4th District IBEW Health Fund

Greenbrier Health & Welfare Plan for Union Employees

2018 Open Enrollment Guide

GREENBRIER HEALTH & WELFARE PLAN FOR UNION EMPLOYEES

Starting July 1, 2018, your health and welfare coverage will be provided through the 4th District IBEW Health Fund ("the Fund") under the Greenbrier Health & Welfare Plan for Union Employees ("the Plan"). The Greenbrier Hotel Corporation contributes on your behalf for coverage under the Plan as explained in this Open Enrollment Guide.

Open Enrollment: May 21 – June 1, 2018. If you want the opportunity to elect your coverage level—Employee Only, Employee Plus One Dependent or Family coverage—you must enroll and make your coverage election by the June 1 deadline. Otherwise, you will default into Employee Only coverage under the Plan and be required to pay the applicable contribution as indicated on page 6. See page 6 for enrollment instructions. The coverage level you elect will become effective on July 1, 2018.

WHAT YOU MUST DO BY JUNE 1, 2018

1. **Review this Open Enrollment Guide.** While most of your coverage options and benefit levels will remain the same, there are some differences in how the Plan is administered and some new programs available to you.
2. **Attend an Open Enrollment Meeting.** Meetings will be held in the Executive Conference Room (close to HR) on the following dates and times:
   - May 24: 11:00 a.m., 1:00 p.m., 3:00 p.m.
   - May 25: 9:00 a.m., 11:00 a.m., 1:00 p.m.
   - May 31: 11:00 a.m., 1:00 p.m., 3:00 p.m.
   - June 1: 9:00 a.m., 11:00 a.m., 1:00 p.m.
3. **Decide if you want coverage.**
   - If you want coverage under the Plan and are enrolling dependents, you must provide proof of their eligibility. See page 5.
   - If you are waiving coverage, you must check the "Waive Coverage" box on the *2018 Enrollment Form* and attach proof of your other coverage (e.g., an ID card). See page 6.
4. **Submit your *2018 Enrollment Form* and required documentation.** Submit your *Form* and documents to the 4th District Health Fund Trust Office, 3150 U.S. Route 60, Ona, WV 25545.
   IMPORTANT: If your signed 2018 Enrollment Form and required documentation, as applicable, are not submitted by June 1, you will default into Employee Only coverage effective July 1, 2018.

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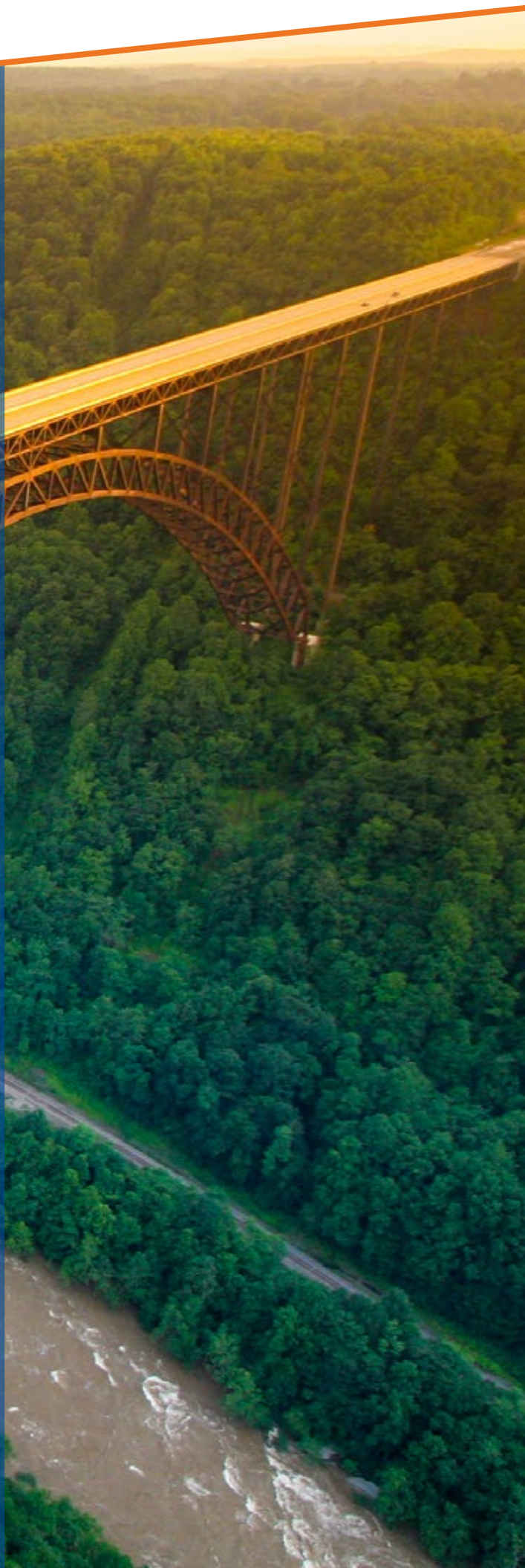
The Fund Office is here to answer your questions about benefits, claims, eligibility, enrollment and more! Contact the Fund Office at:

4th District IBEW Health Fund
3150 U.S. Route 60
Ona, WV 25545
1-888-466-9094 or 1-304-525-0331
www.4thdistricthealthfund.com
jeagle@abchldg.com





WHO'S ELIGIBLE

You and your dependents must meet the Plan's eligibility requirements to be eligible for benefit coverage.

As a Greenbrier Hotel Corporation employee subject to a Participation Agreement, you become eligible for coverage based on the number of hours you work and payment of required contributions by your employer to the Fund on your behalf. You will also be required to pay a premium based on the coverage level you elect—Employee Only, Employee Plus One Dependent or Family coverage (see page 6).

Contributions from the Greenbrier Hotel Corporation are due on the 15th day of the Payroll Month—the month the Fund must receive these amounts—for you to be covered during the following Benefit Month. Greenbrier Hotel Corporation will automatically deduct the required employee premium from your paycheck.

In addition, you must have worked the required number of hours in the previous Calendar Year, see below.

- **May 21 – June 1, 2018:** Open Enrollment for eligible employees to enroll in the Plan. You must have worked at least 1,200 hours in 2017 to be eligible for benefits in 2018.
- **June 15 (Payroll Month):** Greenbrier Hotel Corporation makes the required monthly payment to the Fund for all employees who elected to enroll in coverage during Open Enrollment. This payment includes employer contributions and employee premiums.
- **July 1 (Benefit Month):** Coverage starts for Greenbrier Hotel Corporation employees July 1, 2018.

Note: The first benefit period of coverage with the Fund is ten (10) months. Beginning April 1, 2019, the Fund will offer an Open Enrollment period each year to allow eligible employees the option to change their coverage election (Employee Only, Employee Plus One Dependent or Family coverage). Open Enrollment will last through the month of April and elections made during this time will be effective June 1. **To be eligible for benefits in 2019, you must be a Regular Employee and work 1,350 hours in 2018.**

Dependent Eligibility

If you are eligible and enroll for coverage, the following dependents are also eligible:

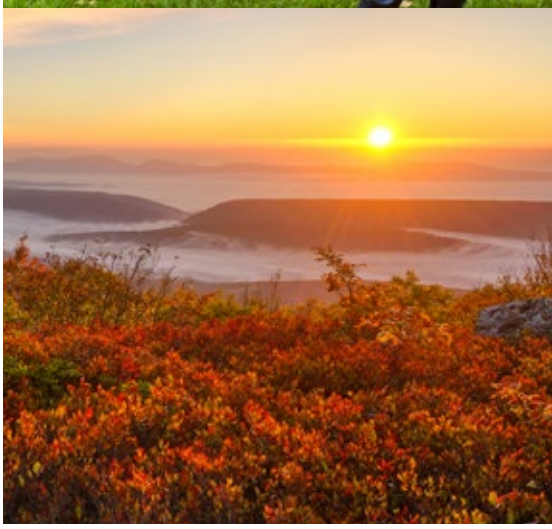
- Your legal spouse, provided you are not legally separated or divorced. This means your current legal spouse as recognized by federal law and the state in which you reside.
- Your children (biological, legally adopted, children placed for adoption and stepchildren) until the date they reach age 26.
- Children covered pursuant to a Qualified Medical Child Support Order (QMCSO).
- Children for whom you have legal guardianship.
- Your disabled children age 26 and older, provided they are disabled under the terms of the Plan and are dependent on you for principal support and unable to earn their own living due to their disability.

Grandchildren, nieces, nephews, siblings, etc., are not eligible for coverage unless you have initiated the adoption process.

Required Documents

When you enroll your dependents for coverage, you are required to submit documentation that confirms their relationship to you (as shown in the table below). The applicable documentation must be attached to your *2018 Enrollment Form*, see page 17. If the required documentation is not provided, benefit claims for your dependents may not be paid.

The Fund regularly conducts a review to verify dependent eligibility for our medical plans. The objective is to confirm that all dependents currently covered under the Plan are eligible for benefits. By ensuring that our Plan only covers eligible participants and their eligible dependents, we can reduce unnecessary health care costs. Otherwise, as a self-insured plan, the Fund may be paying claims for dependents who are not eligible for coverage.



Eligible Dependents	Required Proof of Eligibility
Your spouse (this means your current legal spouse as recognized by federal law and the state in which you reside)	Marriage Certificate
Your children (biological, legally adopted, children placed for adoption and stepchildren until the date they reach age 26)	**Biological child:** Birth Certificate listing the participant as the parent **Adopted child:** Certificate of adoption, petition to adopt (court documents) signed by a judge, ***and*** Birth Certificate **Stepchild:** Marriage Certificate (indicating stepchild's biological parent is married to participant), ***and*** Birth Certificate of stepchild listing spouse as parent **Child up to age 26 under legal guardianship or a QMCSO:** Court Order signed by a judge verifying legal custody of the child ***or*** Medical Support Order issued by a state agency
Your disabled children age 26 and older (provided they are disabled under the terms of the Plan and are dependent on you for principal support and unable to earn their own living due to their disability)	You must submit the required document(s) for one of the dependent categories above as proof that the dependent is your child or the child of your spouse

OPEN ENROLLMENT

Open Enrollment begins May 21, 2018 and goes through June 1, 2018. This is your opportunity to review the benefits and programs available to you and make the decision to enroll or waive Fund coverage. The election you make is for coverage effective July 1, 2018.

If you decided to enroll in the Fund's benefits, you have the following coverage options:

- Employee Only,
- Employee Plus One Dependent, or
- Family.

New employees hired after July 1, 2018. New employees have 30 days from their date of eligibility for coverage to enroll or waive Fund coverage. Otherwise, they will be enrolled automatically for benefits with Employee Only coverage.

If you do not make an election or waive coverage by June 1, 2018, you will be enrolled automatically in Employee Only coverage. Your next opportunity to enroll in benefits or change your coverage level will be April 2019 or if you have a qualifying event, as described on page 7.

Paying for Fund Coverage

You and your employer contribute toward the cost of benefit coverage. The monthly premium is based on the number of dependents you cover, as shown below. The employee premium (the amount you are required to pay) will be the same for the 2018 and 2019 Plan Years. Your required premiums are equally split and deducted from the first two pay periods each month.

Monthly Contributions and Premiums			
Coverage Level	Employer Contribution in 2018	What You'll Pay in 2018 & 2019 (Employee Premiums)	Total Cost in 2018
Employee Only	$520	$118	$638
Employee Plus One Dependent	$1,026	$188	$1,214
Family	$1,237	$267	$1,504

Waiving Coverage

If you have access to medical coverage elsewhere—for example, through your spouse's employer plan—you may waive medical coverage under the Fund. You must still submit a *2018 Enrollment Form* with the "Waive Coverage" option selected and a copy of your proof of other coverage attached to the *2018 Enrollment Form*.

Please note that if you do waive coverage through the Fund and want to enroll later, you will have to wait until the next Open Enrollment period (April 2019 for coverage effective June 1, 2019) or until you have a qualifying event, as described on page 7. If you experience a qualifying event, you'll be required to provide written proof of the qualified status change.

Health Reimbursement Arrangement (HRA) Permanent Opt Out Provision

You may opt out of participating in the HRA. If you do, however, you will not be able to re-enroll for the duration of time you are eligible for coverage. If you elect this permanent opt out provision, any money in your HRA is forfeited, and reverts to the general assets of the Plan. Learn more about the HRA on page 10.

Making Mid-Year Changes

Due to Plan guidelines and IRS requirements, once you make your benefit elections, you may not change them during the Plan Year unless you experience a qualifying event, which includes (but is not limited to) the following:

- Your legal marital status changes (e.g., through marriage, divorce, legal separation or annulment; or the death of a spouse)
- Your number of dependents change (e.g., through the birth or adoption of a child; change in dependent status; or your spouse losing coverage under his or her own plan).

If you experience a qualifying event, you generally have within 30 days or 60 days (as applicable) from the event to change your coverage election. The change in your election must be due to and consistent with the qualifying event. For example, if you adopt a child you can change from "Employee Only" coverage to "Employee Plus One Dependent" but you can't drop coverage altogether.

If you believe you have experienced a qualifying event, contact the Fund Office.

YOUR MEDICAL COVERAGE

If you elect coverage during the Open Enrollment period, you and your covered dependents will be eligible for comprehensive medical coverage. This coverage provides financial protection when you need it most, and includes a Health Reimbursement Arrangement (HRA).

When you need care, you have a choice to go to an in-network or out-of-network provider. However, when you receive care from an in-network provider—a provider who participates in the Anthem Blue Cross and Blue Shield Preferred Provider Organization (PPO) network—you'll receive a higher level of benefits. For information on finding an in-network provider, see page 9.

Using in-network PPO providers can save you money. In-network providers are doctors, hospitals, clinics, and other health care facilities who are part of the Anthem Blue Cross and Blue Shield Preferred Provider Organization (PPO) network. These providers and facilities have agreed to charge negotiated, lower fees for covered services and meet certain criteria and standards to ensure you receive quality care.

As shown in the Medical Plan overview table below, the Greenbrier Care facility is also a convenient and cost-saving option for certain types of care.

Greenbrier Medical Plan Overview

	Greenbrier Care	In-Network	Out-of-Network
Calendar Year Deductible*			
Employee Only	Not applicable	$650	$650
Employee Plus One Dependent and Family		$1,500	$1,500
Calendar Year Out-of-Pocket Maximum (includes deductible)			
Employee Only	Not applicable	$1,800	No limit
Employee Plus One Dependent and Family		$5,400	
Prescription Drug Out-of-Pocket Maximum			
Employee Only	$1,800	$1,800	$1,800
Employee Plus One Dependent and Family	$5,400	$5,400	$5,400
Combined Out-of-Pocket Maximum			
Employee Only	Not applicable	$3,600	No limit
Employee Plus One Dependent and Family		$10,800	
Note: Your in-network and out-of-network eligible expenses cross apply and accumulate toward your in-network deductible and out-of-pocket maximum. In addition, for Plan Year effective July 1, 2018, you may submit Explanations of Benefits (EOBs) for services received January 1, 2018 – June 30, 2018, to have these expenses credited toward your out-of-pocket maximum.			
Coinsurance	Plan pays 100%	You pay 20%	You pay 40%
Adult and Child Well Care	Plan pays 100% Note: Well-baby care is not available.	Plan pays 100%, no deductible	You pay 40%
Office Visits	$10 copay	$40 copay	You pay 40%
Outpatient Diagnostic Testing	Plan pays 100%	You pay 20%	You pay 40%
Emergency Room		You pay $100 copay, then 20%	
Chiropractic Care (up to $500 per Calendar Year, per person)	Not applicable	You pay 20%	You pay 40%
Organ Transplants ($10,000 allowance for transportation and lodging)	Not applicable	**Blue Distinction Provider:** Plan pays 100%, no deductible **Other provider:** You pay 20%	You pay 40%
Outpatient mental health/substance abuse treatment	Not applicable	You pay 20%	You pay 40%
Inpatient mental health/substance abuse treatment	Not applicable	**If pre-certified:** Covered same as any other illness **If not pre-certified:** A $250 per confinement penalty will apply	
Member Assistance Program (MAP)	Visits 1-5: Plan pays 100%, no deductible Visits 6 and up: The Plan pays the same level of benefit as outpatient mental health/substance abuse services		

*Each covered individual must meet the Employee Only deductible requirement before the Plan pays benefits. If three or more of your covered family members meet the Employee Only deductible requirement in a Plan Year, you satisfy the Family deductible requirement for all covered family members.

Finding In-Network Anthem PPO Providers

To find an in-network provider who participates in the Anthem Blue Cross and Blue Shield Preferred Provider Organization (PPO) network, call 800-810-2583 or go online to **www.anthem.com** and follow these steps:

- Click on the Menu button and select "Find a Doctor" from the "Care" section.
- If you are a registered member, log in. You'll then see a list of in-network providers who participate in the PPO network and are located near you.
- If you are not registered, search by your state and network—select the National PPO (BlueCard PPO). Or, simply confirm with the provider if he or she participates in the National PPO (BlueCard PPO) Network.

How the Deductible and Out-of-Pocket Maximum Work

When you or a covered dependent has a medical expense, you will generally share the cost of covered services with the Plan through a deductible, fixed dollar copay or a coinsurance percentage. However, once you reach the out-of-pocket maximum, the Plan pays 100% for eligible expenses. The amount of the fixed copay or percent of coinsurance is based on the type of service you receive and where you receive it. See the overview chart on page 8 for specific benefit levels.

When you visit the Greenbrier Care facility	When you visit an in-network PPO provider or out-of-network provider
• The annual deductible does not apply to services received at the Greenbrier Care facility • Office visits are $10 copay • Adult preventive care and outpatient diagnostics are covered 100% • The out-of-pocket maximum does not apply	• You pay 100% of expenses until you reach the deductible. Note: In-network preventive care is covered 100% by the Fund before you meet the deductible – In- and out-of-network eligible expenses cross apply and accumulate toward your in-network deductible • After you meet your deductible, you'll pay coinsurance or a fixed copay until you meet the out-of-pocket maximum – There are separate out-of-pocket maximums for medical and prescription drugs – The two maximums do not cross apply—you have to meet them separately – In- and out-of-network eligible expenses cross apply and accumulate toward the applicable out-of-pocket maximum • Once you meet the medical or prescription drug out-of-pocket maximum, applicable eligible expenses are covered 100% for the rest of the Calendar Year

Precertification

Precertification is a review process where physicians, nurses, and/or pharmacists determine whether a procedure, treatment, or service is a covered benefit. It is only necessary for in-network and out-of-network care, not care received at the Greenbrier Care facility. Precertification is not a guarantee of coverage; no benefits will be provided for a confinement or service that is not medically necessary or not otherwise covered under the Plan. The following types of care require precertification:

- Inpatient hospitalization
- Skilled nursing
- Surgical procedures
- Inpatient hospitalization for mental health and/or substance abuse treatment.

Contact the Fund Office for additional information and precertification procedures.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

As an eligible employee, you have access to an HRA to reimburse yourself for *qualified expenses not covered by Plan benefits*—for example, amounts you pay before the deductible is met. The Greenbrier Hotel Corporation contributes toward an HRA on your behalf. This contribution is part of the negotiated employer hourly contribution to the Plan.

You can use your HRA to reimburse qualified expenses as you have them or you can let the contributions accumulate year-over-year for future health care needs. When you use the money in your HRA to reimburse qualified expenses, you don't pay taxes on the amount.

Using Your HRA

You can use your HRA to reimburse certain out-of-pocket qualified expenses incurred by you and your eligible dependents. A qualified expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease—for example, prescription drug copays or vision care expenses that exceed the benefit coverage level. A complete list of eligible expenses can be found under Section 213(d) of the Internal Revenue Code at **www.irs.gov**.

What you need to know about using your HRA:

- You must submit eligible expenses to a secondary medical plan or a health Flexible Spending Account (FSA) before you can submit them for reimbursement through your HRA.
- You cannot claim a deduction on your tax return for expenses reimbursed through your HRA.
- You can only reimburse yourself up to the amount in your HRA.
- Unused funds in your HRA at the end of the year roll over to the following year, as long as you remain eligible for coverage.
- There is no maximum on the HRA balance.
- You have the convenience of using the Your Benny Card™ (similar to a debit card) for eligible purchases (see *Reimbursement with Your Benny Card*); otherwise, you must submit a claim for reimbursement to the Fund Office.
- If you receive an overpayment, you are required to refund the overpayment or mistaken reimbursement to your HRA. The Fund reserves the right to offset your future reimbursements equal to the over-paid or erroneous reimbursed amount.

You can't take it with you. Although any unused balance in your HRA accumulates year-over-year, if you retire or leave the Greenbrier Hotel Corporation, any money remaining in your HRA is forfeited.

Track Your HRA Balance. To track and manage your HRA balance, call the Fund Office or visit www.mybenny.com.

Reimbursement with Your Benny Card

You can use the Your Benny Card to conveniently pay for qualified expenses. Similar to how a debit card works, Your Benny Card is linked to your HRA. When you pay for an eligible expense with the Your Benny Card, there's no need to file a paper claim form.

You may only use your HRA Your Benny Card to pay for qualified expenses at the time you receive the service. You can request additional cards for your eligible dependents. Note: Due to the Patient Protection and Affordable Care Act, you cannot use the Your Benny Card to purchase over-the-counter medicines or drugs.

Keep Your Receipts! You must be able to provide proper documentation—typically, a letter of medical necessity, store receipt, or a doctor's prescription—to show you used your HRA for a qualified expense.

YOUR PRESCRIPTION DRUG COVERAGE

Sav-Rx, the Pharmacy Benefit Manager, works with the Fund to administer prescription drug benefits and to help you save money and ensure you are receiving the right prescription for your condition or illness.

The Plan pays benefits for covered prescription drug services when you fill your prescription at a retail pharmacy that participates in the Sav-Rx network or through the Sav-Rx Mail Order Program. No benefits are paid for out-of-network pharmacies.

Prescription Drug Coverage	Sav-Rx Retail Pharmacy (what you pay for up to 34-day supply)	Sav-Rx Mail Order (what you pay for up to 90-day supply)
Deductible	None	None
Generic Drug	$10	$15
Preferred Brand Name Drug	$15	$35
Non-Preferred Brand Name Drug	$50	$80
Out-of-Pocket Maximum	Employee Only: $1,800 Employee Plus One Dependent and Family: $5,400	Employee Only: $1,800 Employee Plus One Dependent and Family: $5,400

As shown above, you'll pay copays for prescription drugs until you reach the separate, annual prescription drug out-of-pocket maximum. Then, the Plan pays 100% of your eligible expenses for the remainder of the Calendar Year. Please note: The prescription drug out-of-pocket maximum is separate from the medical out-of-pocket maximum.

To find a Sav-Rx participating pharmacy, go to www.savrx.com and enter the group number "IBEWD4." Or, call Sav-Rx at 1-866-233-IBEW.

Sav-Rx Prescription Drug Programs	
Program	**Description**
Specialty Drug Program	• Specialty drugs (high-cost drugs used to treat serious and/or chronic conditions) must be filled through the Sav-Rx Specialty Pharmacy; otherwise the Plan does not pay benefits • Specialty drug copays are the same as non-specialty medications
Step Therapy Program	• If you take a prescription on a regular basis for an ongoing condition like arthritis, asthma, or high blood pressure, you must first try a more cost-effective drug before a brand name drug will be covered
Mandatory Generic Program	• Before you try a prescribed brand name drug, you'll try a generic equivalent • If you fill a prescription for a brand name drug without trying the generic equivalent, you'll pay the brand name drug copay PLUS the difference in cost between the generic and brand name drugs • If a brand name medication is medically necessary, your prescribing physician must submit a written letter of medical necessity on your behalf so that you only have to pay the brand name copay and not the cost difference
High Impact Advocacy Program	• Selected specialty medications will be filled at the Sav-Rx Specialty Pharmacy • Sav-Rx will facilitate your enrollment into a manufacturer sponsored coupon program
Therapeutic Quantity Limits Program	• Particular classes of medications will have therapeutic limits to ensure the proper utilization based upon FDA-approved, manufacturer labeling

If you have questions on any of these programs, contact Sav-Rx at 1-866-233-IBEW.

YOUR DENTAL COVERAGE

You and your covered family members have dental coverage for diagnostic and preventive services, restorative services and major services. Plus, your dependent children, up to age 19, have orthodontia coverage, subject to a lifetime maximum.

Delta Dental of Ohio, the administrator of the Plan's dental coverage, provides a national network of dentists and specialists who agree to provide services at a lower negotiated rate. While you may visit any dentist you wish, when you receive care from a dentist who participates in the Delta Dental Network, you'll save on your out-of-pocket costs. This is because even though the Plan pays the same percentage of covered services for both in-network and out-of-network care, in-network providers agree to charge lower negotiated rates for covered services.

If you reach the Plan's Calendar Year maximum (**$1,500** per year of eligible expenses), the charges you incur for the remainder of the year are your responsibility. However, using an in-network provider can help keep your costs low even after the Calendar Year maximum is met.

Dental Benefits*	
Calendar Year Deductible	
Employee Only	$50
Employee Plus One Dependent and Family	$100
Calendar Year Maximum	$1,500 per person
Note: The Calendar Year maximum does not apply to pediatric oral services provided to your dependent children younger than age 19.	
Preventive Services	Plan pays 100%, no deductible
Basic Services	You pay 20%
Major Services	You pay 50%
Orthodontia (dependent children younger than age 19)	You pay 50% $1,000 lifetime maximum

*The percentage you and the Plan pay (coinsurance) is based on the reasonable and customary charge for the covered service. The Plan only pays benefits up to the reasonable and customary charge. In addition to your coinsurance and deductible requirement, you are responsible for any amount in excess of the reasonable and customary charge.

Finding In-Network Delta Dental Providers

To find a dentist in the **Delta Dental PPO** or **Delta Dental Premier Network** log in at **www.deltadentaloh.com**, then:

- Click the "Find a Dentist" link in the upper right corner or the green "Find a Dentist" button in the bottom left corner of the page.
- Click the "Delta Dental PPO and Delta Dental Premier" link.
- Select the "Delta Dental PPO" or "Delta Dental Premier" from the drop-down—you have access to both networks—and enter your zip code.
- Click "Search for a Dentist" to view your results. You can filter your search results by distance, dental specialty, languages spoken, gender, or extended hours. You may also search for a dentist by name.

You may also call Delta Dental's Customer Service department at 800-524-0149 to obtain a customized list of participating dentists. Representatives are available 24 hours a day, seven days a week.

Is your dentist in-network? If your current dentist is not in-network, but is interested in learning how to join Delta's network, you can recommend your dentist for membership. Just go to www.deltadentaloh.com, click "Refer Your Dentist" under "Find a Dentist," and fill out the online form.

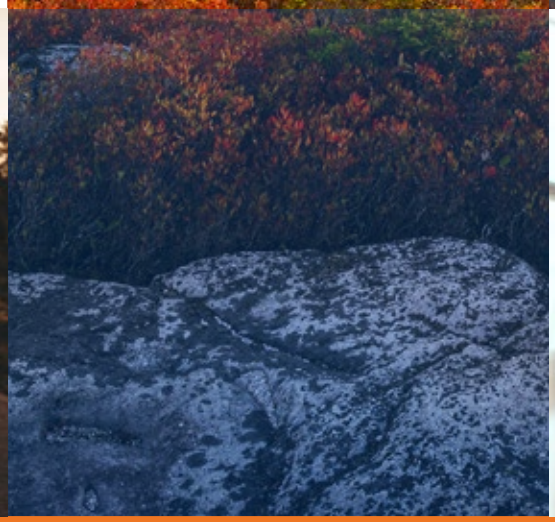
YOUR VISION COVERAGE

The Plan provides you and your covered dependents vision coverage through an arrangement with Vision Service Plan (VSP). You receive discounted services and a higher level of coverage when you use a VSP provider.

	VSP Provider	Non-VSP Provider
WellVision Exam (once every 12 months)	Plan pays 100%, up to $47	Plan pays 100%, up to $47
Lenses and Frames (once every 12 months)	Plan pays 100%, up to $150	Not covered
Contacts (once every 12 months)	Plan pays 100%, up to $150	Not covered

Finding a VSP provider. To locate a participating VSP provider, visit vsp.com or call 800-877-7195. You can receive a 15% discount on laser vision correction services through a participating VSP provider or a 5% discount on the promotional price of such services.

If you are not eligible for coverage at the time you receive vision care services, or in the event the service you receive is not a covered service under the Plan, contact the Fund Office.





YOUR LIFE AND DISABILITY INSURANCE COVERAGE

Weekly Disability Benefits

If you become "totally disabled" due to a non-occupational sickness or injury, you will receive a weekly disability benefit equal to $250, for up to 26 weeks (less mandatory Social Security or disability pension withholding, if applicable).

If you are determined to be eligible for a weekly disability benefit, your benefit begins on the:

- First day of your disability due to the accident; or
- Eighth day of your disability due to sickness.

For more information about weekly disability benefits, including a definition for "totally disabled," contact the Fund Office. Note: This benefit is subject to income tax.

Life and Accidental Death and Dismemberment Insurance

The Plan provides life and accidental death and dismemberment (AD&D) insurance coverage through Metropolitan Life Insurance Company (MetLife). This coverage pays your beneficiary in the event of your death or pays you if you suffer a covered loss due to an accident.

Coverage	Benefit
Life Insurance Coverage	$40,000 to your designated beneficiary in the event of your death.
Accidental Death and Dismemberment (AD&D) Coverage	Up to $40,000 to your designated beneficiary in the event of an accident or death. Payment amount depends on your covered loss. If you die as a result of an accident, the Plan pays an AD&D benefit to your designated beneficiary. For all other covered losses, the Plan pays the AD&D benefit to you.

Accident Benefits

If you or your covered dependent suffers from an accidental injury and incurs expenses for treatment within three months of the accident, you will receive up to $300. The accident benefit is to help you offset the cost of care without having to meet the medical plan deductible and before your medical coverage begins paying benefits. Covered services include surgery, hospital confinement and physical therapy.

ADDITIONAL BENEFITS

Member Assistance Program (MAP)

The **Member Assistance Program (MAP)** is provided through ComPsych at no cost to you and your family members. It offers professional and confidential counseling services to help you handle personal and/or work concerns constructively, before they become major issues. The first five visits are covered 100% by the Plan with no deducible. If additional visits are needed for the same instance, the outpatient mental health benefit applies (see "Your Medical Coverage" on page 8).

MAP counselors provide confidential services and counseling for:

- Personal concerns and relationship issues
- Legal issues such as wills, debt obligations, divorce, or bankruptcy
- Mental health and substance abuse
- Debt, saving for college, estate planning, and taxes.

MAP counselors are available 24 hours a day, seven days a week. Call 877-627-4239 to speak with a counselor. Or, to learn more about the MAP, visit **www.guidanceresources.com** and enter in the Fund ID, "MAP_4_IBEW."

Care Assist and Transition Care Programs

Innovative Healthcare Delivery (IHD) provides a Transition Care Program and a Care Assist Program if you are scheduled for an outpatient procedure or have been admitted to the hospital. These programs help you navigate the health care system and stay healthy to avoid hospital readmission.

Program	Benefit
Transition Care Program	• If you are admitted to a hospital, IHD contacts you to help coordinate your post-discharge care • IHD Navigation Specialists understand the benefits offered to you through the Plan, and can help you balance your available benefits with the complexities of the health care system • They advocate on your behalf to ensure your pathway to recovery is free of any obstacles
Care Assist Program	• If you are scheduled for an outpatient procedure, IHD may call you to help with: – Filling prescriptions – Coordinating your medical records between providers – Scheduling check-ups and evaluations – Ordering durable medical equipment

LiveHealth Online

Through LiveHealth Online, administered by Anthem Blue Cross and Blue Shield, you can have a live "face-to-face" computer consultation with a doctor 24/7. Use LiveHealth Online when you have a minor medical issue that otherwise might require a visit to your primary care provider, an urgent care center, or an emergency room for a non-emergency issue. You may also use LiveHealth Online to see a pediatrician for your eligible minor children, as long as your child is registered to your account and you, as their parent or legal guardian, participate in the session.

- LiveHealth Online uses the same technology as video chat services, such as FaceTime and Skype, but it is delivered using secure, HIPAA-compliant technology, so your virtual office visits are completely confidential.
- For each visit, you pay 20% of covered expenses; the Plan pays 80%. The deductible does not apply, meaning the Plan pays benefits regardless of whether you have met your deductible.
- LiveHealth Online accepts Visa, MasterCard, and Discover cards as payment for an online doctor visit. You must make payment at the time of the service.

LiveHealth Online is NOT for emergencies. Only use LiveHealth Online for non-emergency medical situations. If you need care for an ongoing chronic condition or an annual or routine physical, schedule an in-person appointment with your provider. If your medical concern is an emergency, always call 911.

Register with LiveHealth Online before you need services. Sign up at www.livehealthonline.com and, if using a smartphone, download the app. You'll need the Subscriber ID number (including the three-letter prefix) that is printed on your medical plan ID card. We recommend that you register before you need care so the service is ready to go when you need it.

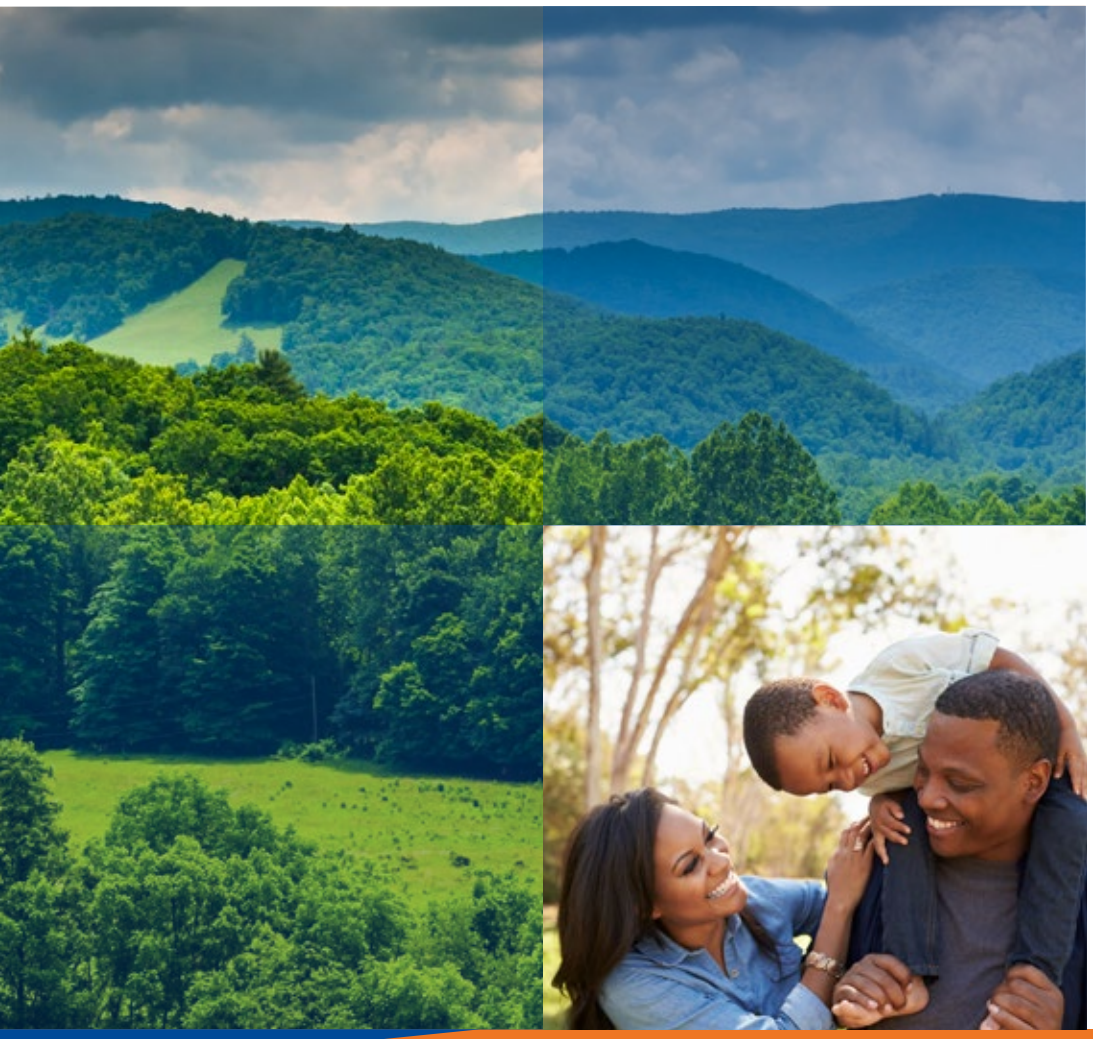
Quit For Life Program

You and your adult dependents can participate in the Quit For Life Program. This program is provided at no cost (other than the cost for prescribed drugs) and covers:

- Up to five coaching calls from a Quit Coach;
- Online support via the Quit Now website—**www.quitnow.net**; and
- One course of a pre-determined dosage of non-prescription nicotine replacement therapy (such as the patch, gum, or lozenges) upon recommendation of a Quit Coach.

The Quit For Life Program can help you set a clear path to quitting tobacco usage. Call 866-QUIT-4-LIFE (866-784-8454), or log on to **www.quitnow.net** for details or to enroll.

Note: The Plan covers prescription and over-the-counter smoking cessation products at 100%, with no copay, for up to two 90-day treatments per year.



Greenbrier Human Resources Department
300 W Main Street
White Sulphur Springs, WV 24986

2018 ENROLLMENT FORM

This form must be completed and returned to the Greenbrier Human Resources Department by **June 1, 2018**.

PARTICIPANT INFORMATION

Last Name	**First Name**	**MI**	
Date of Birth	**Social Security #***		☐ Male ☐ Female
Phone	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	**Local Union Name and Number**	
Mailing Address	**City**	**State**	**Zip**

DEPENDENT INFORMATION Provide the following information for each dependent you enroll. If you are enrolling in "employee only" coverage, you may skip this section.

Note: If you enroll your spouse and/or dependent child(ren), you will need to provide dependent eligibility verification documents. A list of required documents is available in your **Open Enrollment Guide** on page 5. **Please provide copies of required documentation with this completed Enrollment Form**. Eligibility for each person listed below is subject to all provisions and limitations of the participation agreement and plan document as well as to any rules or regulations adopted by the Board of Trustees.

Relationship Codes: SP - Spouse **CH** - Child **SC** - Stepchild **O** - Other (Specify on an additional page)

Code	Last Name	First Name	MI	Date of Birth	Social Security #*	Gender	Medicare Eligible?	Other Insurance Coverage?	Employer name (if employed)?
						☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	

*Federal regulations require health plans to report the names and Social Security numbers of every covered individual to the IRS. Coverage will not begin until Social Security numbers have been provided.

If you or any of your dependents are covered by another group health plan, provide the following information and attach a copy of your plan identification card. If you need to list more than one individual, please attach an additional page to this Enrollment Form.

Covered Person's Name	**Insurance Company or Plan Name**	
Type of Coverage ☐ Medical ☐ Dental ☐ Vision	**Group I.D. or HICN #**	**Effective Date of Coverage**

COVERAGE ELECTION (Select one)	
☐	**I wish to elect "Employee Only" coverage under the Greenbrier Health and Welfare Plan.** I have reviewed the Plan information and understand that the premium amount of $118 will be deducted automatically from my paycheck on a monthly basis.
☐	**I wish to elect "Employee Plus One Dependent" coverage under the Greenbrier Health and Welfare Plan.** I have reviewed the Plan information and understand that the premium amount of $188 will be deducted automatically from my paycheck on a monthly basis. I also understand that I am required to provide proof of dependent eligibility with this Enrollment Form.
☐	**I wish to elect "Family" coverage under the Greenbrier Health and Welfare Plan.** I have reviewed the Plan information and understand that the premium amount of $267 will be deducted automatically from my paycheck on a monthly basis. I also understand that I am required to provide proof of dependent eligibility with this Enrollment Form.
☐	**I wish to waive coverage for myself and my dependents.** I understand that by making this election I will NOT have coverage through the Fund. I have attached proof of my other insurance coverage to this Enrollment Form.

FRAUD NOTICE

I understand that the Health Fund is relying on my answers on this Enrollment Form. I represent, under penalty of perjury, that the answers given to all questions on this Enrollment Form are true and accurate. I understand that if I knowingly and with intent to defraud the Health Fund, provide false information or conceal information concerning any fact material thereto for the purpose of misleading, I may be subject to civil and criminal penalties. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this Enrollment Form.

I understand that federal and state laws require me to enroll any dependents who are receiving health insurance coverage through Medicaid. By signing below I assert that I have enrolled all eligible dependents in the Plan. I understand that, to the fullest extent allowed by law, I will be responsible for any penalties assessed on the Plan by Medicaid due to my failure to enroll a dependent receiving health insurance through Medicaid.

Authorization to Release Information and Authorization to Pay Benefits to Provider

I hereby authorize any physician or hospital to furnish and disclose all known facts concerning my claim. I will reimburse the Fund for any overpayment made to me or on my behalf due to errors on this Enrollment Form. I hereby authorize payment directly to the provider for services as described herein or in supplemental statements, not to exceed the reasonable and customary charges for those services. I understand that this authorization will remain in force until cancelled in writing by me.

Premium Authorization

I authorize Greenbrier Hotel Corporation Payroll/Human Resources Benefits Administration Division to withhold my premiums for this Plan from my pay on a pre-tax basis. By signing this Form, I am requesting that payroll deductions begin as of _____, and agree deductions will be taken in equal amounts from the first two pay periods each month.

Employee Signature _____ **Date** _____

4th District IBEW Health Fund
1-304-525-0331 or 1-888-466-9094
www.4thdistricthealthfund.com

OTHER INFORMATION YOU SHOULD KNOW

Non-Discrimination Notice

Important Disclosure

The 4th District IBEW Health Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The 4th District IBEW Health Fund does not exclude people or treat them differently due to race, color, national origin, age, disability or sex.

The 4th District IBEW Health Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact: American Benefits Corporation, 3150 U.S. Route 60, Ona, WV 25545; 304-781-3912 or 888-466-9094 (Press "3" after the greeting).

If you believe that the 4th District IBEW Health Fund has failed to provide these services or discriminated in any other way on the basis of race, color, national origin, disability or sex, you can file a grievance with: American Benefits Corporation, 3150 U.S. Route 60, Ona, WV 25545; 304-781-3912 or 888-466-9094 (Press "3" after the greeting).

You can file a grievance in person or by mail, fax or e-mail. If you need help filing a grievance, the Plan Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**.

Language Access Services and Non-Discrimination

Language assistance services, free of charge, are available to you. Call 304-781-3192 (TTY: 304-781-3192).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 304-781-3192.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 304-781-3192。

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 304-781-3192.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 304-781-3192.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر اتصل برقم 304-781-3192 لك بالمجان.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 304-781-3192.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 304-781-3192 번으로 전화해 주십시오.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。304-781-3192 まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 304-781-3192.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 304-781-3192.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 304-781-3192.

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 304-781-3192 ।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 304-781-3192.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 304-781-3192.

The Women's Health and Cancer Rights Act of 1998

Women's Health and Cancer Rights Act (WHCRA)

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 lymphedemas. This coverage is subject to the Plan's annual deductible and copayment 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 48 hours following a vaginal delivery, or less than 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 or her newborn earlier than 48 or 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 48 or 96 hours, as applicable.

HIPAA Special Enrollment Rights

If you, or any of your dependents, lose eligibility under another group health plan (or if an Employer stops contributing toward your or your dependent's other coverage), you may be eligible for a special enrollment period. However, you **must request enrollment within 30 days** after your or your dependent's other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your eligible dependent(s). However, you **must request enrollment within 60 days** after the marriage, birth, adoption, or placement for adoption. If you fail to timely enroll a newly eligible dependent or provide evidence of your dependent's eligibility, coverage begins on the first of the month following the day you sufficiently complete the enrollment (coverage is not retroactive to the date of birth, marriage, adoption, or placement for adoption). In addition, the Plan is not responsible for any bills or charges incurred prior to the coverage effective date.

Two additional circumstances allow for a special enrollment period:

- Your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent become eligible for a subsidy under Medicaid or CHIP.

In either of these circumstances, you must enroll yourself or your eligible dependent within 60 days after you or your dependent are terminated from, or determined to be eligible for, such assistance.

To request a special enrollment period or obtain more information, contact the Fund Office. You are responsible for advising the Fund Office of any changes in address, beneficiaries, or dependents.

You must request a special enrollment period within 30 or 60 days (as applicable) of losing your other coverage, your marriage, or of the birth, adoption, or placement for adoption of your dependent.

Confidentiality of Health Care Information

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 and share it with your family.

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.

How We Protect Your Privacy

We are required by law to protect the privacy of your Personal Health Information (PHI) 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 purposes listed below. 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 (PHI) to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your PHI to a health care provider when the provider needs that information to provide treatment to you. We may also disclose PHI 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 PHI to provide payment for the treatment you receive under the Plan. For example, we may use and disclose your PHI to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your PHI 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 PHI as necessary to preauthorize services to you and review the services provided to you. We may also use and disclose your PHI to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your PHI to adjudicate your claims. Also, we may disclose your PHI to other health care providers or entities who need your PHI to obtain or provide payment for your treatment.

Health care operations. We may use or disclose your PHI for our health care operations. We may use or disclose your PHI to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your PHI to provide you with customer service activities or develop programs. We may also provide your PHI to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your PHI 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 PHI to these entities if they have or have had a relationship with you and your PHI 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 Trustees are the Plan Sponsor. We may disclose your PHI to the Plan Sponsor. The Plan Sponsor is not permitted to use PHI 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 PHI as permitted by the Plan, it will restrict access to your PHI to those individuals whose job it is to administer the Plan and it will not use PHI 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 PHI. 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 PHI 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 PHI 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 PHI (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 PHI without your prior authorization in the following circumstances:

- Required by law. We may use and disclose your PHI to comply with the law
- Public health activities. We will disclose PHI 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 PHI 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 PHI 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 PHI 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 PHI requested
- Law enforcement. We may release PHI if asked to do so by a law enforcement official in the following circumstances:
  - To respond to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness or missing person;
  - To assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - To investigate a death we believe may be due to criminal conduct;
  - To investigate criminal conduct; and
  - 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 PHI to facilitate the duties of these individuals
- Organ procurement. We may disclose PHI to facilitate organ donation and transplantation
- Medical research. We may disclose PHI for medical research projects, subject to strict legal restrictions
- Serious threat to health or safety. We may disclose your PHI 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 PHI 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 PHI when necessary to comply with Workers' Compensation laws.

Uses and Disclosures with Your Written Authorization

We will not use or disclose your confidential information, without your written authorization, for any purpose other than the purposes described in this notice. For example, we will not:

- Supply confidential information to another company for its marketing purposes (unless it is for certain limited health care operations);
- Sell your confidential information (unless under strict legal restrictions); or
- 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.

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:

Ryan Jones, Privacy Officer
4th District IBEW Health Fund
3150 U.S. Route 60
Ona, WV 25545
304-525-0331

CONTACT INFORMATION

Contact...	For...	Phone Number	Website
Fund Office (American Benefit Corporation)	General benefits-related questions, including eligibility, dependent information and coverage options Weekly Disability Benefits & Accident Benefits Health Reimbursement Arrangement (HRA) Benefits Life Insurance & Accidental Death and Dismemberment (AD&D) Benefits	888-466-9094 or 304-525-0331	www.4thdistricthealthfund.com
Anthem Blue Cross and Blue Shield	Medical Benefits	800-810-2583	www.anthem.com
Sav-Rx	Prescription Drug Benefits	866-233-IBEW (4239)	www.savrx.com Group Number: IBEWD4
Delta Dental of Ohio	Dental Benefits	800-524-0149	www.deltadentaloh.com
VSP	Vision Benefits	800-877-7195	www.vsp.com
ComPsych®	Member Assistance Program (MAP) Mental Health or Substance Abuse Services Precertification for Inpatient Hospital Admission due to Mental Health/ Substance Abuse	877-627-4239	www.guidanceresources.com Fund ID: MAP_4_IBEW
LabOne	Laboratory Services	800-646-7788	www.LabCard.com
Free & Clear	Quit for Life® Tobacco Cessation Program	866-QUIT-4-LIFE (784-8454)	www.quitnow.net
Innovative Healthcare Delivery	Transition Care Program Care Assist Program	800-554-0281	www.ihdcare.com
American Health Holding, Inc.	Precertification	866-898-9354 Fax: 866-881-9643	

ABOUT THE 4TH DISTRICT IBEW HEALTH FUND

The 4th District IBEW Health Fund was established to provide members with benefits to help cover their health care expenses. To this end, the Fund negotiates with outside companies so members have access to high-quality, low-cost medical, prescription drug, dental and vision services. The Fund is dedicated to the safety and financial security of our members in Ohio, Kentucky, West Virginia, Virginia, Maryland and the District of Columbia. Active members realize significant cost savings on health care services, which is important for a self-funded Plan like ours.

The Fund's benefits are self-funded. This means that the Fund uses the contributions collected from employers—like the Greenbrier Hotel Corporation—to pay for member benefit claims. The Fund pays fees to ABC Holding Company to administer our plans, but the vast majority of what is spent on our health plans goes toward paying actual claims that are incurred by members and their dependents. This is why the Fund's efforts to negotiate lower-cost health care benefits are so important.

In comparison, fully insured plans have higher fees because the cost of their insurance policy is built into the insurer's profit. We choose to operate as a self-funded plan because we've determined it's a more cost-effective way to pay claims. The Fund is self-funded for all benefits except life insurance and AD&D benefits.

The Board of Trustees

The Fund's Board of Trustees is made up of representatives of both union groups and employers. Members of the Board are appointed to set policies and direct the growth and overall sustainability of the Fund.

Union Trustees	Employer Trustees
Troy Ferrell	Steven Allred
James Gillette	Ted Brady
Bill Hamilton	Mike Evans
Joe Samples	John Frantz

4th District IBEW Health Fund
3150 U.S. Route 60
Ona, WV 25545

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May 2018