also means your children: 1) who are considered disabled under the terms of the Plan; or 2) who are less than twenty-six (26) years of age.

The word “children” includes your biological children, your step-children and any legally adopted children. Coverage for adopted children will begin when the child is initially placed in your home for purposes of adoption. Grandchildren, nieces, nephews, siblings, etc. are not eligible unless you have initiated the adoption process.

The children of a divorced or legally separated participant will be eligible for coverage if the Plan receives a Qualified Medical Child Support Order from a state court which meets all the conditions of the Omnibus Budget Reconciliation Act of 1994.

While your dependent coverage is in effect, newly acquired dependents automatically become Covered Individuals on the date they meet this definition of “dependent,” subject to the Effective Date of Benefits provisions appearing in this booklet.

When an eligible employee dies, benefits for his eligible dependents, if any, shall be continued to the end of the employee’s normal termina-

tion date as set forth in the provisions for DISCONTINUANCE OF BENEFITS.

Covered Participant–A covered employee or a dependent with respect to whom an employee is covered.

Total Disability–(except when differently defined in the text of this booklet)–Disability which commences after the effective date of a Covered Individual's benefits and which, with respect to you, prevents you from performing any and all of the duties of your occupation or, with respect to a dependent, prevents the dependent from doing any and all of his or her usual activities.

Hospice Agency–An agency which primarily provides hospice care and services and which is licensed by the State, if required by law.

Hospital–An institution which:

1. provides day and night lodging and is primarily engaged in further providing diagnostic and therapeutic facilities for the diagnosis and treatment of injury or disease under the supervision of doctors;
2. regularly and continuously provides day and night nursing service by or under the supervision of registered graduate nurses;
3. is not primarily a place for rest, a place for the aged, or a nursing or convalescent home; and
4. is operated in accordance with the laws of the jurisdiction in which it is located pertaining to hospitals.

Inpatient–A Covered Participant or dependent who incurs a hospital charge for a day of hospital confinement in other than the outpatient department of the hospital.

Day of Hospital Confinement–A period of twenty-four (24) hours or less for which the hospital makes a full daily Room and Board charge.

Physician–A doctor licensed to practice medicine.

Medicare–The Medical Care Benefits provided under Title XVIII of the Social Security Amendments of 1965 and as subsequently amended.

Durable Medical Equipment - Equipment which meets all of these requirements:

1. it can withstand repeated use;
2. it is primarily and customarily used to serve a medical purpose;
3. it is generally not useful in the absence of an illness or injury;
4. it is appropriate for use in the home;
5. it is not primarily and customarily for the convenience of the individual;
6. it provides direct aid or relief of the medical condition; and
7. it is recommended by a Physician.

Surgery–is an operation or procedure which requires cutting. Surgery

also includes the setting of fractured or dislocated bones. There are other procedures that are considered surgery. The payment for surgery includes the usual care given by a provider before and after your surgery.

When more than one surgical procedure is performed during an operation:
the allowable amount will be paid for a major procedure and
the allowable amount for a secondary procedure will be reduced by 50%.

Payment will not be made for secondary procedures through the same incision that are determined to be incidental.

Usual, Customary and Reasonable Charge–

1. Usual Charge: The amount most consistently charged by a Physician or other provider to patients for a given service.
2. Customary Charge: A charge which falls within the range of Usual Charges for a given or similar service billed by most Physicians or other providers with similar training, experience, certification, qualification, accreditation, and/or experience within a given geographic area.
3. Reasonable Charge: A charge which meets the Usual and Customary criteria, or which the Plan determines is reasonable in the light of the circumstances.

[Charges of an In-Network provider will be deemed by the Plan to satisfy this definition.]

Medically Necessary–services and supplies which are:

1. consistent with the symptom or diagnosis and treatment of the individual's condition, disease, ailments or injuries;
2. appropriate with regard to standards of good medical practice;
3. not solely at the choice of or for the convenience of an individual, Physician, Hospital or other provider; and
4. the most appropriate supply or level of service which can be safely provided to the individual. When applied to the care of an inpatient, most appropriate means that the medical symptoms or conditions require that the services or supplies cannot be provided as an outpatient in a Physician's office or in another facility.

Benefits will not be provided for Hospital stays when based upon the primary reason for the admission, the hospitalization is not Medically Necessary, as determined by the Plan.

THE FACT THAT A PHYSICIAN HAS PRESCRIBED, ORDERED, RECOMMENDED, OR APPROVED A SERVICE, TREATMENT, HOSPITALIZATION OR SUPPLY DOES NOT, OR ITSELF, MAKE SUCH SERVICE, TREATMENT, HOSPITALIZATION OR SUPPLY MEDICALLY NECESSARY NOR DOES IT MAKE THE CHARGE A COVERED EXPENSE. THE PLAN RESERVES THE RIGHT TO MAKE THE FINAL DETERMINATION OF MEDICAL NECESSITY ON THE BASIS OF FINAL DIAGNOSIS AND SUPPORTING MEDICAL DATA.

CLAIMS PROCEDURES

HOW TO OBTAIN INPATIENT HOSPITAL SERVICES

Your Plan has adopted a special rule regarding the ability to obtain inpatient hospital services for mental health and substance abuse treatment. You must follow the Pre-Admission Certification Program outlined on pages 2.3 through 2.4 of your booklet PRIOR to obtaining inpatient treatment.

Once you or your physician contact the Pre-Admission Certification Program, they will contact determine the appropriateness of your hospitalization. This review will be performed as quickly as possible. The Pre-Admission Certification Program will make a decision on the request as soon as possible, but within 15 days.

If the Pre-Admission Certification Program needs additional information from you or your physician to make the decision, you will be notified as to what information must be submitted. You and/or your physician will have at least 45 days to submit the additional information. Once the Pre-Admission Certification Program receives the information from you or your physician, you will be notified of the decision on the claims generally within 10 days.

In the event that the Pre-Admission Certification Program does not approve the admission as requested, this would be considered a denial or "Adverse Benefit Determination." You will receive a Notice of the Adverse Benefit Determination in writing that contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and / or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of the Pre-Admission Certification Program vendor's Appeals Procedure.

HOW TO FILE A CLAIM FOR HOSPITAL AND MEDICAL BENEFITS

When you receive health care services:

- Show your identification card to the provider of service
- Ask the provider to file a claim for you

If the provider of service files a claim for you, he/she will then submit all necessary claim information to the Fund's Claims Administrator and will receive reimbursement directly.

In some cases, however, you may have to submit a claim for benefits directly to the Fund. If you must submit a claim for health care services received, you should:

- Obtain an itemized bill from the hospital, doctor or medical facility
- Obtain a claim form from the Fund's Administrative Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form
- An itemized bill generally includes all of the following:
    - Patient's name and address
    - Date of Service
    - Type of Service and diagnosis
    - Itemized charges
    - Provider's complete name, address, and tax identification number

Payment for eligible benefits will be made to the health care vendor unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not considered filed until it is received by the Fund's Administrative Office. The Fund's Administrative Office will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund may request additional information from you or the provider. You and/or your physician will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Plan, you will be notified by the Fund's Administrative Office that the claim is denied, with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Plan's Appeals Procedure.

PRESCRIPTION CLAIMS SAV-RX PROGRAM

You will receive a personalized SAV-RX Prescription Benefits Identification Card with eligible family status listed on the card once you become eligible in this Plan. You must present your Prescription Benefits Identification Card along with your Doctor's prescription to any participating SAV-RX pharmacy. No benefits are payable for prescriptions filled at a non-network pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will generally ask you to sign the form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase of a prescription is not a claim for benefits.

If you elect to have your prescription filled by a pharmacy other than a participating pharmacy, no benefits are payable by the Plan.

If you are not eligible for benefits at the time you contact the pharmacy or in the event that the prescription is not a covered drug under the Plan, you must contact the Fund's Administrative Office for additional information regarding the adverse benefit decision. The Fund's Administrative Office will provide you with a Notice of the Adverse Benefit Determination in writing that contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material

or information is necessary;

- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Plan's Appeals Procedure.

VISION BENEFIT CLAIMS

NATIONAL VISION ADMINISTRATORS PROGRAM

To locate a participating vision care provider refer to the directory provided by the administrator for the program (National Vision Administrators). The selected provider should then be contacted for an appointment and advised of the availability of benefits through this program. At the time of the appointment, the vision care provider should be presented with the identification card you received.

If you elect to receive services from a provider who does not participate in the panel of network providers, you will still be entitled to benefits through the program, however you will be responsible for the difference between the amount paid by the program and the charge amount. You may be required to make a payment for the balance due at the time services are received.

If you are not eligible for benefits at the time you obtain services from the vision care provider or in the event that the desired service is not covered under the Plan, you must contact the Fund's Administrative Office for additional information regarding the adverse benefit decision. The Fund's Administrative Office will provide you with a Notice of the Adverse Benefit Determination in writing that contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Plan's Appeals Procedure.

DENTAL BENEFIT CLAIMS

(Delta Dental PPO and Delta Dental Premier)

You will receive a Delta Dental of Ohio reference card once you become eligible in this Plan. To locate a participating Delta Dental PPO or Premier provider you may visit www.deltadentaloh.com or call customer service at (800) 524-0149. The selected provider should then be contacted for an appointment and advised of the availability of benefits through this program. At the time of the appointment, the dental care provider should be presented with the reference card you received.

If you elect to receive services from a provider who does not participate in the Delta Dental network, you will still be entitled to benefits through the program, but at an overall lower calendar year maximum, as shown in the Self-Funded Schedule of Benefits. You will also be responsible for the difference between amount paid through the program and the charge amount from the Out-of-Network provider. This difference may be charged at the time services are rendered.

If you seek care from a dentist who participates in the Delta Dental PPO or Premier network, your dentist will fill out and file claims for you. Out-of-Network dentists may not fill out and file your claims. If this is the case, you can print a claim form from www.deltadentaloh.com and send the paperwork to:

Delta Dental
P.O. Box 9085
Farmington Hills, MI 48333-9085

If you are not eligible for benefits at the time you obtain services from the dental care provider, or in the event the desired service is not covered under the Plan, you will receive a written Notice of Adverse Benefit Determination that contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material or information is necessary.
- The notice of any internal rule or guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of the Appeals Procedure.

WEEKLY DISABILITY CLAIMS

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund's Administrative Office to be completed by you and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

The Fund's Administrative Office will make a decision on the claim and notify you of the decision within 45 days. If the fund requires an extension of time due to matters beyond its control, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45 day period. A decision will be made within 30 days of the time the Fund's Administrative Office notifies you of the delay.

If the Fund's Administrative Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund's Administrative Office receives the information from you, you will be notified of the decision on the claim within 30 days.

The Fund's Administrative Office will provide you with a Notice of the Adverse Benefit Determination in writing that contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Plan's Appeals Procedure.

HOW TO FILE CLAIMS UNDER THE MEDICARE SUPPLEMENT PROGRAM

The Plan offers a Medicare Supplement Program for Medicare eligible Participants. This Medicare Supplement Program provides payments for eligible expenses under Medicare which are not covered by the Participant's Medicare Part A or B benefits.

Most providers will file a request for reimbursement for a Medicare-covered service electronically. If the electronic filing procedure is used, the Fund will handle the necessary coordination, to include issuing payment where necessary to cover the Fund's portion of the expense. As a result, you will not be involved in the claim process when the claims are electronically filed by the provider, which is typically the case.

In some instances, however, your provider may not use the electronic filing procedure. In these cases, the following process applies:

- In order to file a claim for coverage, you must provide written notice of the claim to the Fund as soon as possible after incurring the claims for benefits. However, before any claims are paid under the Medicare Supplement Program, you must file the claim with Medicare and receive an Explanation of Benefits from them.
- Once you receive the Explanation of Benefits from Medicare, you must:
  - Complete the Medicare Supplement Program Claim Form;
  - Send a copy of the original itemized bill sent to Medicare;
  - Send a copy of the Medicare Explanation of Benefits.
  - Please remember to make copies of the items before sending them to the Medicare Supplement Program at the address indicated on the Claim Form.
- The Fund will process your claim within 30 days unless special circumstances require additional processing time. If additional time is needed to process your claim, the Medicare Supplement Program may request additional information from you or the provider. You and/or your physician will have at least 45 days to submit additional information.

When certain expenses are not eligible under the Medicare Supplement Program, you will be notified by the Fund that the claim is denied with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of any appeals rights that you may have available.

HOW TO FILE CLAIMS UNDER THE LIFE INSURANCE PROGRAM

Claims for Death, Accidental Death and Accidental Dismemberment Claims will be provided through an Insurance carrier (Metropolitan Life Insurance Company). However, you or your beneficiary, in the event of your death, must contact the Fund's Administrative Office in order to obtain a claim form and submit the completed claim form with all required documentation to the Fund's Administrative Office.

Generally, the Insurance carrier will notify your beneficiary of the decision on the claim for benefits within ninety (90) days. In the event that the Insurance carrier needs additional time to review the claim for benefits or needs additional information, he/she will be provided with the information on the status prior to the expiration of the initial ninety (90) day period.

When the claim for life insurance benefits falls within the policy exclusions, your beneficiary will be notified by the Insurance carrier that the claim is denied with an explanation of the reasons for the denial. He/she will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and the right to receive a copy;
- A notice of the right to a written explanation of any exclusion which affects the claim; and
- A description of the Insurance carrier's Appeals Procedure.

CLAIMS REVIEW AND APPEAL PROCEDURES

REVIEW PROCEDURE FOR CLAIMS DENIED BY THE PRE-ADMISSION CERTIFICATION PROGRAM

If you receive notice that your Pre-Admission claim has been denied in whole or part, you may request a review of the denied claim within 180 days of the receipt of the notice of denial. The appeal of the denial of an inpatient procedure prior to the service being performed is called a "pre-service" claim. Since the Plan does not require Pre-Admission Certification of inpatient stays that are due to an emergency prior to admission, the Plan should not have any claims for "urgent care services."

You will be provided a complete review of your claim for pre-service inpatient admission. You can file your appeal either in writing or orally. You will receive a written confirmation that they have received your appeal. Your appeal will be reviewed at the first level by a physician advisor of an appropriate clinical expertise. You will receive the decision on this first level of appeal within 15 days. You will have the right at that time to file an appeal under the second level to the full Appeals Committee. This Committee will review the denial of the inpatient admission and notify you of the decision within 15 days. You will receive written notice of the denial on appeal that includes the following:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file suit under ERISA Section 502 (a)

If the patient is hospitalized or if the treating physician states there could be serious adverse consequences to the patient's health during the time required for a standard appeal, an expedited process will be followed. The appeal is handled by a physician advisor of appropriate clinical expertise who was not involved in the initial denial decision. The physician advisor reviews the case, attempts peer-to-peer review with the requesting/treating physician and verbally communicates his/her decision to the treating provider within one business day. Expedited appeals are also available at the second level and are again handled by an Appeals Committee.

The review procedure for claims denied by the pre-admission certification program is modified to include the changes to the internal and external appeals process as required by the Patient Protection and Affordable Care Act. Key elements of the new processes are detailed on pages 2.21 and 2.22 of this Summary Plan Description.

REVIEW PROCEDURE FOR MEDICAL, VISION, PRESCRIPTION DRUG AND WEEKLY DISABILITY CLAIMS

You or your authorized representative may appeal the decision by the Fund's Administrative Office to deny any claim for medical, vision or weekly disability benefits in whole or in part. An "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization. Additionally, any point of service purchase of prescription benefits, which is not covered at the pharmacy, can be appealed through this Review Procedure.

You may file a written notice of appeal to the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number and the fact that you are appealing from the decision of the Fund's Administrative Office, giving the date of the Notice. The Appeal should be addressed as follows:

Board of Trustees
4TH District IBEW Health Fund
609 3rd Avenue
Chesapeake, OH 45619

During the appeals process, you will also be afforded with access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgement, the Board of Trustees shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Board of Trustees will consider your appeal of a claim for payment of services that you already obtained, called a "post-service claim", at its next regularly scheduled quarterly meeting. In the event that your appeal is received less than thirty (30) days prior to the scheduled meeting date, it will be reviewed at the second quarterly meeting following the receipt of the appeal. You will be notified of the decision of the Board of Trustees as soon as possible after the meeting, but in no case later than five (5) days after the decision is made.

The Patient Protection and Affordable Care Act requires non-grandfathered health plans to have specific rules for internal appeals processes. For internal appeals, the following additional standards apply:

- Benefit determinations relating to urgent care claims generally must be made to claimants as soon as possible, but no later than 72 hours from receipt of the claim;
- Note that an "adverse benefit determination" includes rescissions of coverage, pre- and post-service claim determinations, exclusions, limitations, and eligibility determinations;
- Claimants must be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan or Anthem in connection with the claim. The information must be provided as soon as possible and sufficiently in advance to give claimants reasonable oppor-

tunity to respond;
- Notices must be provided in a culturally and linguistically appropriate manner;
- All claims and appeals must be handled in a way that is designed to ensure the decision-maker's impartiality; and
- Notices to claimants must provide additional content such as identifying information on the claim, denial codes, any standard used in denying the claim, description of available appeals processes and contact information for any applicable health insurance consumer assistance or ombudsman office.

The Patient Protection and Affordable Care Act requires non-grandfathered health plans to have specific rules for external appeals processes. A claimant may request an external appeals review after an initial claim denial and subsequent internal review claim denial if the denied claim involves medical judgment (excluding those that involved only contractual or legal interpretation without any use of legal judgment) or rescission of coverage. The timeline for an external review is as follows:
- Request for External Review: Must be allowed if requested within four (4) months after receipt of notice of adverse benefit determination. An immediate external review must also be allowed if the Plan has failed to adhere to the PPACA appeals regulations unless the violation was: 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond the Plan's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance. If the Plan asserts an exception, the claimant is entitled, upon written request, to an explanation of the Plan's basis for asserting the exception. If the external reviewer rejects the claimant's request for immediate review on the basis that the Plan has met the five-element exception, the claimant is permitted to resubmit and pursue an internal appeal.
- Preliminary Review: Must be completed within five (5) business days after receipt of request and within one business day after completion of preliminary review. The Plan must issue notification in writing to the claimant. Note that for an urgent care issue, the preliminary review must be done immediately and the claimant must be notified of the decision immediately.
- Referral to Independent Review Organization (IRO): The Plan must contract with at least two (2) IROs by January 1, 2012 (and at least three (3) IROs by July 1, 2012). Within five (5) business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. (For an urgent care issue, the information must be sent electronically, by fax or other expeditious means). The IRO must provide written notice of its decision within 45 days of assignment. (For urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.)
- Implementation of Reversal: Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

REVIEW PROCEDURE FOR DENTAL BENEFITS

If you receive notice of an adverse benefit determination, and if you think that Delta Dental incorrectly denied all or part of your claim, you can take the following steps:

First, you or your Dentist should contact Delta Dental's Customer Service department at their toll-free number, (800) 524-0149, and ask them to check the claim to make sure it was processed correctly. You may also mail your inquiry to the Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of your claim, you must send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

You must include your name and address, the Member ID number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and indicate in your letter that you are requesting a formal appeal of your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your appeal within 180 days of the date on which you receive your notice of the adverse determination of the Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, he will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time.

The Dental Director will make his decision within 30 days of receiving your request for the review of Pre-Service Claims and within 60 days for Post-Service Claims. If your claim is denied on the review (in whole or in part), you will be notified in writing. The notice of any adverse determination by the Dental director will (a) inform you of the specific reason(s) for the denial,

(b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at not cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part), and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgement, or necessity, the notice of his adverse determination will explain the scientific or clinical judgement on which the determination was based or include a statement that a copy of the basis for that judgement can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate speciality, the notice will include the name(s) of those expert(s).

If your claim is denied in whole or in part after you have complete this required Claims Appeal Procedure, or Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within the timelines established by the Plan.

Following the conclusion of the appeal process through Delta Dental, you have the option to request an informal review by the Board of Trustees. The appeal to the Board is strictly voluntary and only available once you have pursued the mandatory appeal with Delta Dental. The request for review must be in writing and submitted to the Board within 180 days of the final decision on appeal from Delta Dental. The request should state your name, address, Social Security number and a copy of any documents you would like the Board to consider. The material should be sent to:

Board of Trustees
4th District IBEW Health Fund
609 3rd Avenue
Chesapeake, OH 45619

The Board will consider your optional appeal at its next regularly scheduled quarterly meeting. You will be notified of the decision of the Board as soon as possible, generally within 5 days after a decision is made. You are under no obligation to pursue a voluntary appeal before filing a civil action and the Plan waives any defense relating to your failure to exercise this option. Additionally, any defense the Plan may have based on timeliness is tolled while you are pursuing the voluntary level of appeal.

PROOF OF CLAIMS

Written proof of claims for payment of Covered Services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically. **All claims must be submitted by you or the Provider no later than ninety (90) days from the date on which the services were incurred.** Failure to furnish the claim within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of the claim within that time period and that written proof was provided as soon as reasonably possible. **However, all claims must be filed within one (1) year from the date the claim was incurred and if they are not submitted, they will be denied as untimely.**

No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeals procedures set forth in this Section. Additionally, no action shall be brought at all unless brought within three (3) years from the expiration of the time which the proof of claim is required.

PHYSICAL EXAMINATION

The Plan at its own expense shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Plan when and so often as the Trustees may reasonably require while a claim is pending. The Trustees have the right to ask for an autopsy in the case of death, provided this is not forbidden by law.

LIMITATIONS PERIOD

No action at law or equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeal procedures set forth in this Section. Additionally, any legal action must be brought within three (3) years from the expiration of the time in which the proof of claim is required. Any action at law or equity based upon an alleged breach of fiduciary responsibility must be brought within three (3) years of the date the breach was alleged to have occurred or be forever barred.

AUTHORITY OF TRUSTEES

The Trustees, except to the extent delegated to the Claims Administrator, shall have the sole authority and discretion to determine eligibility for participation in the Plan, determine eligibility for the payment of benefits under the Plan, determine the amount of any benefits payable under the Plan and authorize and direct payment of such benefits, make and apply such rules and regulations and prescribe the use of such forms as shall be necessary to carry out the provisions of the Plan, contract with certain organizations, do such other acts reasonably required to administer the Plan, rule on all appeals, interpret and construe terms of the Trust Agreement, Plan Rules and Regulations and all other documents coming before them. All decisions of the Trustees shall be final and binding.

FRAUDULENT CLAIMS

The filing of false claims will be deemed as fraud and the Trustees will pursue to the fullest extent of the law. Additionally, if payments are made under this Plan based upon fraudulent misrepresentations, the Plan may refuse to honor future claims until the amount paid due to fraudulent misrepresentations has been recouped as an offset against such claims.

RIGHT TO MODIFY

Any provision in this document notwithstanding, due to the exigencies inherent in any health & welfare fund and the duty of the Trustees to provide benefits for all of the participants in amounts and kinds which may vary from time to time, no participant shall be deemed to have any vested interest in any benefit provided by the Fund and the Trustees expressly reserve the right to modify, add to, subtract from, or eliminate any benefit to any participant or group or class of participants as may be required under the circumstances.

RELEASE OF INFORMATION

If you file a claim for benefits, you are required to authorize any physician, hospital, employer, government agency or any other person, corporation or organization having information which may be required for a proper determination of the claim to release such information to the Trustees.

RIGHT OF RECOVERY

The Plan reserves the right to recover any monies paid in error to or on behalf of an individual, or to providers of health care. To the extent that payments are made by the Plan which are either in excess of the maximum amount necessary to satisfy the obligations of the Plan or are subsequently determined to have been incorrectly made, regardless of to whom such payments have been made, the Plan shall have the right to recover such excess or incorrect payments from any person or other entity to whom or for whom such payments were made (including the

individual), any insurance companies, or any other person or entity for whom repayment is appropriate as the Plan shall determine. Any individual may be required by the Plan to furnish information, to execute and deliver such documents, and otherwise to cooperate in whatever manner may reasonably be required to secure the Plan's rights to recover such payments.

ASSIGNMENT

Any individual or Custodial Parent over eighteen (18) years of age may authorize the Plan to pay benefits applicable to expenses for care and treatment directly to the provider of service(s) on whose charge a claim is based.

CASE MANAGEMENT

The Plan reserves the right to contract with any appropriate firm for case management review services. Individuals are required to cooperate with the firm providing the case management review with regard to providing authorization to receive medical records and other reports as requested. Failure to cooperate with the case management review firm may result in the Plan's denial of normal benefits.

CHANGE OF ADDRESS

If you change your address, you must notify the Administration Office. If you fail to do so, your Self-Contribution Notice may be delayed or lost and you will lose your eligibility.

YOUR SOCIAL SECURITY NUMBER

Your hours are processed by computer and you are classified by your Social Security Number. It is very important your Social Security Number is correctly reported to your employer and shown on the reporting forms.

NON-DISCRIMINATION

Any provision of the Plan notwithstanding, the Plan shall at all times be interpreted, applied and administered so as to comply with the Health Insurance Portability and Accountability Act of 1996. The Plan will not discriminate with respect to rules for eligibility or benefits based upon a health factor including: 1) health status; 2) medical condition; 3) claims experience; 4) receipt of health care; 5) medical history; 6) genetic information; 7)evidence of insurability; or 8) disability.

PROCEDURE TO APPOINT AN AUTHORIZED REPRESENTATIVE

Federal regulations allow a health plan to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a participant. The Plan will require a participant to complete a form that includes details about the covered participant, the designated authorized representative and the scope of the appointment. In addition, because in virtually all cases an authorized representative would need

access to the participant's protected health information to effectively act on their behalf, a form allowing for disclosure of the protected health information must also be completed.

Effective March 1, 2010, any participant who would like an individual to act on his behalf with respect to the Plan must complete an Appointment of Authorized Representative Form. In addition, an Authorization Form for PHI Disclosure must be completed if the appointed authorized representative will be allowed access to the individual's protected health information (PHI).

WEEKLY DISABILITY BENEFIT

(For Eligible Active Participant Members Only)

If, while you are covered, you become totally disabled due to accidental bodily injury or disease, you will be paid the amount of Weekly Disability Benefits shown in the Schedule of Benefits. Benefits will begin with the first day of disability as the result of an accident, with the eighth day of disability as the result of sickness and will continue during the continuance of total disability for up to twenty-six (26) weeks.

The benefit paid will be offset by the amount of any disability benefit received from the Social Security Administration and from a negotiated pension plan in which the individual participates. The amount applied to offset the Weekly Disability Benefit will be the total of the monthly Social Security and pension benefits divided by the number of calendar weeks, including fractions thereof, in the applicable month(s). If the total of the weekly value(s) of the Social Security and Disability Pension benefits exceeds the Weekly Benefit shown in the Schedule of Benefits (page 2.1), then no benefit will be paid by the Plan under this Weekly Disability Benefit.

Successive periods of disability separated by less than two (2) weeks of continuous full-time active work shall be considered as one period in determining the benefits available to you, unless the subsequent disability is due to an injury or disease entirely unrelated to the causes of the previous disability and commences after your return to full-time active work.

Weekly Disability Benefits are subject to mandatory Social Security withholding.

Weekly Disability Benefits do not apply to retired participants.

LIMITATIONS

Weekly Disability Benefits are subject to the General Limitations.

In addition, no benefits are paid for:

1. A period of disability commencing after the retirement of a

participant or

2. A period of disability commencing before the participant's date of eligibility or
3. A period of disability for a spouse or child or
4. An occupational illness or injury.

ACCIDENT BENEFIT

If, while eligible, you or any of your dependents suffer injuries in an accident and incur expense for treatment within three (3) months of the accident, you will be paid a benefit in the amount of such expense for:

1. services of a doctor or surgeon;
2. confinement in a hospital or treatment in the outpatient department of a hospital;
3. services of a registered nurse;
4. x-ray and laboratory examinations;
5. braces, crutches, artificial limbs or eyes, dressings, rental of durable medical equipment; and
6. physical therapy treatments.

The benefits under this Accident Benefit will be provided prior to the payment of benefits under the Major Medical Expense Benefit and will be limited to $300 for any one accident.

LIMITATIONS

Accident Benefits are subject to the General Limitations. In addition, no benefits are payable under this Accident Benefit for:

1. eye refractions or the purchase of fitting of glasses or contact lenses;
2. charges incurred for treatment of an illness;
3. prescription drugs or medicines;
4. treatment not certified by a doctor as being necessary in connection with an accidental bodily injury; or
5. treatment received more than three (3) months following the date the injury occurred.

PRESCRIPTION DRUG BENEFIT

If you or any of your dependents incur expense for covered prescription drugs received while not hospital confined, benefits will be provided as described in the Schedule of Benefits on page 2.2 This benefit is administered by SAV-RX.

Benefits are available at the retail pharmacy level and through the SAV-RX Mail Service Pharmacy. Prescription drugs prescribed for short-term use should be obtained from a retail pharmacy that participates in the SAV-RX Retail Program network. **Benefits are not payable for prescriptions filled at a pharmacy that does not participate in the Sav - RX network.** Prescription drugs prescribed for long-term maintenance use should be obtained from SAV-RX's Mail Service Pharmacy.

When there is a federally equivalent generic available, a prescription may be "dispensed as written" and filled with a brand name drug if a letter of medical necessity is provided to the Administrator by the attending physician. This prescription will be subject to the non-formulary brand name drug co-payment factor as detailed in the Schedule of Benefits on pg. 2.2. **However, when a federally equivalent generic is available, a prescription filled with a brand name drug without a letter of medical necessity, and where the claimant has requested the brand name drug, will be subject to the appropriate co-payment factor PLUS the claimant will be responsible for the difference in cost between the generic equivalent and the brand name drug.**

LIMITATIONS

The Prescription Drug Benefit is subject to the General Limitations. In addition,

1. The maximum supply available at the retail pharmacy level is the greater of a 34-day supply or 100 units;
2. The maximum supply available through SAV-RX's Mail Service Pharmacy is a 90-day supply;
3. Benefits for erectile dysfunction medications are limited to six (6) tablets per month;
4. Benefits for prescription Non-Sedating Antihistamines are only available subject to a 100% co-payment by the participant; However; Singulair will be covered subject to the Co-Payment Factors shown in the Schedule of Benefits for severe allergic rhinitis, subject to prior authorization by Sav-Rx, upon receipt of certification from the individual's physician that the individual suffers from severe allergic rhinitis and that all other medications have failed to provide the appropriate level of relief;
5. Topical creams for short-term treatment of a skin condition will be available only through the retail program and will be limited to the initial fill and one refill;
6. For individuals age 24 and over, Retin A and growth hormones are only covered upon receipt of a physician's statement of medical necessity; and
7. Benefits are not available for:
   a. Diet medications, nutritional and diet supplements and vitamins, except pre-natal,
   b. Fertility drugs,

c. Lifestyle drugs, including, but not limited to, Propecia, Renova, anabolic drugs and non-prescription smoking cessation products,
d. Vaccines, taxoids, and non-RSV disease prevention drugs,
e. Over-the-counter drugs and medicines or drugs and medicines not legally dispensed by a registered pharmacist or physician according to a written prescription of a doctor,
f. Fluoride preparations,
g. Contraceptive devices, injectable and kits, except as otherwise provided on Page 2.33 through 2.34A,
h. Experimental or investigative drugs.

Coordination of Benefits applies to the Prescription Drug Benefit. If you or a dependent has primary coverage for prescription drugs under another plan, your prescriptions or your dependent's prescriptions will not be covered through the SAV-RX Retail and Mail Service programs. You will be required to submit your prescription drug claims through the primary plan first and submit the balance to American Benefit Corporation for benefits under the 4th District IBEW Health Fund as the secondary plan.

SAV-RX has been granted the authority to administer several appropriate programs:

- Therapeutic Interchange Program to encourage a shift from a single-source brand-name drug (no generic available) to an equivalent generic drug in the same therapeutic class;
- Specialty Drug Program to oversee the administration of expensive specialty drugs, including the limiting of dosages to thirty (30) days unless prior authorization determines a larger supply is appropriate.
- Step Therapy Program for first-time users of common brand-name medications where over-the-counter drugs or generics are available; and
- Human Growth Therapy Program to limit usage to individuals less than age nineteen (19) with specific indications for growth failure.

NOTICE TO MEDICARE ELIGIBLE PARTICIPANTS

The Plan provides normal Prescription Drug Benefits to Medicare eligible retirees and spouses. You do not need to purchase a Medicare Part D prescription drug benefit policy. In fact, if you do purchase a separate Part D policy, you will not be permitted to continue coverage through this Plan.

The coverage provided by this Plan is better than the basic Part D coverage. As such, should you ever decide to terminate your participation in the Plan, you will be provided a Certificate of Creditable Coverage. This Certificate will protect you from having to pay the surcharge for late enrollment in any Part D coverage you elect to purchase.

COMPREHENSIVE MAJOR MEDICAL BENEFIT

If you or any of your dependents incur Covered Medical Expenses (defined below) which within a year are in excess of the Deductible Amount, the Fund will pay you, subject to the maximum benefit specified below, the following benefits:

a. for chiropractic treatments and manipulations, a benefit determined by multiplying such expenses by the appropriate payment factor shown in the schedule of benefits, limited to a benefit of $500 for all charges incurred by an individual in a calendar year; and
b. 100% of the charges incurred for routine childhood immunizations administered by a state, county or city health department; and
c. 80% of the charge for purchase of a hearing aid(s) for children age 18 and under, subject to a lifetime maximum benefit of $1,500.00 and 80% of the charge for the purchase of augmentative communication devices for children age 18 and under, subject to a lifetime maximum benefit of $7,500.00. The plan will cover 80% of these expenses after the individual has met their calendar year deductible. Any such co-payment made in connection with this section do not apply to the out-of-pocket maximum limit; and
d. 80% of the charges for augmentative communication devices will be covered for individuals 19 and over, provided the device is an eligible expense under Medicare. The Plan will cover 80% of these expenses after the individual has met their calendar year deductible. Any such co-payment made in connection with this section do not apply to the out-of-pocket maximum limit; and
e. for all other Covered Medical Expenses, a benefit determined by multiplying such expenses by appropriate payment factor shown in the schedule of Benefits, and subject to the family out-of-pocket maximums also shown in the Schedule of Benefits.

LIFETIME MAXIMUM BENEFITS

The maximum benefit payable over an individual's lifetime for the attendance of a registered graduate nurse in the individual's home is $50,000.

IN-NETWORK PROVIDERS

Doctors and Hospitals signatory to a contract with a Preferred Provider Organization network are in-network providers.

In addition, the charges of 1) a hospital based provider (emergency room physician, radiologist, pathologist, anesthesiologist, etc.); 2) an emergency ambulance service and 3) a medical professional providing services to a covered patient during a period of hospital confinement in a network facility and under the care of an attending physician participating in the network will be considered as in-network charges by the Plan.

(If a patient seeks follow-up care from a specialist or other non-network provider following the period of hospital confinement, out-of-network benefits will be payable.)

COVERED MEDICAL EXPENSES

Covered Medical Expenses are expenses incurred in connection with the diagnosis and treatment of an illness for the following medical services and supplies:

1. Treatment by a doctor.
2. Surgery.
3. Care and treatment furnished by a hospital, except daily room and board charges in excess of the average charge of the hospital for semi-private accommodations.
4. Inpatient services at other health care facilities, including skilled nursing facility, rehabilitation hospital and sub-acute facility, subject to a combined maximum coverage period of sixty (60) days per calendar year.
5. Attendance of a registered graduate nurse who is not a member of your, or your dependent's, immediate family or ordinary household.
6. The following additional services or supplies, if not included above:
   a. Anesthesia and its administration;
   b. Diagnostic X-ray and laboratory service;
   c. Oxygen and rental of equipment for its administration; (However, if benefits are provided for a concentrator unit, benefits will not be provided for refills of stationary tanks or for more than two refills of portable tanks per month.)
   d. X-ray, radium and radioactive isotope therapy;
   e. Rental of durable medical equipment required for temporary therapeutic use;
   f. Whole blood and blood plasma and their administration;
   g. Emergency transportation to a local Hospital by a licensed professional ambulance service when Medically Necessary; (Transportation is limited to the nearest facility which can provide covered services to treat the condition. If appropriate care is not available locally, the Fund will pay the Usual, Customary, and Reasonable Charge to transport the individual outside the local area to the nearest facility able to provide care. Air ambulance is covered only in emergency situation and only when use of a surface ambulance would cause a serious risk to life or health. Transportation costs incurred outside the United States and Canada are not covered.)
   h. Casts, splints, crutches, trusses and braces;
   i. Artificial limbs and eyes required by an injury or disease occurring while covered, and medically necessary replacements;
   j. Treatment by a physiotherapist when under the supervision of a doctor;
   k. Hospice services, including bereavement counseling, drugs and supplies, provided in the home or in a hospice facility, if the following conditions are satisfied:
      i. the patient's life expectancy, as certified by a Physician, is six (6) months or less;
      ii. pain control and symptom relief, rather than curative care, is considered by the Physician to be more appropriate and the

Physician refers the patient to the hospice program; and
iii. the patient is formally admitted to the hospice and the Physician concurs with the treatment plan;

l. Medical and surgical services provided to a covered person in connection with a mastectomy:
   i. Reconstruction of the breast on which the covered mastectomy was performed;
   ii. Surgery and reconstruction of the other breast, is desired, to produce a symmetrical appearance and
   iii. Prosthesis and treatment of physical complications of all stages of the mastectomy, in a manner determined in consultation with the attending physician and patient;

m. 80% of the charges for purchase of hearing aid(s) for children age 18 and under, subject to a maximum benefit of $1,500;

n. Testing performed to determine the cause of infertility; and

o. Vision exams necessary to test diabetic individuals for retinopathy.

p. Blue Distinction Centers for Transplants (BDCT) Program provides 100% coverage for charges at a participating BDCT facility, without application of the calendar year deductible.

q. 100% of the charges for out-patient laboratory services at a free-standing network provider.

r. Charges for speech therapy provided to dependent children deemed by the Plan to be in treatment of developmental delay in communication skills, limited to a calendar year maximum of $1,500.

DEDUCTIBLE AMOUNT FOR EACH COVERED INDIVIDUAL

The Individual Deductible Amount is the amount of Covered Medical Expenses which must be incurred by a Covered Individual within a calendar year before a benefit is payable for subsequent expenses incurred in that year.

FAMILY DEDUCTIBLE AMOUNT LIMIT

If three (3) or more members of a family (you and your dependents) incur Medical Expenses in a calendar year (not including Deductible Amount Carry-Over from a prior year), and if the portion of such expenses applied toward Individual Deductible Amount requirements equals the Family Deductible Amount Limit, all of your family members shall be deemed to have met the Individual Deductible Amount requirement with respect to Covered Medical Expenses incurred in that year.

DEDUCTIBLE AMOUNT CARRY-OVER

Covered Medical Expenses incurred in the last three (3) months of a calendar year and applied to a Covered Individual's Deductible Amount for that year will also be applied to that individual's Deductible Amount requirement for the following calendar year.

FAMILY MEMBERS IN ONE ACCIDENT

If two (2) or more members of a family (you and your dependents)

incur Covered Medical Expenses in a calendar year as the result of injuries sustained in the same accident and if the amount of such expenses applied toward Individual Deductible Amounts equal the Individual Deductible Amount, each family member will be deemed to have met his Individual Deductible Amount requirement with respect to Covered Medical Expenses due to the accident and incurred in that or the next calendar year.

LIMITATIONS

Major Medical Expense provisions are subject to the General Limitations.

ORGAN TRANSPLANT PROVISIONS

When an organ or tissue is secured from a living donor, the unpaid medical expense of the donor and/or recipient are reimbursed as outlined below:

1. When this Plan covers the recipient, the expenses of the donor will be covered as part of the recipient's claim if:
   a. the donor does not have health insurance coverage or
   b. the donor's health insurance plan denies coverage for the expenses incurred.
2. When this Plan covers the recipient and the donor has coverage under a health insurance plan, the expenses of the donor will be covered as part of the recipient's claim by coordinating between the two plans. This Plan will pay the lesser of normal benefits or the balance unpaid by the donor's health insurance plan.
3. If both the recipient and the donor are covered by this Plan, benefits will be provided for each individual's medical expenses up to the normal benefit amounts under the individual/separate claims.

BLUE DISTINCTION CENTERS FOR TRANSPLANTS PROGRAM

This program recognizes quality medical facilities with established experience and skill in performing transplant procedures and providing necessary follow up care. You must obtain propr authorization and have all transplants performed at a BDCT network facility. For specific information about transplant benefits, please contact the Fund Office. The procedure must be a mationally recognized protocol for the diagnosis requiring the transplant. The transplant types included in the program are:

a. Heart transplants:
b. Heart/lung transplants:
c. Lung transplants:
d. Liver transplants:
e. Pancreas/kidney transplants:
f. Pancreas transplants:
g. Liver/kidney transplants:
h. Bone marrow/stem cell transplants.

The benefit will include a $10,000 allowance for transportation and lodging prior to, during and after the transplant procedure for the patient and one family member or companion.

PREVENTIVE CARE BENEFIT

ACTIVES, NON-MEDICARE RETIREES AND DEPENDENT ONLY CLASSES

Benefits for Preventive Care as detailed below will be paid at 100%, up to the reasonable and customary charge, without application of the In-Network Calendar Year Deductible. These benefits will be provided to all eligible non-Medicare Plan participants regardless of benefits previously paid or applied to the deductible under the Major Medical Benefit. **Benefits will be provided only for services rendered by In-Network providers. No benefits will be paid for any preventive care services received from an Out-of-Network provider.**

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Feeding** support, supplies, rental of equipment and counseling,

- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breast Feeding** interventions to support and promote breast feeding
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Contraceptive Methods and Counseling** for all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity
- **Counseling** for sexually transmitted infections (STIs) for all sexually active women
- **Counseling and screening** for human immunodeficiency virus (HIV) for all sexually active women,
- **Folic Acid** supplements for women who may become pregnant
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human papillomavirus (HPV)** testing every three years beginning at age 30,
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Screening and counseling** for interpersonal and domestic violence
- **Screening** for gestational diabetes,
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-woman visits**

Covered Preventive Services for Children

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Blood Pressure** screening for children
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Depression** screening for adolescents at higher risk
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 —doses, recommended

ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

This listing of covered preventive care services may change from time to time based upon the recommendations of the United States Preventive Services Force, the Advisory Committee on Immunization Practices of the centers for Disease Control and Prevention and the Health Resources and Services Administration.

The Plan will rely on established techniques and the relevant evidence base to determine the frequency, method, treatment or setting for which a recommended preventive service will be available without cost-sharing requirements.

Coverage for preventive care services only applies to those services rendered by a provider in the Anthem Blue Cross Blue Shield network. No benefits are payable for services of a provider outside of that network.

BENEFITS WILL NOT BE PROVIDED UNDER THIS PREVENTIVE CARE BENEFIT FOR THE TREATMENT OF ANY ILLNESS OR INJURY. CHARGES FOR THE TREATMENT OF A DIAGNOSED ILLNESS OR INJURY WILL BE CONSIDERED UNDER THE ACCIDENT BENEFIT, COMPREHENSIVE MAJOR MEDICAL BENEFIT OR LAB CARD PROGRAM AS DETAILED HEREIN.

LABORATORY SERVICES

Lab Card is a program administered by LabOne, Inc. which provides full coverage for necessary laboratory tests performed on an outpatient basis. When LabOne performs the testing of specimens, the Plan will pay 100% of the charge from LabOne. In addition, the bill from LabOne is sent directly to the Fund Office without your having to complete and file a claim form and possibly pay the cost of the test in advance, if so required by the provider.

Your Lab Card covers routine outpatient laboratory testing, such as pap smears, throat cultures, and blood and urine testing. This program does not cover charges for lab work performed by another laboratory, ordered during a hospital confinement or needed on an emergency (STAT) basis.

You should have received a packet of information describing this program more fully from the Fund Office. Please feel free to contact that office for additional supplies or if you have any questions about this program. Also you can call LabOne at 1-800-646-7788 toll-free to ask questions you may have.

OTHER LABORATORY SERVICES

The Plan will pay 100% of covered discount charges incurred at a laboratory facility in the Anthem Blue Cross Blue Shield (BCBS) network, including a hospital, for **outpatient laboratory** testing. All BCBS network laboratory testing, except for that performed while you or your dependent is confined in a hospital, will be covered at 100% without application of the calendar year deductible.

The laboratory charges incurred while confined in a BCBS network hospital will continue to be covered at 80%, subject to the calendar year deductible.

All laboratory charges incurred for laboratory services at a non-network facility, whether inpatient or outpatient, will continue to be covered at 60%, after satisfaction of the calendar year deductible.

Contact the Fund Office to locate a network laboratory site or access the Anthem BCBS website at www.anthem.com.

VISION BENEFIT

ACTIVES, RETIREES AND DEPENDENT ONLY CLASSES

This program is administered by National Vision Administrators (NVA).

Under this plan you may use any vision provider to obtain coverage for you and your eligible dependents. However by using a participating NVA provider your benefits are greatly improved. NVA has negotiated discounts with vision providers throughout your area and the entire U.S. NVA providers have agreed to accept discounted fees for exam services and offer lenses and frames at significant discounts.

Each eligible participant and their covered dependents are entitled to one vision examination each calendar year.

The benefit entitles you to a paid in full exam.

For NON-PANEL providers, you will be required to pay the provider retail charges at the time of service and NVA will reimburse you up to $30 for the cost of an exam.

Lenses, frames, contact lenses, photochromatic lenses, tinted lenses, progressive lenses, coatings. scratch resistant lenses, and polycarbonate lenses are not covered under the plan, but are discounted at NVA providers.

EXCLUSIONS

Vision Benefits are Subject to General Limitations. In addition, expenses due to any of the following are not covered:

1. Medical or surgical treatments, including LASIK, LASEK, or similar surgery.
2. drugs or medications,
3. non-prescription lenses,
4. examinations or materials not listed as a covered service,
5. replacement of lost, stolen or broken glasses,
6. services of materials provided by federal, state, local government or worker's compensation,
7. procedures, training or materials not listed,
8. safety lenses and safety frames, and
9. parts or repair of frame/sunglasses.

DENTAL BENEFIT

PARTICIPANTS ARE ENCOURAGED TO OBTAIN REGULAR PREVENTIVE DENTAL CARE. THIS PLAN PAYS 100% OF THE REASONABLE AND CUSTOMARY CHARGES FOR ROUTINE PREVENTIVE CARE WITH NO DEDUCTIBLE.

If, while covered, you or any of your dependents incur Covered Dental Expenses (defined below), you will be paid a benefit in the amount determined by the Schedule of Dental Benefits on the following page.

SCHEDULE OF DENTAL BENEFITS

Deductible Per Calendar Year
- Preventive Expenses .... None
- Other Covered Expenses
  - Per Individual...$75
  - Per Family $225

Payment Factors
- Preventive Expenses 100%
- Other Covered Expenses.. 75%

Calendar Year Maximum
- Per Individual $750

**The Calendar Year Maximum does not apply to pediatric oral services.

COVERED DENTAL EXPENSE

Covered Dental Expenses are charges incurred for necessary dental treatment as listed below:

1. Preventive Expenses
   a. Periodic oral examination (limited to two in a calendar year);
   b. Intra-oral x-rays–complete series (limited to one series in a consecutive three calendar year period);
   c. Bitewing x-rays(limited to one set in a calendar year);
   d. Prophylaxis, with or without oral examination, (limited to two in a calendar year);
   e. Periodontal prophylaxis;
   f. Topical application of stannous fluoride for individuals less than age nineteen (limited to once in a calendar year) and
   g. Sealants for dependent children (limited to one series in a consecutive three calendar year period).
2. Other Covered Expenses
   a. Space maintainers, fixed, unilateral
   b. Amalgam fillings
   c. Silicate cement
   d. Simple extractions
   e. General anesthesia and IV sedation when necessary and in

connection with oral surgery

f. Acrylic or plastic fillings
g. Composite acrylic resin filling
h. Root canal therapy-including treatment plan and follow-up care
i. Apicoectomy
j. Gingivectomy or gingivoplasty
k. Osseous surgery
l. Periodontal scaling
m. Repairs and adjustments of dentures (not covered if performed within six (6) months of installation of dentures)
n. Replace broken tooth on complete or partial denture, not in conjunction with other repairs
o. Recement Bridge
p. Surgical extractions-impacted
q. Crown restorations
r. Gold inlay fillings
s. Bridge pontics and abutment crowns
t. Partial or complete dentures
u. Dental implants.

DEDUCTIBLE AMOUNTS

1. Per Covered Individual
   The Individual Deductible amount of $75 is the amount of Covered Dental Expenses which must be incurred by a covered individual within a calendar year before a benefit is payable for subsequent expenses incurred in that year. (Does not apply to Preventive Expenses.)
2. Per Family
   If three (3) or more members of a family (you and your dependents) incur Covered Dental Expenses in a calendar year and if the portion of such expenses applied toward individual deductible amount requirements equal the Family Deductible amount of $225, all of your family members shall be deemed to have met the Individual Deductible amount with respect to Covered Dental Expenses incurred in that calendar year.

LIMITATIONS

Dental Care Benefits are subject to the General Limitations. In addition, no benefits will be provided for:

1. Charges made which are in excess of Usual and Customary charges or for charges for unnecessary treatment.

2. Charges made for prosthetic devices started prior to your effective date of coverage.
3. Services not recommended and approved by a legally qualified dentist or physician.
4. Unless otherwise specifically indicated in this SPD, surgical implants of any type.
5. Services and supplies which are cosmetic in nature.
6. Replacement of an existing prothesis (fixed bridgework, removable partial or complete dentures) which has been mislaid, lost or stolen.
7. Replacement of existing prosthodontic appliance unless the existing appliance is at least five (5) years old and cannot be made serviceable.
8. Services and supplies for full mouth reconstruction, orthognathic surgery or for correction of temporal mandibular joint dysfunction (TMJ).
9. Orthodontic treatment.
10. Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a dentist.
11. Any duplicate prosthetic device or any other duplicate appliance.
12. Oral hygiene and dietary instruction.
13. A plaque control program.
14. Dental care or services paid for or furnished by at the direction of any governmental agency, but only to the extent paid for or furnished.
15. Dental procedures which are included as covered medical expenses under the Comprehensive Benefit.
16. Temporary services.
17. Infection control/sterilization procedures.
18. Veneers.

SUMMARY PLAN DESCRIPTION

Prepared by Trustees of the
4th District IBEW Health Fund

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each participant (or eligible participant) in an employee benefit plan. This is your Summary Plan Description. Contributions to this Plan are made by the Participating Employers and under certain circumstances by the participant only. Contributions are based on negotiated contribution rates as set forth in the Collective Bargaining Agreement.

PLAN IDENTIFICATION NUMBER

E.I.N. 31-6068797 P.N. 501

This Plan is provided through the Trustees of the:
4th DISTRICT IBEW HEALTH FUND
609 Third Avenue
Chesapeake, OH 45619

Agent for Service of Legal Process:
Trustees of the 4th District IBEW Health Fund
609 Third Avenue
Chesapeake, OH 45619

The Administrator for this Plan is
(as defined by Sec. 3(16) of the Act):
Trustees of the
4th DISTRICT IBEW HEALTH FUND
609 Third Avenue
Chesapeake, OH 45619
Phone 304/525-0331

The Plan Year for this Plan commences on October 1 and consists of an entire Plan Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies. Relevant provisions of the Collective Bargaining Agreements, the names of the parties and their expiration dates may be reviewed at the:

4th DISTRICT IBEW HEALTH FUND
Administrative Office
609 Third Avenue
Chesapeake, OH 45619

The Collective Bargaining Agreements are between the NECA and LOCAL UNIONS 32, 141, 306, 317, 466, 575, 596, 968, 972 and 1105 of the INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS (AFL-CIO), who are participants of the Health Fund.

4th DISTRICT IBEW HEALTH FUND

UNION TRUSTEES

Mr. Mark Douglas
I.B.E.W. Local 306
2650 So. Main St., Suite 200
Akron, OH 44319

John Clarke
I.B.E.W. Local 141
82 Burkham Ct.
Wheeling, WV 26003

William Hamilton
I.B.E.W. Local 1105
5805 Frazeysburg Rd.
Nashport, OH 43830

Dana Joe Samples
I.B.E.W. Local 466
800 Indiana Ave.
Charleston, WV 25302

EMPLOYER TRUSTEES

Richard Speelman
Speelman Electric, Inc.
358 Commerce Street
Tallmadge, OH 44278

Ted Brady
Progressive Electric
P.O. Box 3695
Charleston, WV 25336

Steven Allred
WV-OH Valley Chapter NECA
#1 Players Club Dr., Suite 401
Charleston, WV 25311

John Frantz
Sidney Electric Company
840 Vandemark Rd.
Sidney, OH 45365

RIGHTS AND PROTECTIONS UNDER ERISA

As a participant in the Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's Office and at other specified locations, such as work sites and union halls, all Plan Documents including insurance contracts, Collective Bargaining Agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's Annual Financial Report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
4. Continue health care for yourself, your spouse or dependents if there is a loss of coverage under the plan as a result of a quali-

fying event. You or your dependents may have to pay for such coverage. (Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.)

5. Reduction of elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under this Plan or exercising your rights under ERISA. If your claim for a benefit under this Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider you claim, all within certain time schedules.

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

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or

about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

LIST OF LOCAL UNIONS

LU. 32	Lima, Ohio
LU. 141	Wheeling, West Virginia
LU. 306	Akron, Ohio
LU. 317	Huntington, West Virginia
LU. 466	Charleston, West Virginia
LU. 575	Portsmouth, Ohio
LU. 596	Clarksburg, West Virginia
LU. 968	Parkersburg, West Virginia
LU. 972	Marietta, Ohio
LU. 1105	Newark, Ohio

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective on February 17, 2010.

This Notice applies to the health benefits provided under the following health plan (the "Plan"):

4th District IBEW Health Plan

The references to "we" and "us" throughout this Notice mean the Plan.

This Notice has been drafted to comply with the "HIPAA Privacy Rules", under federal law. Any terms that are not defined in this Notice have the meaning specified in the HIPAA Privacy Rules.

Please provide this Notice to your family.

How We Protect Your Privacy

We are required by law to protect the privacy of your protected health information and to provide you with this notice of our privacy practices. We will not disclose confidential information without your authorization unless it is necessary to provide your health benefits and administer the Plan, or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this Notice to protect your confidentiality.

We maintain confidential information and have procedures for accessing and storing confidential records. We restrict internal access to your confidential information to employees who need that information to provide your benefits. We train those individuals on policies and procedures designed to protect your privacy. Our Privacy Officer monitors how we follow those policies and procedures and educates our organization on this important topic.

How We May Use and Disclose Your Protected Health Information

We will not use your confidential information or disclose it to others without your written authorization, except for the following purposes. When required by law, we will restrict disclosures to the Limited Data Set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

Treatment. We may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your protected health information to a health care provider when the provider needs that information to provide treatment to you. We may also disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

Payment. We may use or disclose your protected health information to provide payment for the treatment you receive under the Plan. For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your protected health information to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to preauthorize services to you and review the

services provided to you. We may also use and disclose your protected health information to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your protected health information to adjudicate your claims. Also, we may disclose your protected health information to other health care providers or entities who need your protected health information to obtain or provide payment for your treatment.

Health Care Operations. We may use or disclose your protected health information for our health care operations. We may use or disclose your protected health information to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your protected health information to provide you with customer service activities or develop programs. We may also provide your protected health information to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your protected health information to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

Disclosures to the Plan Sponsor. The Board Trustees of the 4th District IBEW Health Plan is the Plan sponsor. We may disclose your protected health information to the Plan sponsor. The Plan sponsor is not permitted to use protected health information for any purpose other than the administration of the Plan. The Plan sponsor must certify, among other things, that it will only use and disclose your protected health information as permitted by the Plan, it will restrict access to your protected health information to those individuals whose job it is to administer the Plan and it will not use protected health information for any employment-related actions or decisions. The Plan may also disclose enrollment information to the Plan sponsor. The Plan may also disclose summary health information to the Plan sponsor for purposes of obtaining bids for health insurance or lending or modifying the Plan.

Disclosures to Business Associates. We contract with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use or disclose protected health information. We require the business associates to agree in writing to contract terms to safeguard your

information, consistent with federal law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management.

Disclosures to Family Members or Others. Unless you object, we may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

Other Uses and Disclosures. The law allows us to disclose protected health information without your prior authorization in the following circumstances:

Required by law. We may use and disclose your protected health information to comply with the law.

Public health activities. We will disclose protected health information when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse.

Reports about victims of abuse, neglect or domestic violence. We will disclose your protected health information in these reports only if we are required or authorized by law to do so, or if you otherwise agree.

To health oversight agencies. We will provide protected health information as requested to government agencies that have the authority to audit or investigate our operations.

Lawsuits and disputes. If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the protected health information requested.

Law enforcement. We may release protected health information if asked to do so by a law enforcement official in the following circumstances: (a) to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

(d) to investigate a death we believe may be due to criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).

Coroners, medical examiners and funeral directors. We may disclose protected health information to facilitate the duties of these individuals.

Organ procurement. We may disclose protected health information to facilitate organ donation and transplantation.

Medical research. We may disclose protected health information for medical research projects, subject to strict legal restrictions.

Serious threat to health or safety. We may disclose your protected health information to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.

Special government functions. We may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.

Workers' compensation or similar programs. We may disclose your protected health information when necessary to comply with worker's compensation laws.

Uses and Disclosures With Your Written Authorization

We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice, without your written authorization. For example, we will not (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations), (2) sell your confidential information (unless under strict legal restrictions), or (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions we already have taken.

Your Individual Rights

You have the following rights:

Right to inspect and copy your protected health information. Except for limited circumstances, you may review and copy your protected health information. Your request must be addressed to the Privacy Officer. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

If you request copies of your protected health information, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your protected health information, upon your request if you agree to the rules and cost (if any) in advance.

Right to correct or update your protected health information. If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. Your request must be made in writing and must be addressed to the Privacy Officer. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.

We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person who created the information is no longer available to make the amendment;

- Is not part of the protected health information we keep about you;

- Is not part of the protected health information that you would be allowed to see or copy; or

- Is determined by us to be accurate and complete.

If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your protected health information.

Right to obtain a list of the disclosures. You have the right to get a list of protected health information disclosures, which is also referred to as an accounting. You must make a written request to the Privacy Officer to obtain this information.

The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include other disclosures, including incidental disclosures, disclosures we have made for national security purposes, disclosures to law enforcement personnel or disclosures made before April 14, 2003. The list we provide will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period.

You may also request and receive an accounting of disclosures of electronic health records made for payment, treatment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1. 2009, or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Right to choose how we communicate with you. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

Right to request additional restrictions on health information. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket.

Questions and Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, put your complaint in writing and address it to the Privacy Officer listed below. The Plan will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

Future Changes to Our Practices and This Notice

We are required to follow the terms of the privacy notice currently in effect. However, we reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. We will send or provide a copy of the revised Notice. You may also obtain a copy of any revised Notice by contacting the Privacy Officer.

Contact Information

Kenneth Joos, Privacy Officer

4th District IBEW Health Fund

3150 US Route 60

Ona, WV 25545

304.525.0331

IMPORTANT NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under federal law, Group Health Plans that provide medical and surgical benefits in connection with mastectomy must provide benefits for certain reconstructive surgeries. This covers reconstruction of the breast to produce symmetrical appearance and prostheses and physical complications of all stages of mastectomy, including lymph edemas.

This coverage is subject to any of the plan's normal annual deductible and co-payment provisions.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Group Health Plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a Cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother of her newborn earlier than forty-eight (48) or ninety-six (96) hours, as applicable. In any case, plans and insurers may not require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours, as applicable.

HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

While the Health Reimbursement Arrangement (HRA) Plan is described in more detail below, and in substantially more detail in the Plan Document, the Plan allows the Fund to allocate a specified amount each month to an individual account designed to reimburse a participant's qualified, approved, out-of-pocket medical expenses.

Read this Summary Plan Description carefully so that you understand the provisions of our HRA Plan and the benefits you will receive. You should direct any questions you have to the HRA Plan Administrator. (See page 4.6) There is a Plan Document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan Document, the Plan Document will control.

HOW THE HRA WORKS

The purpose of the HRA Plan is to reimburse Eligible Participants of the 4th District IBEW Health Fund ("the Fund"), up to certain limits, for their own and their covered Spouses' and Dependents' Medical Care Expenses. You determine how you want to use the money in your HRA. You can use it as you incur eligible health care expenses or save up and use it for future eligible expenses. Reimbursements for Medical Care Expenses paid by the HRA Plan generally are excluded from taxable income.

The HRA Plan has an effective date of June 1, 2008. This HRA includes the assets of the previous HRA Plan established for the Flexible Choice participants on January 1, 2007.

You will be eligible to join the HRA Plan as of the date you become eligible for coverage under the Fund, but no earlier than the HRA Plan's effective date of June 1, 2008, except for Flexible Choice participants. If you are a Participant, you may also be reimbursed for eligible Medical Care Expenses incurred by your Spouse and Dependents. Dependents are limited to those as defined by the 4th District IBEW Health Fund.

Self-employed individuals such as sole proprietors, 2% shareholders of an S-Corp, partners in a limited or general partnership, or members of a limited liability company may not participate in the HRA Plan.

You will continue to remain eligible for participation in the HRA Plan until the first day of the month following the twelve consecutive month period during which your HRA account balance begins at $0 and remains at $0.

If you cease to be an Eligible Participant in the 4th District IBEW Health Fund (for example, if you die, retire or terminate employment), you will be offered COBRA continuation coverage. Regardless of whether or not you elect COBRA continuation coverage, your COBRA continuation coverage period (which varies based upon which qualifying event has occurred) will nonetheless run concurrently with your continued eligibility in the HRA Plan. You will continue to be reimbursed for any Medical Care Expenses incurred, up to your account balance in the HRA account, provided that you comply with the reimbursement request procedures required under the HRA Plan (see below for more information on the reimbursement request process). In addition, if a Retiree returns to covered employment, his or her HRA account will be credited for post-retirement contributions.

BENEFITS

Once you become a Participant, the HRA Plan will maintain an "HRA Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Contributions are automatically allocated to your HRA Account. Your account will be credited with a portion of the contributions to the Plan paid on your behalf. Contributions made on your behalf will not be credited to your HRA until they are received by the Fund. Therefore, there may be a lag between the time contributions are required on your behalf and when they are available for your use. Your HRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses. The amount available for reimbursement of Medical Care Expenses as of a given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date. To find out what your account balance is, call the HRA Plan Administrator or visit their website. After the end of the Calendar Year, the unused amount (if any) in your HRA Account will rollover and remain available to you. There is no cap on the amount of funds available for rollover in the HRA Account.

Your HRA Account is merely a recordkeeping account; it is funded through contributions from Employers and it does not bear interest. Qualifying expenses must first be reimbursed from any health insurance plan (as well as any available Health FSA accounts) before any Benefits are payable from this HRA Plan.

The HRA Plan allows you to be reimbursed for certain out-of-pocket medical, dental and vision expenses which are incurred by you and your dependents. The expenses which qualify are those permitted by Section 213(d) of the Internal Revenue Code. The HRA Plan also allows you to be reimbursed by the Fund for co-pays, deductibles and self-payments under the 4th District IBEW Health Fund which are incurred by you or your dependents. The maximum allowed reimbursement each year is the

amount available in your HRA Account. Your HRA account cannot go below a zero balance.

CLAIM FOR REIMBURSEMENT

You may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each calendar year. Expenses are considered "incurred" when the service is performed, not when it is paid for. Any amounts reimbursed to you under the HRA Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including any health flexible spending account.

The HRA Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your HRA Account. Under the following claim reimbursement procedure, claims must be submitted in writing. The HRA Plan Administrator may require that Participants submit claims on a form provided by the Administrator. The claim must set forth:

- The individual(s) on whose behalf the Medical Care Expenses were incurred;
- The nature and date of the Medical Care Expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred by you, your Spouse, or your Dependent during the time that you were a Participant under this HRA Plan and showing the amounts of such Medical Care Expenses, along with any additional documentation that the HRA Plan Administrator may request. Generally, a written claim for reimbursement will not be made unless and until the aggregate claims for reimbursement total at least $25.00, although there is an exception made for the final reimbursement claim for a Plan Year. Checks from the HRA Plan not presented for payment will be forfeited and revert to the HRA Plan after 12 months. In no event will forfeited amounts be paid in cash to any person.

DEBIT CARD

In addition to the reimbursement procedure described above, Participants and Eligible Retirees may opt to use their HRA Plan debit card to pay for qualified medical expenses. Each Participant and Eligible Retiree and, upon request, their eligible dependents, will be issued a debit card with which certain qualified medical expenses may be paid. The debit card may not be used for any other reason. Your debit card will be deactivated when there have been no contributions to the account for 12 months and the account balance is $0. Please refer to the materials issued with your card for instructions on its use and other limitations.

Note that, pursuant to the Patient Protection and Affordable Care Act, HRA debit cards may not be used to purchase over-the-counter medicines or drugs. HRA debit cards may still be used for medical expenses other than over-the-counter medicines or drugs.

ELIGIBLE EXPENSES

Only qualified Medical Care Expenses under Internal Revenue Code Section 213(d) are covered by the HRA Plan. A Medical Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible Medical Care Expenses are: (a) prescription medicines; b) over-the-counter drugs only if the medicine is prescribed (note: a "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state); c) insulin; d) over-the-counter items that are not considered a medicine or drug (such as bandages, splints, contact lens solutions, etc.); e) dental expenses; f) dermatology; g) physical therapy; and h) contact lenses or glasses used to correct vision impairment. The Fund or HRA Plan Administrator can provide you with more information about which expenses are eligible for reimbursement.

The following list sets forth expenses that are <u>not</u> reimbursable under the HRA Plan. The list is not exhaustive. If you have questions about whether a particular expense is allowable, please contact the HRA Plan Administrator.

The following expenses are not reimbursable:

- Dancing/swimming lessons (even if recommended for the general improvement of the individual's health)
- Diaper service
- Expenses for trip or vacation taken for a non-medical reasons (even if on a physician's advice)
- Funeral service
- Group medical insurance premiums from a spouse's employer
- Health club dues or membership fees
- Hot tub or Jacuzzi
- Meals and lodging away from home for medical treatment <u>not</u> received at a medical facility
- Nursing services for a healthy baby
- Psychoanalysis received as a part of training to be a psychoanalyst
- School expenses for problem children
- Custodial care
- Bottled water
- Cosmetics, toiletries, toothpaste, etc.

- Uniforms or special clothing, such as maternity clothing
- Transportation expenses of any sort, including transportation expenses to receive medical care
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician
- Household and domestic help (even though recommended by a qualified physician due to an Employee's, Spouse's, or Dependent's inability to perform physical housework)
- Long-term care services
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to, a congenital abnormality, a personal injury arising from an accident or trauma, or any procedure that is directed at improving the person's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

CLAIMS AND APPEALS

A claim is defined as any request for a HRA Plan benefit, made by a claimant or by a representative of a claimant that complies with the HRA Plan's reasonable procedure for making benefit claims. If your claim is denied, you have certain appeal rights and are entitled to a full and fair review of the denial by the Board of Trustees. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. Upon concluding the review, the Board of Trustees or appointed designee will issue a written decision reaffirming, modifying or setting aside the Plan's former action. The Trustees' written decision will conclude the appeal process under this Plan.

Please refer to the HRA Plan Document for a more detailed explanation of the Claims and Appeals procedure.

GENERAL INFORMATION ABOUT THE HRA PLAN

The HRA Plan Administrator keeps the records for the HRA Plan and is responsible for the administration of the HRA Plan, including the actual processing of claims. The Administrator will also answer any questions you may have about our HRA Plan. The HRA Plan Administrator has the exclusive right to interpret any appropriate HRA Plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the HRA Plan.

The name, address, business telephone number and website of the HRA Plan Administrator are:

American Benefit Corporation
3150 US Route 60
Ona, WV 25545
304-781-3912 or 888-466-9094
(Press “3” after the greeting.)

Claims may be faxed to 304-525-6005
Claims may be mailed to the address above “ATTN: 4th HRA Dept.”
Claims may be emailed to hra@abcwv.com

To review your HRA account on-line go to: www.mybenny.com.

You may contact a Customer Service representative at this number with any questions.

The HRA Plan is not insured. Benefits are paid from the general assets of the Fund.

While there are no up-front or set-up fees for participants in the HRA Plan, the Board of Trustees may, in their sole discretion, opt to institute an administrative fee to cover the costs of administration of the Plan. Such fees, if instituted, will be deducted from each participant’s HRA account, regardless of whether the participant has been drawing reimbursements from the account. In addition, forfeited Plan account balances will be used to pay for the Plan’s administrative expenses. At such time as the interest generated by the Participants’ HRA accounts exceeds the administrative costs of the program, the Board of Trustees reserves the right, in its sole discretion, to declare an annual interest or dividend payment to all Participant accounts. Such payments may only be used for qualifying medical expenses.

MISCELLANEOUS PROVISIONS

Although the Trustees expect to maintain the HRA Plan indefinitely, it has the right to terminate the HRA Plan at any time. The Trustees also reserve the right to amend the HRA Plan at any time and in any manner that it deems reasonable, in its sole discretion. The money in the HRA Accounts is not vested and may be forfeited at any time by a vote of the Board of Trustees.

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the HRA Plan generally are not taxable to you. However, the Fund cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

This HRA Plan will comply with all applicable federal laws, including but not limited to the FMLA, ERISA, HIPAA, USERRA, and COBRA.

If it is determined that you and/or your spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA Plan. If you do not refund the overpayment or erroneous payment, the HRA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment.

No benefit payable at any time under the HRA Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind, except as may be required by law.

The HRA Plan is not to be construed as giving you any rights against the HRA Plan except those expressly described in this document. The HRA Plan is not a contract of employment between you and the Employer.

You may not suspend your HRA Account. However, you are not required to use the account and may choose to allow the account balance to grow in order to have the maximum assets available for use in later years or after retirement, subject to the provisions of the Plan.

NOTES