SUMMARY PLAN DESCRIPTION OF THE NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND

AS RESTATED AND AMENDED THROUGH JUNE 1, 2012

Dear Members and Dependents:

We are pleased to provide you with this updated Summary Plan Description ("SPD") for the New England Electrical Workers Benefits Fund. This SPD describes the benefits available to you and your eligible Dependents. It is also intended to constitute the written Plan document in accordance with the Employee Retirement Income Security Act of 1974 ("ERISA").

This Summary Plan Description describes all benefits available to Participants in the Benefits Fund. If a benefit, treatment, coverage or other related item is not specifically described in this document, it is not covered by the Benefits Fund.

We all recognize the need for a comprehensive personal medical coverage program that provides hospital, doctor, prescription drug, vision care, and dental benefits. It is also important to have continuation of income during periods of total disability, and Life Insurance.

However, many of us would find the costs of such coverage beyond our financial means if we had to pay for all of it, individually. The Trustees are pleased to be able to provide these benefits to you and your family through the Benefits Fund. We will continue to do everything possible to maintain the Fund on a sound financial basis, so that the level of benefits described in this SPD can continue to be made available to you.

You and your family will be able to take full advantage of the benefits offered through this Fund only if you are aware of all of the provisions of the Fund and the wide scope of services the Fund covers. This SPD furnishes a description of the benefits to which Participants and Eligible Dependents are entitled, the rules governing these benefits, and the procedures that you must follow when making a claim. We have also included, in the back of this booklet, certain information concerning the administration of the Fund as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Trustees reserve the right to amend, modify, or discontinue all or part of this plan whenever, in their judgment, conditions so warrant. The Trustees have complete discretionary authority to determine eligibility for benefits under the Fund or to construe and interpret the terms of the Fund, including ambiguous or disputed terms and meanings, and any other instruments or policies of the Fund. The Trustees have discretionary authority to make all factual findings.

This booklet replaces all other Summary Plan Descriptions previously published by the Trustees. We suggest you read this booklet carefully in order to fully understand the benefits to which you may be entitled. If you have any questions on claims payment, benefit coverage, or eligibility rules please call the Fund Office at (800) 832-6538.

Sincerely,

Board of Trustees, New England Electrical Workers Benefits Fund

IMPORTANT NOTICES

TRUSTEES' AUTHORITY AND DISCRETION

The Trustees have complete discretionary authority to interpret and apply the provisions of the Plan including, but not limited to, determinations of eligibility for benefits, the right of individuals to participate, the manner by which contributions are credited and the level, extension or discontinuance of benefits. The Trustees have complete discretionary authority to construe and interpret the terms of the Plan and/or any other policy or instrument including ambiguous or disputed terms and meanings. Furthermore, the Trustees have discretionary authority to make all factual findings.

LIMIT ON AUTHORITY OF NON-TRUSTEES

No Local Union, Local Union Officer, Business Agent, Local Union Member, Employer or Employer Representative, Fund Office employee, attorney or consultant is authorized to speak for or to commit the Board of Trustees of this Fund on any matter without express written authority from the Trustees.

TRUSTEES' RIGHT TO AMEND, MODIFY OR DISCONTINUE BENEFITS AT ANY TIME

The Trustees reserve the right to amend, modify, or discontinue all or part of these benefits provided by this Fund whenever, in their judgment, conditions so warrant. Benefits, rules governing eligibility and other provisions may change after the date of this SPD booklet. Benefits are not vested. Contact the Fund Office if you have questions regarding current benefits.

YOUR RESPONSIBILITY FOR SELECTION OF PROVIDERS

The selection of medical professionals and service providers is your responsibility. If the Board has contracted with a network of providers, it has tried to find the best selection of providers available. However, the Board disclaims any responsibility for the qualification or action of any provider of goods or services.

FOREIGN LANGUAGE ASSISTANCE/SI NO HABLA INGLES

If you do not understand English and have a question about the benefits or the rules of the Fund, contact the Fund Office for assistance.

Si usted no entiende inglés y tiene una pregunta acerca de los beneficios o las reglas del Fondo, llame la oficina de Fondo para asistencia.

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BASIC INFORMATION

Name of Fund

New England Electrical Workers Benefits Fund

Address of Fund

c/o Insurance Programmers, Inc.
P.O. Box 5817
Wallingford, CT 06492-3730
(800) 832-6538

Employer Identification Number / Fund Number

06-0860627 / 500

Fiscal Year of the Fund (Fund Year)

January 1 through December 31

Plan Sponsor

New England Electrical Workers and participating employers established and maintain the Fund. Participants of the Fund can receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Fund. If the employer or employee organization is a sponsor of the Fund, the Fund Office will provide the sponsor's address. Pursuant to ERISA, the Board of Trustees is considered to be the Plan Sponsor.

Type of Administration of the Fund

The Fund is administered and maintained by a joint Board of Trustees as of June, 2012 consisting of ten Union Trustees and ten Employer Trustees. The Board of Trustees is governed by the Trust Agreement established and maintained in accordance with Collective Bargaining Agreements.

The Fund Office currently handles the day to day administration of the benefits under this Plan, including your medical and hospitalization benefits, on behalf of the Trustees. Most benefits under the Fund are self-insured. Some, including life insurance coverage, are purchased from insurance companies "insured benefits" .

Board of Trustees

Union Trustees

Mr. Milton R. Moffitt, Jr.
I.B.E.W. Local Union No. 42
379 Wetherell Street
P.O. Box 1260
Manchester, CT 06045
Phone: ..... (860) 646-7297
Fax: ..... (860) 643-7092

Mr. Jeffrey Wimette
I.B.E.W. Local Union No. 300
3 Gregory Drive
South Burlington, VT 05403
Phone: ..... (802) 864-5864
Fax: ..... (802) 862-6379

Mr. Gary K. Stacy
I.B.E.W. Local Union No. 104
130 West Street
Walpole, MA 02081
Phone: ..... (508) 660-3900
Fax: ..... (508) 660-0986

Mr. Richard Deering
I.B.E.W. Local Union No. 567
P.O. Box 1289
238 Goddard Road
Lewiston, ME 04240
Phone: ..... (207) 786-9770
Toll Free: ..... (800) 696-8974
Bangor office: ..... (207) 990-2940
Fax: ..... (207) 786-9773

Mr. K Richard Rogers
I.B.E.W. Local Union No. 1837
16 Old Winthrop Road
Manchester, ME 04351
Phone: ..... (207) 623-1030
Fax: ..... (207) 446-4239

Mr. Joseph M. Casey
I.B.E.W. Local Union No. 490
48 Airport Road
Concord, NH 03301
Phone: ..... (603) 224-4239
Fax ..... (603) 224-0247

Management Trustees

Mr. Jerry L. Belanger
Central CT Cable
93 Waterbury Road
Thomaston, CT 06787
Phone: ..... (860) 283-5867
Fax: ..... (750) 283-6021

Mr. Thomas M. Driscoll
E.S. Boulos Co., Inc.
45 Bradley Drive
Westbrook, ME 04092
Phone: ..... (207) 464-3706
Fax: ..... (207) 464-1833

Mr. Michael Gilchrist
Northeastern Line Contractors Assoc.
NELCAF
700 White Plains Road - Suite 271
Scarsdale, NY 10583
Phone: ..... (914) 723-2527
Fax: ..... (914) 723-2536

Mr. Glenn W. Kingsbury
Executive Manager
Boston Chapter, NECA
106 River Street
West Newton, MA 02465
Phone: ..... (617) 969-2521
Fax: ..... (617) 969-5455

Mr. Kevin W. McDonough
McDonough Electric
10 Commercial Avenue
Bedford, MA 01730
Phone: ..... (781) 275-4140
Fax: ..... (781) 275-3055

Mr. Stephen Scarponi
Scarponi Electric
45 Allen Street, Unit 5
Rochester, NH 03867
Phone ..... (603) 332-5011

Union Trustees	Management Trustees
Mr. Daniel D'Alma I.B.E.W. Local Union No. 7 185 Industry Avenue Springfield, MA 01104 Phone: (800) 640-4239 Fax: (413) 746-4568	**Mr. Michael Smith** Blanchard & Daly Electrical Contractors, Inc. 107 Middle Road Southampton, MA 01073 Phone: (413) 527-1234 Fax: (413) 529-9153
Mr. David Fenton I.B.E.W. Local Union No. 223 P.O. Box 1238 111 Rhode Island Road Lakeville, MA 02347-7238 Phone: (508) 947-8555 Fax: (508) 946-5417	**Mr. G. Thomas Chabot** RI & SE Mass. Chapter, Inc., NECA P.O. Box 10357 779 Park Avenue Cranston, RI 02910 Phone: (401) 785-2990 Fax: (401) 785-2991
Mr. Peter F. Carroll I.B.E.W. Local Union No.488 501 Main Street Monroe, CT 06468 Phone: (203) 452-7679 Fax: (203) 459-2553	**Mr. Michael R. Moconyi** Conn. Chapter, NECA 306 Industrial Park Road, Suite 108 Middletown, CT 06457 Phone: (860) 635-1117 Fax: (860) 635-1119
Mr. Bruce A. Silva I.B.E.W. Local Union No. 35 208 Murphy Road Hartford, CT 06114 Phone: (860)525-5438 Fax: (860) 278-4372	**Mr. Edward T. McPhee, Jr.** 99 Beechwood Lane Bristol, CT 06010 Phone: (860) 583-3721

The Trustees have complete discretionary authority to determine eligibility for benefits under the Fund or to construe and interpret the terms of the Fund, including ambiguous terms and meanings, and any other instruments or policies of the Fund.

Plan Administration / Fund Office

Pursuant to ERISA, the Board of Trustees is considered the "Plan Administrator." The Fund is administered by and for the Trustees through the Fund Office:

New England Electrical Workers Benefit Fund
c/o Insurance Programmers, Inc.
P.O. Box 5817
Wallingford, CT 06492-3730
Telephone Number: (800) 832-6538
Fax Number: (203) 284-8656

The Fund Office is open Monday through Friday, excluding holidays, from 8:00 a.m. until 4:30 with limited access until 5:30 p.m. However, you can access your claim information at any time by visiting the Fund

Office's web site: **www.insuranceprogrammers.com**. Click on Member **Access** (on the right side of the site) and enter your "Login ID," which is the members last name in ALL CAPITAL LETTERS; your "Password" is the last four digits of the members social security number, which you can immediately change. Call the Fund Office between the hours of 8:00 A.M. and 4:30 P.M. with limited access until 5:30 P.M., Monday through Friday at (800) 832-6538 if you need assistance with your on-line login.

Agent for the Service of Legal Process

New England Electrical Workers Benefit Fund
c/o Insurance Programmers, Inc.
10 Technology Drive
P.O. Box 5817
Wallingford, CT 06492-3730
Telephone Number: (800) 832-6538
Fax Number: (203) 284-8656

Service of legal process may also be made on any Trustee.

Legal Counsel

Robert M. Cheverie & Assoc., P.C.
Commerce Center One
333 East River Drive
Suite 101
East Hartford, CT 06108

Fund Consultant

The Savitz Organization, Inc.
15 Simms Court
Suite 100
Newton, MA 02465

The Collective Bargaining Agreement

This Fund is maintained pursuant to various Collective Bargaining Agreements. You may obtain copies of these Agreements upon written request to the Plan Administrator or the Union, and they are available for examination at the Benefits Fund Office.

Participants in the Fund can receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is a contributing employer under the Plan, as well as the contributing employer's address.

Copies of the latest Collective Bargaining Agreement or Agreements are available for examination by visiting the Fund Office or may be obtained for a nominal charge by writing to the Fund Office.

Funding Medium

The Trustees hold the assets and reserves of the Benefits Fund in trust, in a Trust Fund pursuant to the Agreement and Declaration of Trust. Contributing Employers contribute to the Fund at the hourly rates established by and in accordance with the Collective Bargaining Agreements.

Plan Change or Termination

The Board of Trustees reserves the right to change or discontinue the types and amounts of benefits available under the Fund and the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated. The Board of Trustees also reserves the right to change or increase the cost of coverage charged to all Employees, or to any class or classes of Employees.

Plan benefits and eligibility rules for active, retired, or disabled participants:

1. Are not guaranteed;
2. Are not vested;
3. May be changed or discontinued by the Board of Trustees at any time;
4. Are subject to the Trust Agreement which establishes and governs the Fund's operations;
5. Are subject to the provisions of any group insurance policies purchased by the Board of Trustees.

The nature and amount of benefits under the Fund are always subject to the actual terms of the Fund as it exists at the time the claim for benefits is made.

If the Plan of benefits is changed or discontinued, it will not affect you or your Eligible Dependent's right to the payment of any benefit if and to the extent that the claim for benefits has already been made.

IMPORTANT: ANY BENEFITS NOT DESCRIBED IN THIS DOCUMENT ARE NOT PART OF THE NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND UNLESS AMENDED BY THE TRUSTEES.

BENEFITS AND ELIGIBILITY RULES DESCRIBED IN THIS DOCUMENT[1] ARE THE ONLY BENEFITS AND ELIGIBILITY RULES THAT APPLY TO PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS OF THOSE PARTICIPANTS UNLESS AMENDED BY THE TRUSTEES.

[1] From time to time, you may receive one or more "Summary of Material Modifications (SMM)" whose purpose is to modify this Summary Plan Description. These SMMs are considered to be part of this document. We suggest you keep all SMMs with this SPD.

SECTION 1. ELIGIBILITY RULES

BASIC ELIGIBILITY RULES

Eligibility Rules for Employees

The following employees may become eligible for coverage if required contributions are paid to the Fund on their behalf and if they:

1. Are employees of participating Employers; and
2. Are working under the jurisdiction of a Collective Bargaining Agreement entered into with a Union that requires the Employer to make periodic payments to the Benefits Fund for the purpose of providing and maintaining medical benefits coverage, or under an agreement requiring reciprocation of such payments, or under the terms of a Participation Agreement between the Employer and the Board of Trustees to make such payments.

After your coverage becomes effective, your eligibility shall continue during each calendar month for which sufficient contributions are made to the Fund on your behalf because of credited hours of employment from one or more participating Employers, and shall continue for the period during which banked hours are available.

Eligibility Rules for Spouse/Dependents

1. The term "Eligible Dependent" shall mean lawful spouse of either gender, and does not include common law spouse, spouse lawfully separated by the courts, divorced spouses, or domestic partners. Your spouse will be covered from the date of your marriage, provided that the eligible Participant presents a valid marriage certificate to the Fund Office.
2. The term "Eligible Dependent" shall also mean all natural, or legally adopted children of a Participant (see SECTION 25, Definitions,) under 26 years of age who do not have employer-sponsored health benefits available to them (other than through a parent), and who are not members of the armed services on active duty. A child under 26 years of age who is a full time student is eligible regardless of whether employer-sponsored health insurance is available, so long as proof of full-time student status is provided.
3. Newborn children are covered as part of the mother's coverage for the first thirty (30) days of the newborn's life. To continue coverage for a newborn after the first thirty days, the eligible Participant must present a valid birth certificate to the Fund Office listing the Participant as the child's parent.
4. The term "child" also includes any child under 26 years of age for whom you have legal guardianship. The effective date of such child's enrollment will be the first day of the first calendar month after the date you provide a certified or attested copy of the court order appointing you Guardian of the child to the Fund Office. The court that issues the appointment must be a court of competent jurisdiction. The Participant must immediately notify the Fund Office in the event your appointment is no longer effective, is revoked or modified, or if you are no longer the legal Guardian of such child. Copies of pertinent papers or other sufficient proof must be sent to the Fund Office.

5. The term "child" also includes any stepchild under 26 years of age. A stepchild is the child a Participant's spouse and the Participant's spouse must be listed as the parent of the child on the child's birth certificate. The effective date of such child's enrollment will be the first day of the first calendar month after the date you provide such birth certificate.

6. An "Eligible Dependent" shall also mean a child 26 years of age or older who is unable to earn a living due to a physical or mental incapacity and who is dependent upon a Participant for support. Proof of the continued existence of such incapacity and of the Participant's support shall be furnished to the Fund Office upon request. Notification of the child's incapacity should be submitted to the Fund Office within 31 days after the child turns 26.

7. The term "Eligible Dependent" shall also mean a child under the age of 26 years of age who is placed with a Participant for adoption by a legally licensed adoption agency before being formally adopted by the Participant. Such child must not have attained age 26 as of the date of placement for adoption. In addition, the Participant with respect to such placement for adoption must have assumed and retained a legal obligation for the total or partial support of such child in anticipation of the adoption of such child and for the period before being formally adopted by the Participant. The Plan considers the child's placement with the Participant to terminate upon the termination of such legal obligation.

8. The term "Eligible Dependent" shall also mean a child under the age of 26 years of age for whom you are required to provide coverage pursuant to a Qualified Medical Child Support Order

9. The term "Eligible Dependent" shall also mean your child under the age of 26 years, born out of wedlock, for whom you acknowledge paternity, if appropriate, in writing, and who otherwise meets the conditions for "Eligible Dependent" described in Paragraph 2 (above).

Documents required by the Fund Office to establish coverage as an "Eligible Dependent" follow:

- Marriage Certificate
- Birth Certificate showing both parents' names
- Court documents from a court of law showing legal guardianship/adoption
- Affidavit stating that a Dependent child, between the ages of 19 and 26, does not have employer-sponsored health benefits available (other than through a parent).
- Student Status information for Dependent children between the ages of 19 and 23 if the child has employer-sponsored health benefits available.
- Documentation and medical records showing proof of a Dependent child's mental or physical incapacity, because of which he or she cannot maintain self-supporting employment, where applicable.
- Documentation that a child is being placed for adoption.

When enrolling an individual as an Eligible Dependent or in determining or making any payments for benefits for an individual as an Eligible Dependent, the Fund will not take into account the fact that the

individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid). In addition, when enrolling a Dependent the Fund Office must receive a copy of a birth certificate or a marriage certificate. In no event will such Dependent be eligible for benefits without this documentation. In no event will such Dependent be eligible for benefits more than 12 months before the Fund Office receives such documentation.

Dependent children of bargaining unit employees of a signatory Local Union who are Actively Working or Available for Work in Covered Employment, who lose coverage due to the dependent child's no longer meeting the Eligibility Rules for Dependent Children, will be offered COBRA.

ELIGIBILITY AND BANK OF HOURS: COLLECTIVELY BARGAINED INSIDE AND OUTSIDE CONSTRUCTION EMPLOYEES

You become eligible on the first day of the calendar month next following your having accumulated 500 hours of credited employment within the previous 12 months for one or more participating Employers, if the required contributions have been made on your behalf to the Fund by the participating Employers.

For newly organized employees, payment in an amount that would allow "Initial Eligibility" (currently 500 hours times the contribution rate in effect) can be accepted as a lump sum from Contributing Employers on behalf of such employees. Any such employees are afforded coverage on the first of the month after the contributions are credited.

Bank of Hours

You will be credited with one (1) hour in your "Bank of Hours" for each hour you work in covered employment for which the Benefits Fund receives contributions from a Participating Employer.

The maximum number of hours you can accumulate in your bank is 900 hours (6 months of coverage).

Continuation of Coverage

Your bank will be credited with hours reported by a contributing Employer on your behalf, for which the Benefits Fund receives contributions. These contributions are generally made monthly, in the month following the month in which you worked. One hundred and fifty (150) hours will be deducted on the first of the month from your Bank of Hours for each month of coverage. If you are credited with more than 150 hours during a month (based on contributions received by the Benefits Fund), the excess hours will remain in your Bank of Hours, up to the 900 hour cap (6 months of coverage).

Skip Month

If your bank falls below 150 hours after you have established eligibility, these hours in your bank will be used to grant you one "Skip Month." Your eligibility will be maintained for that Skip Month and all of the hours will be deducted from your bank. You are only entitled to one Skip Month in a row. You are entitled to two Skip Months in any consecutive twelve-month period. These Skip Months cannot be consecutive.

"Buy-In" of Coverage

If your bank falls below 150 hours after you have established eligibility, but have at least 110 hours in your bank, you may "buy in" up to 40 hours at the hourly rate in effect for that month. You will then be eligible for coverage in the following month. This provision may be used to maintain eligibility instead of using a Skip Month. This "buy in" provision may also be used to reinstate health benefits for a participant working towards reinstatement.

You may not use this provision more than six times in any twelve consecutive months.

Forfeiting Your Bank of Hours upon Leaving Covered Employment

If you no longer work in Covered Employment and you are not available for work pursuant to the rules of your home Union or the Union in whose jurisdiction you worked in Covered Employment, you forfeit your Bank of Hours. You will be offered COBRA privileges immediately.

Please note that this forfeiture *does not apply* to participants unable to work due to a disability, the Family Medical Leave Act (see Page 79) or military service (see Page 80).

See "Effect of Transfer of Membership" section on Page 16 for situations where you transfer to an I.B.E.W. Local that does not participate in the Fund.

When Coverage Begins

You will be covered on the first day of the calendar month following the month you qualify for coverage. Each of your Eligible Dependents will be covered on the date you become covered, or the date this person becomes your Eligible Dependent (if later).

Eligibility While Disabled

If you are disabled and receive Weekly Disability Income Benefits from the Benefits Fund, or you are disabled on the job and receive benefits under a Workers' Compensation Law and the Benefits Fund is not receiving contributions on your behalf, the Benefits Fund will freeze your Bank of Hours for the period of time you are receiving either Weekly Disability Income or Workers' Compensation. You will continue to maintain eligibility during this period, up to a maximum of a six-month extension. If you are still disabled after six months, the Benefits Fund will begin deducting 150 hours per month from your Bank of Hours. Once your Bank of Hours has been exhausted, you will be offered COBRA coverage (see "COBRA" Section below).

If you are working in Covered Employment in an effort to reinstate coverage and become disabled, you will be offered COBRA coverage. If you elect COBRA coverage, you will be eligible to receive Weekly Disability Income benefits.

Reinstatement of Eligibility

If you lose eligibility because you do not have enough hours in your Bank of Hours, your eligibility can be reinstated on the first day of the month following the date on which you have accumulated at least 150 hours in your Bank of Hours, provided you have maintained coverage under COBRA. If you are working in Covered Employment and have accumulated at least 110 hours in your Bank of Hours, you may "buy in" up to 40 hours to reinstate your benefits the first day of the following month.

If you have not maintained eligibility by work in covered employment or COBRA self-payment, you must satisfy the Initial Eligibility rules again. If you are working in Covered Employment and have accumulated at least 400 hours in your Bank of Hours within a twelve (12) month period, you may "buy in" up to 100 hours to reinstate your benefits the first day of the following month.

If you have exhausted your Bank of Hours and have worked at least 110 but fewer than 150 hours, you can "buy in" additional hours, as described on Page 8.

Newly-Organized Employees

Initial Eligibility can be accepted as a lump sum from a Contributing Employer on behalf of newly organized employees. These employees are covered on the first day of the month after the contributions are received.

ELIGIBILITY AND BANK OF HOURS: EMPLOYEES OF PARTICIPATING UTILITIES

Initial Eligibility for New Employees of a Participating Utility or Employees of a Newly Organized Utility

As a newly hired employee of a Participating Utility, you will become eligible on the first day of the month following the month that you begin such work, if the required contributions have been made on your behalf to the Fund by the participating Employer. As an employee of a Newly Organized Utility or utility that is newly participating in the fund, if you had health coverage on the day before your Utility began participation in the Fund, you will become eligible on the first day that your Utility becomes a Participating Utility.

Bank of Hours

For each week you work, contributions will be made for 40 hours of work.

You will begin your participation in the Fund with a "negative Bank of Hours" of five hundred (500) Hours. The negative Bank of Hours will be reduced each month by the amount contributed by the employer in excess of the hours required to maintain Continued Eligibility (150 hours per month). You will not accumulate any positive banked hours and, thus, will not have any extended eligibility until such time as the negative hours in the bank have been totally repaid and you have begun to accumulate a positive Bank of Hours.

Continuation of Coverage

Your bank will be credited with hours reported by a contributing Employer on your behalf, for which the Benefits Fund receives contributions. These contributions are generally made monthly, in the month following the month in which you worked and are based upon a 40 hour work week. One hundred and fifty (150) hours will be deducted on the first of the month from your Bank of Hours for each month of coverage. If you are credited with more than 150 hours during a month (based on contributions received by the Benefits Fund), the excess hours will remain in your Bank of Hours, up to the 900 hour cap (6 months of coverage).

Skip Month

If you have a positive hour bank and your bank falls below 150 hours after you have established eligibility, these hours in your bank will be used to grant you one "Skip Month." Your eligibility will be maintained for that Skip Month and all of the hours will be deducted from your bank. You may use two (2) Skip Months in a twelve (12) consecutive month period.

Leaving Covered Employment

If your employer does not make the required contribution to the Benefits Fund, and you have not accumulated any positive hours in your Bank of Hours, you will be issued a COBRA notice, effective the first day of the following month, and you may continue coverage on a self-payment basis under the COBRA rules (see below, Page 17).

If you leave employment for any reason, you will run out your Bank Hours, if any, and you will be issued a COBRA notice, effective the first day of the following month, and you may continue coverage on a self-payment basis under the COBRA rules (see below, Page 17).

Reinstatement of Eligibility

If you lose eligibility because you do not have enough hours in your Bank of Hours, your eligibility can be reinstated on the first day of the month following the date on which you have accumulated at least 150 hours in your Bank of Hours, provided you have maintained coverage under COBRA. If you have not maintained eligibility by work in covered employment or COBRA self-payment, you must satisfy the Initial Eligibility rules again.

Retirees from a Participating Utility

You will be eligible to receive retiree benefits from the Benefits Fund if 5,000 hours are contributed to the Benefit Fund on your behalf. If you retire before working the required number of hours, the Utility may continue to contribute at the rate of 160 or 200 hours per month, at the in-force contribution rate, until you qualify. Once 5,000 hours are received on your behalf, you may continue benefits as a retiree, effective the first day of the month following the month of qualification, at the regular monthly retiree self-payment rate.

ELIGIBILITY PROVISIONS FOR NON-COLLECTIVELY BARGAINED EMPLOYEES

With the approval of the Board of Trustees, a Contributing Employer currently contributing to the Benefits Fund on behalf of employees covered by a Collective Bargaining Agreement with a Participating Union may provide coverage under this Plan to its employees who do not work in employment covered by a Collective Bargaining Agreement with a Participating Union, and who are not members of another union. Such Employer may limit such participation to its employees who are "alumni employees" with the approval of the Board. "Alumni employees" previously worked in employment covered by a Collective Bargaining Agreement with a Participating Union, which was the basis of their participation in the Benefits Fund before accepting their current employment with this Employer.

A contributing Employer in good standing must submit a request to the Board of Trustees and must sign a Participation Agreement and Certificate of Contributing Employer before the Fund will accept contributions on behalf of its Non-Collective Bargaining employees. The Employer has two choices for Participation Agreements:

> *If the employer selects to use the Alumni Only Participation Agreement*, only those employees who formerly participated in the Fund based on their work in employment covered by a Collective Bargaining Agreement with a Participating Union can be included, but the Employer must cover all alumni employees unless they opt-out of coverage.
>
> *If the employer chooses the Non-Collectively Bargained Participation Agreement*, all of the Employer's non-collectively bargained employees must participate in the Fund unless they opt-out of coverage.

A non-collectively bargained employee may "opt out" of coverage under either Participation Agreement by signing an affidavit stating that the employee has other coverage.

For its non-collectively bargained employees to participate in the Fund, the Contributing Employer must agree to the following:

1. The Employer's covered employees shall include all full-time and regular part-time employees, who are scheduled to work twenty (20) hours per week or more who have not opted out of coverage; and

2. Contributions on behalf of these non-collectively bargained employees will be made monthly at rates determined by the Board of Trustees. These rates are subject to change at any time at the discretion of the Trustees.

3. Contributions are made consistently and at the same time contributions are made for collectively bargained plan participants.

4. If both a husband and wife are non-collectively bargained employees of a Contributing Employer and the Contributing Employer remits 150 hours per month on behalf of one of them, special rules apply. Rather than making contributions for both non-collectively bargained employees under the provisions of this Section, the Employer will contribute on behalf of the spouse (at a special rate to be determined by the Board of Trustees, subject to change at any time at the discretion of the Trustees) and the spouse will receive the same Life Insurance benefit, Accidental Death and Dismemberment coverage, and Weekly Accident and Sickness benefits afforded to all non-collectively bargained Participants.

Eligibility for Non-Collectively Bargained Employees

Initial

Non-collectively bargained employees of Employers who have agreed to contribute to the Fund on their behalf at the required monthly rate will become covered on the first day of the month following the receipt by the Fund of two (2) months of contributions. For example, if a non-collectively bargained employee is hired on October 1, 2012, and continues working in November and December and the employer contributes two full months on November 15, 2012, then coverage will begin on November 1, 2012.

Continuation of Health Coverage

Health coverage will be continued, on a monthly basis, as long as the monthly contributions are remitted timely.

Termination

Eligibility for benefits will terminate on the last day of the following month after the earliest occurs:

- You stop working for a Contributing Employer;
- Your Employer is no longer a Participating Employer;
- Your Employer fails to make contributions for your coverage;
- The Fund terminates or no longer allows coverage for non-collectively bargained employees.

For example, you leave employment on January 18, 2012, you will be offered COBRA privileges effective February 28, 2012.

Reinstatement

Non-collectively bargained employees do not have any reinstatement provisions, they will be offered COBRA privileges when they leave employment pursuant to the COBRA rules (see Page 17, below).

Bank of Hours

Non-collectively bargained employees do not accrue a Bank of Hours.

Non Collectively Bargained Employees who Retire

Each month worked by a non-collectively bargained employee for whom the required contributions are received by the Fund is recognized as a full month worked when determining if the employee meets the 5,000-hour requirement to be eligible for retiree benefits. If the non-bargained employee does not meet the 5,000-hour requirement, the Employer may remit one hundred sixty (160) or two hundred (200) hours a month at the in-force contribution rate, until the requirement is met. The Board of Trustees may adjust this hour requirement at any time.

COVERAGE FOR RETIREES

Before Medicare Eligibility

If you retired on or after turning 55 years of age, you are eligible to continue your coverage under the Fund until you are eligible for Medicare coverage or age 65 (whichever comes first), if you meet all of the following requirements:

1. You are eligible for benefits on your retirement date, with either hours worked, banked hours, or COBRA self-payments
2. You have been credited with at least 5,000 hours worked in the seven years immediately preceding your retirement. For this purpose, you will be credited with 40 hours per week for each week you received Weekly Accident & Sickness benefits or Workers' Compensation benefits for which no contributions were made on your behalf. If you do not have 5,000 hours during that period, you will not be eligible for coverage as a retiree under this Fund, but you will be eligible for COBRA coverage.
3. You agree to make the required monthly self-payment rate on time. The monthly self-payment rate is determined annually, and may change during your pre-Medicare period.
4. Effective March 1, 2009, you (a) have been a participant for at least 10 consecutive years immediately before retirement of a Fund that has merged into this Fund and (b) have been continuously available for work or have worked for a Participating Utility for at least 10 consecutive years immediately before retirement and participated in that utility's health plan prior to the time it became a Participating Utility and have participated in the Fund from the time your utility became a Participating Utility .

Medicare Eligible

Once you become eligible for Medicare **YOU MUST** apply for and enroll in Medicare Parts A or B) and then your coverage will change to a MEDICARE SUPPLEMENTAL BENEFIT. The Benefit Fund coordinates with your Medicare benefits (see "Medicare: Coordination" on Page 53 for additional information). **If you do not elect Medicare Parts A and B when you become eligible, the Benefit Fund will not consider your Part A or Part B claims until proof of Medicare eligibility is provided the Fund Office.**

This Fund offers its retirees Prescription Drug Coverage that is actuarially equivalent to the coverage provided under Medicare Part D.

Opting Out of Retiree Coverage

Upon retirement, an otherwise eligible plan participant may "opt out" of retiree coverage if the participant/retiree has coverage through the participant's/retiree's spouse's employment. Such retiree and

spouse may elect to participate in the Fund at a later date, upon the occurrence of any of the following events:

1) The retirement of the spouse from the spouse's employer

2) The death of the spouse

3) The divorce of the retiree and the spouse

At the time of reinstatement of coverage, both the retiree and spouse must show proof of continuous coverage from the date of the "opt out" through the date of reinstatement.

A retiree's spouse who is actively at work may also "opt out" of his or her retired spouses' coverage if the active spouse has coverage through his or her employment. Such active spouse may elect to participate in the Fund at a later date, if:

1) The actively working spouse retires and his or her employer does not provide retiree health coverage and

2) The retired spouse continues to participate in the Fund.

At the time of reinstatement of coverage, the retired active spouse must show proof of continuous coverage from the date of the "opt out" through the date of reinstatement, which cannot be later than three (3) months after his or her retirement date.

COVERAGE FOR DISABLED MEMBERS

Participants who become disabled before age 62 and whose Bank of Hours has been used up may be eligible to continue coverage under this Fund. Participants who are determined Totally and Permanently Disabled by Social Security and/or who are deemed "occupationally disabled" by the New England Electrical Workers Money Purchase Plan and Trust or a similar Trust Fund affiliated with the Benefit Plan before age 55 may continue health benefits as an eligible retiree at the in force monthly self-payment rates.

COVERAGE UPON ACTIVE MILITARY SERVICE

Upon your entry into Active Military Service, your coverage will terminate on the last day of the month you are called into Active Military Service. However, your Bank of Hours will be frozen on that date.

Your family will continue to be covered for eighteen (18) months following your being called into Active Military Service. At the end of eighteen months, your Bank of Hours will be activated. Once your Bank of Hours is exhausted, your family will receive coverage under COBRA (see the Section regarding "COBRA").

See Page 80 for information about "USERRA," the Uniformed Services Employment and Reemployment Rights Act of 1994.

NON-COLLECTIVELY BARGAINED PARTICIPANTS WHO GO TO WORK IN EMPLOYMENT COVERED BY A COLLECTIVE BARGAINING AGREEMENT

A non-collectively bargained Participant who leaves such employment to immediately work in employment covered by a Collective Bargaining Agreement providing for contributions to the Benefits Fund, must meet the requirements to become Initially Eligible. This Participant's Employer may continue to remit monthly contributions pursuant to the Participation Agreement in addition to the contributions under the Collective Bargaining Agreement until the Participant meets the Initial Eligibility requirements, or this Participant can be offered COBRA privileges and self-pay for benefits until he or she meets the Initial Eligibility rules of the Fund. For employees of a Participating Utility, the employer may opt to make contributions to eliminate the negative bank of hours.

COLLECTIVELY BARGAINED PARTICIPANTS WHO GO TO WORK IN NON-COLLECTIVELY BARGAINED EMPLOYMENT

A collectively bargained Participant who leaves employment covered by a Collective Bargaining Agreement to work for a Contributing Employer in non-collectively bargained employment, may either run out his or her Bank of Hours, or request the Fund Office, in writing, to freeze his or her Hour Bank. A participant who requests that his or her Hour Bank be frozen must notify the Fund Office when he or she leaves work at the Contributing Employer.

SPOUSE AND DEPENDENTS' COVERAGE AFTER A PARTICIPANT'S DEATH

If you die while you are an active Participant, your spouse and your Dependents will be provided with full coverage under the Benefits Fund, at no cost, for a period of three (3) years. Spouses will first run out the Hour Bank, if any, before the three (3) year period commences. Thereafter, your spouse will be eligible for benefits through the Benefits Fund for your spouse's lifetime, as long as your spouse agrees to timely make monthly payments at the subsidized COBRA monthly premium unless your spouse remarries.

If you die while you are an eligible retiree, your spouse and your Dependents will be will be provided with full coverage under the Benefits Fund, at no cost, for a period of three (3) years. Thereafter, your spouse will be eligible for benefits through the Benefits Fund for your spouse's lifetime, as long as your spouse agrees to make monthly payments at the age appropriate monthly retiree premium, timely, unless your spouse remarries.

DEPENDENTS' COVERAGE AFTER A PARTICIPANT'S DEATH

Dependent children who have a parent who was a Participant covered by the Plan who is either deceased or incarcerated and who was eligible for benefits through the Benefits Fund, prior to their parents death or incarceration, will have benefits extended to them, at no cost, until they no longer meet the eligibility requirements as an Eligible Dependent, or become eligible for benefits elsewhere, whichever is sooner.

PRE-EXISTING CONDITIONS

The Fund has no pre-existing condition exclusions.

However, if you leave the Fund and go to work elsewhere, the health plan provided by your new employer may have a pre-existing condition exclusion. "Pre-existing condition exclusion" means that for a certain period of time, usually one year, any condition for which you or an eligible Dependent received medical attention within the last six months will not be covered by your new health plan.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), such an exclusion must be reduced by any period of time you carried "creditable coverage" for such a condition. If you leave the Fund and go to work elsewhere, your new employer may ask you to provide information regarding your "creditable coverage" under HIPAA. You can obtain the Certificate of Creditable Coverage from this Fund. More information about HIPAA begins on Page 70 of this SPD.

Because some people have had creditable coverage through multiple sources, you should always check with all sources of prior health coverage to be sure you get the credit you deserve. If you lose your certificate, you can go back and request another one, free of charge. In most cases, even if you do not receive a certificate, you can use other evidence to prove creditable coverage. These include:

- Pay stubs that reflect a premium deduction;
- Explanation of benefit forms;
- A benefit termination notice from Medicare or Medicaid and;

- Verification by a doctor or your former health care benefits provider that you had prior health coverage.

You also can request a certificate describing your coverage under a particular group health plan, policy, or contract (free of charge) at any time while you are still covered or up to 24 months after the coverage has ended. Each certificate that you request should describe the creditable coverage you have received for the prior 24 months.

Additional information about HIPAA is available at the Heath Care Financing Administration web site: www.hcfa.gov/medicaid/hipaa.

TERMINATION/CHANGES OF COVERAGE

Termination of Coverage

Coverage will terminate on the earliest of the following dates:

1. The date the Fund terminates
2. The date you no longer satisfy the eligibility rules for such coverage
3. The date you die (See "Spouse and Dependents' Coverage After a Participants' Death" above for additional information about continuing coverage on Page 15

The Trustees may, in their sole discretion, from time to time, change or discontinue all or any part of the benefits for Participants and Eligible Dependents. Such change or discontinuance may be retroactive as determined in the sole discretion of the Trustees. This right to change, modify, or discontinue benefits includes, but is not limited to, the right to change eligibility requirements or benefits for Participants and Eligible Dependents. The Trustees also may, in their sole discretion, adopt and amend from time to time any rules, policies or regulations they may deem appropriate. The Trustees may, in their sole discretion, change from time to time the premiums that shall be paid to maintain coverage under the Fund.

Termination of Dependent Coverage

Coverage for Eligible Dependents will terminate on the earliest of the following dates:

1. The date on which the Participant's coverage terminates (See "Spouse and Dependents' Coverage After a Participants' Death" above for additional information on Page 15)
2. The date a Participant no longer satisfies the eligibility rules for Dependent coverage
3. Coverage of each Eligible Dependent terminates when he or she no longer qualifies as an Eligible Dependent. However, an Eligible Dependent whose coverage is terminating may be eligible to elect COBRA continuation coverage.
4. The date the Dependent does not make the appropriate monthly self-payment.

Effect of Transfer of Membership

A Participant who transfers their membership to an I.B.E.W Local that does not participate in the NEEWBF may run out their Hour Bank, however, once the Hour Bank is exhausted, the participant shall be deemed "Unavailable for Work in Covered Employment." The Fund, through its Administrator, shall be notified of a transfer via the Electronic Reciprocal Transfer System (ERTS) and the participant will be offered "Not Available for Work" COBRA continuation privileges. See "Forfeiting your Bank of Hours" on Page 9 for other provisions..

CONTINUATION OF COVERAGE

In General

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") is a law that entitles Participants and their Eligible Dependents to continue certain coverage provided by the Plan on a self-pay basis if their coverage would otherwise terminate due to the occurrence of certain "Qualifying Events" (defined below).

When a Participant or an Eligible Dependent notifies the Fund Office that a Qualifying Event has happened, the Fund Office will notify him of his right to choose continuation of coverage. Satisfactory evidence of good health will not be required to purchase continued coverage.

The rules concerning eligibility to elect COBRA continuation coverage follow:

1. If a covered Participant loses coverage under the Fund due to the termination of employment (for other than gross misconduct) or a reduction in work hours, the covered Participant may purchase continued coverage under the Fund for up to eighteen (18) months. If the spouse or dependent child would also lose coverage under the Fund, each of them may separately elect to purchase coverage for the 18 months. If, during the 18-month period, another Qualifying Event occurs, an Eligible Dependent may elect another continuation. However, the length of the combined continuation periods may not exceed 36 months from the date of the original Qualifying Event.

2. If the Participant entitled to the COBRA continuation coverage is disabled (as determined under the Social Security Act) the Fund provides COBRA continuation coverage for 29 months, rather than 18 months. The disability extension applies if the Participant is disabled at the time of the termination of employment or if the Participant becomes disabled at any time during the first 60 days of COBRA continuation coverage. If the Participant entitled to the disability extension has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29-month disability extension. Note that the monthly COBRA premium reverts to 150% of the current monthly premium throughout this eleven (11) month extension.

3. To be eligible for COBRA, the person must have been eligible for coverage under the Fund at the time of the Qualifying Event, i.e., the termination of employment or reduction in hours. However, a child who is born to or placed for adoption with the Participant during a period of COBRA continuation coverage may make an election to continue COBRA continuation coverage, if the Participant elects COBRA coverage during the election period and enrolls the new child upon birth or adoption.

4. If the spouse or dependent child of any covered Participant is covered by the Fund and loses coverage due to one of the following Qualifying Events, they may purchase continuing coverage under the Fund for up to thirty-six (36) months:

    - Death of the covered Participant
    - Divorce of the covered Participant and spouse
    - A dependent child is no longer considered a dependent child as defined by the Fund; or

- A dependent child or spouse loses coverage because the covered Participant becomes entitled to Medicare.

5. A covered Participant's spouse or dependent child's right to elect COBRA continued coverage is subject to limitations and may be terminated before the period stated above. In no event will the maximum period of continued coverage for any Qualifying Event, or any combination of Qualifying Events, exceed thirty-six (36) months from the first Qualifying Event.

6. Any former employee of an I.B.E.W. Local Union Health Fund Office that merges into the New England Electrical Workers Benefit Fund, and who – as a result of such merger – becomes unemployed by the Local Union Health Fund, will be offered the "subsidized COBRA rate.

Notifying the Fund Office

A covered Participant, spouse, or dependent child must notify the Fund Office within sixty (60) days after a divorce or a dependent child's loss of Fund eligibility. Failure to notify the Fund Office regarding your divorce or a dependent child's loss of eligibility will make you financially responsible for all claims which may have been paid on behalf of your ineligible family member. If the Participant has been determined by the Social Security Administration to be disabled and wishes to purchase up to 29 months of continued coverage, they must provide a copy of the Social Security Administration's determination to the Fund Office within sixty (60) days after the date such a determination is made and in no event later than the expiration of the 18 month period. The notices should be sent certified mail to the following address:

New England Electrical Workers Benefits Fund
c/o Insurance Programmers, Inc.
P.O. Box 5817
Wallingford, CT 06492-3730
Attention: COBRA Notification

Important: Be sure to provide the notice in the manner and time as stated to ensure the Fund Office receives your notice. If the covered Participant, spouse, or dependent child fails to notify the Fund Office within sixty (60) days of the date of disability determination, date of the divorce, or the dependent child's loss of eligibility, the covered Participant, spouse, or dependent child will forfeit any right to elect continued coverage. Once the Fund Office has been so notified, the Fund Office will then respond as described herein. The Fund intends to notify you (or your Eligible Dependent) of the loss of active coverage by first class mail to the last known address on file at the Fund Office.

The Fund assumes no responsibility or liability if you or your Eligible Dependent allows coverage to terminate. It is the Participant's or Eligible Dependent's responsibility to contact the Fund Office to verify eligibility status.

COBRA Premium Payment

COBRA is paid in monthly installments. The amount of the monthly COBRA premium will be provided when eligibility for COBRA continuation coverage has been determined. Monthly premiums must be paid on time. If payments are not made on time (including any grace period), coverage will terminate. The first payment must be received by the Fund Office forty-five (45) days from the date of COBRA election or coverage will end. Under no circumstances will the option to make self-payment to the Fund be permitted on a retroactive basis, except as described in this Section of the booklet. The rates charged for individual and

family COBRA continuation coverage will be established by the Trustees from time to time, and may be modified by the Trustees.

NOTE: It is recommended that COBRA payments be received in the Fund Office the month prior to the coverage month, i.e., January's COBRA payment received by the Fund Office on December 20th. This will avoid any interruption of claim and/or prescription coverage.

The type of coverage will generally be the same as the type of coverage the covered Participant, spouse, or dependent child had the day before the Qualifying Event. The type of coverage, however, may be reduced or modified if such coverage is reduced or modified in the same manner to similarly situated beneficiaries under the Fund with respect to whom a Qualifying Event has not occurred. Your COBRA coverage will include coverage of Accident and Sickness benefits, as described in this Summary Plan Description. Your monthly COBRA premium includes a premium for coverage of this benefit.

If during a COBRA continuation of coverage period a Participant whose coverage was based on his or her employment marries and wishes to enroll their new spouse on the Fund, the Participant should notify the Fund. The Participant may then elect to change from single to family coverage. Change in coverage status will take effect the 1st day of the month following the notice to the Fund.

COBRA Length of Coverage

Your continuation of coverage with COBRA may end earlier than the 18, 29, or 36 months (whichever is applicable) if any of the following situations occur:

1. You do not pay the required premium on time (including any grace period required under COBRA); or
2. You or your Eligible Dependent who is continuing coverage first become covered under any other group health plan (in a plan without pre-existing condition limitations as defined in the federal law known as HIPAA) after the date of the election to continue coverage; or
3. You or your Eligible Dependent who is continuing coverage first becomes eligible for Medicare after the date of the election to continue coverage; or
4. Your employer no longer provides coverage under any group health plan to any employee; or
5. You obtained COBRA continuation coverage because of disability under Title II or XVI of the Social Security Act and have been given a final determination by Social Security that you are no longer disabled. You must notify the Fund Office of such determination no later than thirty (30) days after the date Social Security has deemed the Participant as no longer disabled; or
6. The Plan terminates.

SECTION 2. WEEKLY ACCIDENT AND SICKNESS BENEFITS (LOSS OF TIME)

If a Participant is unable to work because of a non-work related illness or injury, they may be eligible to receive a Weekly Accident and Sickness benefit. In order to be eligible for this benefit a Participant must be receiving regular care or treatment from a licensed certified medical doctor. Call the Fund Office to determine eligibility for this benefit. A statement of claim form must be completed by your attending physician and returned to the Fund Office in a timely fashion. You will be asked to have your licensed certified medical doctor complete an Attending Physician Statement, periodically throughout your period of disability.

If you are disabled and receive Weekly Disability Income Benefits from the Benefits Fund, or you are disabled on the job and receive benefits under a Workers' Compensation Law and the Benefits Fund is not receiving contributions on your behalf, the Benefits Fund will freeze your Bank of Hours for the period of time you are receiving either Weekly Disability Income or Workers' Compensation. You will continue to maintain eligibility during this period, up to a maximum of a six-month extension. If you are still disabled after six months, the Benefits Fund will begin deducting 150 hours per month from your Bank of Hours. Once your Bank of Hours has been exhausted, you will be offered COBRA coverage (see "COBRA" Section below).

If you are working in Covered Employment in an effort to reinstate coverage and become disabled, you will be offered COBRA coverage. If you elect COBRA coverage, you will be eligible to receive Weekly Disability Income benefits.

ELIGIBILITY

To be eligible for the Weekly Accident and Sickness benefit described in this Section, you must be eligible for benefits as an active or COBRA Participant and you must be unable to work because of a non-work related accidental injury or illness. If such eligibility is based on illness, the first weekly benefit will not be paid until you have completed a seven (7) day waiting period. No benefit will be payable if you apply for such benefits later than the last day of the 6th month following the month in which you were disabled. Periods of disability due to the same or related causes will be considered one period of disability unless they are separated by at least two (2) consecutive weeks of active work.

The Fund will not pay more than 26 weeks of Weekly Accident and Sickness benefit during any 52-week period. The 52-week period begins on the first day that a participant begins receiving Weekly Accident and Sickness benefits.

For a Participant working as a lineman who is diagnosed with ICD 250.6 ("diabetes with neurological manifestations[2]"), this Weekly Accident and Sickness benefit is extended for a period of 30 to 90 days, based upon the time of year, effective January 1, 2007.

This benefit is payable to Participants on COBRA, regardless of their work status.

A Participant may request an extension of weekly disability benefits through the duration of the Participant's eligibility based on the Participant's Bank of Hours if the Participant has applied for Social Security disability benefits. The Trustees have the discretion to approve such requests. The Participant must agree, in writing, to reimburse the Fund for such extended disability benefits if Social Security

[2] Including peripheral neuropathy, neurogenic arthropathy or polyneuropathy, with a medical history of frostbite or lCD 250.9 Diabetes with unspecified complication

determines that he/she is disabled and eligible for Social Security benefits during the period he/she receives disability benefits from the Plan. Proof of application to Social Security disability benefits must be provided to the Trustees. The Participant's Bank of Hours will not be frozen during the period of extended weekly disability benefits. Weekly Accident and Sickness benefits will cease when the Participant's Bank of Hours runs out, unless the participant elects COBRA.

Active collectively bargained Participants will have their Hour Bank frozen until they are no longer receiving Weekly Benefits.

Note that monthly contributions from Contributing Employers continue to be due and payable when a non-collectively bargained participant is being paid Weekly Benefits.

AMOUNT OF WEEKLY BENEFIT

A weekly benefit, currently $400, will be payable to you if you satisfy the eligibility requirements. Such amount shall be subject to FICA Taxes and reduced by any requested withholding taxes. The Board of Trustees pays the "Employer" portion of any FICA taxes from the Benefits Fund.

WEEKLY BENEFITS

Weekly Accident and Sickness Benefits will begin on the first day you are unable to work due to an accident, or the eighth day you are unable to work due to an illness, as long as you satisfy the eligibility requirements.

If you are not covered but working in covered employment to become reinstated for benefit and become disabled, you will be offered COBRA coverage.

RESTRICTION ON PAYMENT: OTHER INCOME

In the following situations, your Weekly Benefits will be reduced or eliminated

1. If you are retired and are receiving pension benefits from an I.B.E.W. Pension Fund or Social Security, Workman's Compensation, you are not eligible to receive Weekly Income Benefits from this Fund.
2. If you are receiving benefits via an Automobile No-Fault provision, you will be eligible for Weekly Income Benefits only if the monthly benefit you are receiving under the Automobile No-Fault provision is less than the Weekly Income Benefit payable from this Fund. Under those circumstances, this Fund will pay you the difference between the Weekly Income Benefit and the amount you are receiving from the Automobile No-Fault provisions.
3. If you are receiving recurring periodic disability payments (that is, weekly, monthly, quarterly, annually, and so on) from any I.B.E.W. Pension Fund or Social Security , or you are receiving payments under a Workers' Compensation statute, you will not be entitled to Weekly Accident and Sickness benefits from this Fund.
4. If you are receiving weekly disability benefit from an outside Fund, your employer or your Local Union, this Fund will pay you the full weekly benefit, up to the Fund's maximums and pursuant to all guidelines.

TERMINATION OF WEEKLY BENEFIT

1. You have received 26 Weekly Accident and Sickness benefit payments;
2. Your death;
3. The date you no longer satisfy the eligibility rules for benefits;

4. The date you are determined not to be disabled by your licensed certified medical doctor;
5. The date you are reemployed regardless of part-time or full-time status;
6. The date the Trustees, in their sole discretion, determine that you are able to return to work.

The Trustees have the right to change, limit, or discontinue Plan benefits at any time. The Trustees also have the right to require a Second Opinion from a licensed certified medical doctor selected by the Benefit Fund, which would be paid for by the Benefit Fund. If the Trustees eliminate the Weekly Accident and Sickness benefit, in whole or in part, the effective date of such amendment is the date in which a Participant's accident and sickness benefits terminate.

EXTENSION OF WEEKLY BENEFIT

Effective May, 1, 2009, you may be entitled to an extension of Weekly Accident and Sickness benefits. The conditions for the extensions require that you:

1. Are Totally and Permanently disabled (proof of which must be submitted by your provider and approved by a medical professional selected by the fund),
2. Are entitled to the Weekly Accident and Sickness benefit,
3. Have applied for Social Security disability benefits, and
4. You agree, in writing, to reimburse the Fund for these extended disability benefit, should you be awarded Social Security disability benefits.

SEPARATE PERIODS OF DISABILITY

Separate periods of disability resulting from the same or related causes will be considered one period of disability, unless:

- Separated by your return to active work with a Contributing Employer for more than two (2) consecutive weeks,
- Availability for work pursuant to the rules of your home Union for more than two (2) consecutive weeks.

Separate periods of disability resulting from unrelated causes will be deemed one period of disability, unless separated by your return to active work or you are available for work for at least one (1) full day.

WORK RELATED INJURY

If you are disabled on the job and receive benefits under a Workers' Compensation Law and the Benefits Fund is not receiving contributions on your behalf, the Benefits Fund will freeze your Bank of Hours for the period of time you are receiving either Weekly Disability Income or Workers' Compensation. You will continue to maintain eligibility during this period, up to a maximum of a six-month extension. If you are still disabled after six months, the Benefits Fund will begin deducting 150 hours per month from your Bank of Hours. Once your Bank of Hours has been exhausted, you will be offered COBRA coverage (see "COBRA" Section below).

SECOND OPINION

The Trustees, in their sole discretion, have the right to request a second opinion regarding a Participant's ability or inability to return to work. The Benefits Fund will pay for any such second opinion.

SECTION 3. MEDICAL BENEFITS

Since August 1, 1976, the Fund has administered its own self-funded health plan. Your employer makes payments to the Fund on your behalf under Collective Bargaining Agreements negotiated between the Unions and various employers and employer associations. In addition, you and your family pay a "Copayment" for most covered medical services received within the Network (as described later in this document).

At times, you will be asked for certain additional information pertaining to your claim. Because work-related injuries or illnesses are not covered by the Fund, you will be asked for more information concerning your work-related injury or illness claims. Spouses and Dependents of eligible Participants will be required to submit work and other insurance information. The New England Electrical Workers Benefits Fund requires this information to determine if any other insurance may be liable for claims submitted to the Fund for payment.

OBTAINING INFORMATION ABOUT YOUR MEDICAL CLAIMS

Telephone

Medical claims are processed and paid at the Fund Office. You can obtain information regarding your medical claims by calling the Fund Office between the hours of 8:00 A.M. and 4:30 P.M., Monday through Friday at (800) 832-6538 and with limited access to 5:30

Internet

You may also access your claim information at any time by visiting the Fund Office's web site: www.insuranceprogrammers.com. Click on Member Access (on the right side of the site) and enter your "Login ID," which is the Participant's last name in ALL CAPITAL LETTERS; your "Password" is the last four digits of the Participant's social security number, which you can immediately change. Call the Fund Office between the hours of 8:00 A.M. and 4:30 P.M., Monday through Friday, with limited access to 5:30 at (800) 832-6538 if you need assistance with your on-line login.

PREFERRED PROVIDER NETWORKS (PPO NETWORK)

To reduce and control health care costs, the Fund has contracted with the Anthem Blue Cross Blue Shield "Preferred Provider Organization Network (PPO)." This network allows Participants of the Fund to pick doctors and hospitals from a select group. When you choose providers from this group, you will incur no out-of-pocket expenses, except for your Copayment. This Fund does not require doctor referrals. Please call Anthem Blue Cross Blue Shield's Provider Locator at (800) 810-BLUE to locate an In-Network provider, or use the Internet.

Quick Internet Reference – Please note that Anthem Blue Cross Blue Shield periodically changes the procedures to locate an In-Network Medical or Dental provider, on line. If the following procedures do not work, please call the Fund Office at (800) 832-6538, for assistance.

To locate a MEDICAL Provider that participates with Anthem Blue Cross Blue Shield:

- Go to **www.anthem.com**
- On the right hand side of screen SELECT Find A Doctor

  There are 4 steps on the next screen
  1. Select what you are searching for: Doctors
  2. (can be optional) Select the provider specialty
  3. Select the # of miles and enter your home zip code
  4. Select the first bullet and enter EWQ (EWQ is the first 3 letters of Member ID #)

- Select: Search

To locate a DENTAL provider that participates with Anthem: Go to: www.Anthemlife.com

- Go to **www.anthem.com**
- On the right hand side of screen SELECT Find A Doctor

  There are 5 steps on the next screen
  1. Select Dental
  2. Dental Plan Dentist
  3. Skip Over (is optional)
  4. Select the # of miles and enter your home zip code
  5. a. State: from the drop down box select **Connecticut**. You **MUST** select **Connecticut** as this is the State in which the Plan originated.
     b. Plan Type: Dental Plan
     c. Plan Name: Copayment/Full Pay/Flex Dental

- Select: Search

SCHEDULE OF BENEFITS

The following is a summary of covered benefits provided through the Fund. Use this chart for quick reference when you need these services. In the table below, you will be responsible for any In-Network copayments. For Out-of-Network services, you will be responsible for paying any difference between the portion of the "Reasonable & Customary" amount that the Fund pays. In addition, you may be responsible for any Out-of-Network charges in excess of the "Reasonable & Customary" allowance, up to the actual billed charges.

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: After you pay the Up Front Deductible, the PLAN PAYS
Routine Services		
Pap Smears	$20 Copayment	50% of "Reasonable and Customary" Amount
Gynecological Examinations Age 16 and over; one exam per calendar year	$20 Copayment	50% of "Reasonable and Customary" Amount
Mammogram One mammogram per calendar year	$20 Copayment	50% of "Reasonable and Customary" Amount
Routine Well Baby Care (includes immunizations) Up to 2 years of age	$20 Copayment	50% of "Reasonable and Customary" Amount
Routine Examinations (includes immunizations) Age 2 and over; one exam per calendar year[3]	$20 Copayment	50% of "Reasonable and Customary" Amount
Physical Examination for Federal Commercial Driver License (1 per year) (in lieu of a Routine Examination)	$20 Copayment	You pay: $20 Copayment
Proctoscopy/Sigmoidoscopy	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Prostate Specific Antigen	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Colonoscopy	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Endoscopy	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount

3 There will be no additional copayment required for laboratory charges and/or X-ray charges billed separately in conjunction with an office visit

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: After you pay the Up Front Deductible, the PLAN PAYS
Cardiac Rehab/Phases I, II and III (with documented diagnosis during the preceding 12 months)	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Pulmonary Rehab (with documented diagnosis during the preceding 12 months)	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Gastric Bypass/Lap Band Surgery (when approved by Health Care Strategies as medically necessary)	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Wound Care/Hyperbaric Chamber	$20 Copayment	50% of "Reasonable and Customary" Amount
Neuropsychology Testing (educational testing is not a covered expense)	$20 Copayment	50% of "Reasonable and Customary" Amount
Crisis Intervention	$20 Copayment	50% of "Reasonable and Customary" Amount
Hospital Expenses		
Inpatient (Room & Board and all related charges, including physician, x-ray, lab, etc.) [4]	$150 Copayment per day to a maximum of 3 days per stay ($450[5]). This Copayment covers all services (for example, surgeon, anesthesia, and so on) at facility.	50% of "Reasonable and Customary" Amount
Outpatient (Facility charge; excludes physician charges)	$100 Copayment. This Copayment covers all services (for example, surgeon, anesthesia, and so on) at facility.	50% of "Reasonable and Customary" Amount
Urgent Care Centers/Walk-In Clinics	$50 Copayment	50% of "Reasonable and Customary" Amount
Emergency Room	$75 Copayment. Emergency Copayment is waived if Participant is admitted into hospital	50% of "Reasonable and Customary" Amount

4 The Fund does not restrict benefits or any hospital length of stay in connection with childbirth for the mother or newborn child. This Fund complies with the Newborns' and Mothers' Health Protection Act ("NMHPA").

5 The maximum amount that you will spend for your family in one calendar year is $900 (6 days). Once you have exceeded this amount, any future inpatient stay will have no copayment for the remainder of the calendar year. For purposes of determining an inpatient admission, any readmission that occurs within two calendar days of a discharge will be treated as Part of the original inpatient admission.

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: After you pay the Up Front Deductible, the PLAN PAYS
Pre-admission testing	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Organ Transplants		
Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment, based upon review by HCS 50% of "Reasonable and Customary" Amount		
Note that expenses do not include travel, lodging or food.		
Physicians' Expenses		
Surgery (outpatient services include related charges, such as assistant surgeon, x-ray, lab, etc.)	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Anesthesia	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount[6].
Oral Surgery- Boney Impacted Wisdom Teeth	$20 Copayment	50% of "Reasonable and Customary" Amount
Maternity/Obstetrical Care – Inpatient (participant, eligible spouse or dependent daughter)	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Heart Catherization	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Infertility: Coverage for *in vitro* fertilization, embryo transfer, and artificial insemination. (Office Visit = $20 co-pay) Lifetime Maximum of $20,000 per person.[7]	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Elective Abortion - Outpatient	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Intrauterine Device ("IUD")	$100 Copayment	50% of "Reasonable and Customary" Amount

6 Note: if treatment is provided by an In-Network physician at In-Network facility, Anesthesia will be considered "In-Network"

[7] This plan covers in vitro fertilization, embryo transfer, and artificial insemination, subject to the following limits:

- The lifetime maximum benefit is $ 20,000, regardless of the number of in vitro procedures you undergo.
- Network providers are paid at 100% of the negotiated rate, after you satisfy your Copayment.
- Non network providers are paid at 50% of the Reasonable & Customary charge. The patient is responsible for any balance, up to the member's (or the member's family) maximum annual out-of-pocket amount.
- Any drugs required are not Part of this coverage. Instead, drugs are covered under the "Prescription Drug Fund" portion of this Summary Plan Description.

This benefit excludes coverage of artificial insemination and embryo placement. Other infertility treatments are covered by the Fund. No benefit is payable for experimental procedures or treatment..

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: After you pay the Up Front Deductible, the PLAN PAYS
Voluntary Sterilization (includes physician and hospital expense) Vasectomy Tubal Ligation	Covered by "Inpatient ($150)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Radiation Therapy	Nothing, effective January 1, 2009	50% of "Reasonable and Customary" Amount
Chemotherapy	Nothing, effective January 1, 2009	50% of "Reasonable and Customary" Amount
Office Visits (includes Allergy Treatment)	$20 Copayment[8]	50% of "Reasonable and Customary" Amount
Allergy Treatments where there is no Office Visit	$5 Copayment	50% of "Reasonable and Customary" Amount
Injections to treat a disease or illness (B12 shots, cortisone, etc.)	$20 Copayment	You pay: $20 Copayment
Vaccination to prevent disease (regardless of where vaccination is administered) (Flu shots, shots to prevent disease, shingles, pneumonia, etc.)	$20 Copayment	You pay: $20 Copayment
Therapies • Chiropractic Care • Physical Therapy • Occupational Therapy • Speech Therapy • Massage Therapy[9] (limited to 30 combined visits per calendar year)	$5 Copayment; $20 Copayment for Office Visits	50% of "Reasonable and Customary" Amount
Second and Third Surgical Opinion	$20 Copayment	50% of "Reasonable and Customary" Amount
Diagnostic X-Ray/Laboratory Tests	Nothing	50% of "Reasonable and Customary" Amount
Major Imaging (MRI, CAT Scan, PET Scan, Bone Density, etc.)	$100 Copayment	50% of "Reasonable and Customary" Amount
Ambulance Services	$20 Copayment **only** if charges incurred because of injury or life threatening illness. **The Fund will not pay any ambulance charges for services incurred strictly for the convenience of the patient.**	

[8] Note: Medicare Retirees are responsible for the Thirty Dollar ($20.00) co-payment for routine physical examinations. Should Medicare pay for all or a portion of these charges, the co-payment is waived.

- Licensed midwives are eligible providers.

[9] Massage Therapy is treated as any other therapy, up to the combined thirty (30) visits per calendar year with a $5 copayment. The Fund's current network, Anthem Blue Cross Blue Shield Preferred Provider Network, does not include in-network massage therapists. However, claims from a licensed massage therapist are considered and paid as In-Network.

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: After you pay the Up Front Deductible, the PLAN PAYS
Skilled Nursing/Convalescent Facility		
Inpatient (Room & Board and all related charges, including physician charges, x-ray, lab, etc.); Calendar year maximum of 120 days *combined* In- and Out-of- Network	$100 Copayment	50% of "Reasonable and Customary" Amount
Home Health Care		
Calendar year maximum of 80 visits *combined* In- and Out-of- Network	$20 Copayment	50% of "Reasonable and Customary" Amount
Hospice Care		
	"One Time: $100 Copayment	50% of "Reasonable and Customary" Amount
Bereavement counseling for the immediate family	15 visits payable at 50%	15 visits payable at 50%
Temporomandibular Joint Dysfunction ("TMJ")[10]		
For charges in excess of $1,500 benefits can only be paid if Health Care Strategies determines that the treatment is medical necessity	$20 Copayment	50% of "Reasonable and Customary" Amount
Mental and Nervous Benefit		
Inpatient (Room & Board and all related charges, including physician charges, x-ray, lab, etc.) Calendar year maximum of 60 days combined In- and Out-of-Network Partial Hospitalization considered 2 to 1	$100 Copayment	50% of "Reasonable and Customary" Amount
Outpatient Treatment (includes intensive treatment) Calendar year maximum of 26 visits combined In- and Out-of-Network	$20 Copayment	50% of "Reasonable and Customary" Amount
Alcohol/Drug Addiction Treatment		
Inpatient (Room & Board and all related charges, including physician charges, x-ray, lab, etc.) Lifetime maximum of 60 days combined In- and Out-of-Network Partial Hospitalization considered 2 to 1	$100 Copayment	50% of "Reasonable and Customary" Amount

[10] Medically necessary expenses for the treatment of temporomandibular joint ("TMJ") disorders in excess of $1,000 are covered once medical necessity is determined by Health Care Strategies. Coverage of TMJ appliances and adjustments are included in this benefit. No benefits will be paid for procedures, services, or supplies used to increase the height of teeth such as bridges or crowns.

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: After you pay the Up Front Deductible, the PLAN PAYS
Outpatient Treatment (includes intensive treatment) Calendar year maximum of 30 visits combined In- and Out-of-Network	$20 Copayment	50% of "Reasonable and Customary" Amount
Durable Medical Equipment[11]	$20 Copayment	50% of "Reasonable and Customary" Amount
Dialysis Benefits	Nothing, effective January 1, 2010.	50% of "Reasonable and Customary" Amount
Hearing Care Benefits (See Page 35 for additional information)	You Pay: $20 Copayment per aid; Service from authorized facilities only. Maximum per hearing aid $2,500.	
Vision Care Benefits	For all but Lasik, see schedule on Page 38	50% of "Reasonable and Customary" Amount
Lasik Surgery (includes flexible corrective lenses and conductive keratoplasty)	Fund pays 100% of total cost of surgery to a lifetime maximum of $1,000.	50% of "Reasonable and Customary" Amount up to a lifetime maximum payment of $1,000
Prosthetic Devices	$20 Copayment	50% of "Reasonable and Customary" Amount
Orthotics	$20 Copayment	50% of "Reasonable and Customary" Amount
Acupuncture	$20 Copayment	50% of "Reasonable and Customary" Amount
Nutritional/Educational Services for Diabetes (Maximum 10 visits per calendar year[12]) Additional 2 visits for any other diagnosis	$20 Copayment; benefit applies only to Participants who are diagnosed with diabetes	50% of "Reasonable and Customary" Amount
Feeding Specialist[13] . The Fund provides up to 30 Feeding Specialist visits per calendar year, for any patient who meets the guidelines noted below.	$20 Copayment	50% of "Reasonable and Customary" Amount

[11] The Participant must submit a letter from a physician indicating medical necessity for any major durable medical equipment. Durable Medical equipment includes but is not limited to:

- Hospital Beds
- Wheelchairs
- Prosthetic Devices
- Rental is not to exceed the purchase price

[12] Additional educational sessions, in excess of the Fund's standard ten per calendar year limitation, may be allowed, upon receipt and review of a letter of medical necessity and a detailed educational plan, from the participants' provider.

[13] Applies only in the case where the patient is a triplet with severe gastroesophageal reflux disease who requires a feeding tube as well as profound and significant neurodevelopmental delays presumed secondary to a mitochondrial disorder

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: After you pay the Up Front Deductible, the PLAN PAYS
Wigs or Hair Prosthesis, due to the loss of hair resulting from chemotherapy, radiation therapy, burns, lupus, alopecia totalis, or fungus.	$100 Copayment	$100 Copayment
Prescription Baby Formula (includes Neocate) See Page 37 for additional information	$25 Copayment	$25 Copayment
Naturopath/Homeopathic/Osteopathic services (does not include supplies)	$20 Copayment	50% of "Reasonable and Customary" Amount
Smoking Cessation Program	$20 Copayment	$20 Copayment

PRECERTIFICATION

Precertification through Health Care Strategies (800) 582-1535

The Fund has contracted with Health Care Strategies to provide the Fund and its Active and Non Medicare Retired Participants with a "Precertification" process. The program is designed to help you evaluate the care you need when you are planning an inpatient stay at a Hospital.

Precertification Review

During the precertification review process, Health Care Strategies will help you and/or your Physician answer important questions, such as:

- Is the treatment appropriate for the diagnosed condition or symptom?
- Is the proposed level of care necessary?
- Is there a less risky, medically appropriate treatment alternative?
- Is the proposed treatment or service a covered benefit under this Fund?
- Are the proposed health care providers considered In-Network providers under this Fund?

Of course, any decision regarding treatment is left up to you and your Physician. Precertification review can help you make a more informed decision before undergoing any recommended treatments.

How Precertification Review Works

- Precertification is required for a Hospital admission. If your Physician recommends a Hospital admission, remind him or her that you will need to obtain this precertification.
- You or your Physician should call Health Care Strategies at the precertification phone number (800) 582-1535 before a scheduled treatment. You must call at least one business day before your Hospital admission; you may want to call as early as seven days before you are admitted. If you are admitted to the Hospital on an emergency basis, call the precertification phone number by the second business day following your admission. In most cases, your Physician or the Hospital will make the call for you.

- When you call, the precertification staff will review the diagnosis and the recommended treatment and proposed level of care. They will compare proposed procedures to those of medically accepted guidelines for treating your condition.
- If necessary, the review staff will contact your Physician for additional medical information.
- You, your Physician, and/or the Hospital will be notified in writing of the review decision.

Regardless of Health Care Strategies' decision, if you and your Physician decide to proceed with a medically necessary procedure, you may do so with no financial penalty.

Case Management

As an added benefit, the Benefit Fund contracts with Health Care Strategies to provide participants with Case Management services. If you or one of your dependents are hospitalized, a Nurse Case Manager may call to ensure that you are receiving all of the appropriate medical care, and to answer any questions you may have.

MENTAL HEALTH SERVICES

Inpatient Hospital Benefit

Before receiving Inpatient Mental Health Services, you and your eligible Dependents are required to contact the **Lower Hudson Valley Building and Construction Trades Employee Assistance Program** at (800) EAP-2799 [1-800-327-2799] to ensure that you are receiving the appropriate quality care. Lower Hudson Valley's involvement may also result in a lower out-of-pocket cost for you and your family.

Covered Mental Health Services (excluding alcohol and substance abuse) during a Hospital stay will be made on the same basis as any other illness. Please see the Schedule of Benefits for information regarding any day or visit limitation.

Partial Inpatient Hospital Benefit

Payment for Covered Mental Health Services provided on a Partial Inpatient Hospital basis is considered under the Inpatient Hospital benefit rules. Please see the Schedule of Benefits for information regarding any day or visit limitation.

Outpatient Benefit

You will be responsible for a $20.00 Copayment per visit at an In-Network facility or with an In-Network Provider. You will be responsible for the Deductible and Coinsurance at an Out-of-Network facility or with an Out-of-Network Provider. Please see the Schedule of Benefits for information regarding any day or visit limitation.

ALCOHOL AND SUBSTANCE ABUSE

Inpatient Hospital Benefit

Before receiving Inpatient Alcohol and Substance Abuse treatment, you and your eligible Dependents are required to contact the Lower Hudson Valley Building and Construction Trades Employee Assistance Program at 1-800-EAP-2799 [800-327-2799] to ensure that you are receiving the appropriate quality care. Lower Hudson Valley's involvement may also result in a lower out-of-pocket cost for you and your family.

Partial In-Patient Hospital Benefit

Payment for covered Alcohol and Substance Abuse treatment provided on a Partial Inpatient Hospital basis is considered under the In-Patient Hospital benefit rules. Please see the Schedule of Benefits for information regarding any day or visit limitation.

Outpatient Benefits

You will be responsible for a $20.00 Copayment per visit at an In-Network facility or with an In-Network Provider. You will be responsible for the Deductible and Coinsurance at an Out-of-Network facility or with an Out-of-Network Provider. Please see the Schedule of Benefits for information regarding any day or visit limitation.

IMPORTANT "IN-NETWORK/OUT-OF-NETWORK" NOTICES

"Out-of-Network" Services when there is No "In-Network" Medical Provider

If it can be verified that there is no Medical In-Network Provider within a ***30 mile radius*** of a Participant's home zip code, services rendered by an Out-of-Network Provider within that radius will be considered by the Fund as "In-Network," and the Fund will apply the In-Network benefit rules, including copayments .

"Out-of-Network" Services That the Participant is Not Aware Are "Out-of' Network"

If a Participant uses an In-Network Hospital or Provider, and, without the Participant's knowledge, the In-Network Hospital or Provider uses Out-of-Network services (including but not limited to the reading of a mammogram, diagnostic procedures, ultrasounds, or CT Scans), the initial "Out-of-Network" service will be considered and processed as "In-Network."

To clarify: if a Participant receives services in an In-Network facility and uses the services of an In-Network physician and/or surgeon, on a *non-emergency* basis, all related expenses will be considered and paid as if all services rendered were In-Network. When it is an *emergency*, if a participant receives services in an In-Network facility, all related expenses will be considered and paid as if all services rendered were In-Network.

MEDICAL BENEFITS: DEDUCTIBLES, MAXIMUMS

Annual Cash Deductible/Coinsurance: In-Network

There is no deductible amount for medical services "In-Network." In addition, there is no coinsurance aside from the listed In-Network co-payments for any In-Network services.

Annual Cash Deductible: Out-of-Network

A deductible is payable each calendar year for services "Out-of-Network" according to the following schedule:

Individual Deductible (you pay)..... $400 per year

Family Deductible (you pay)..... $800 per year

When one family member has met the yearly individual deductible in full, deductible amounts incurred by other family members may be combined to meet the family deductible.

Carry-Over Deductible

If you satisfy any portion of the Out-of-Network deductible late in a calendar year, i.e., October, November, and December, the portion that you have satisfied will reduce the Out-of-Network deductible for the next calendar year.

Coinsurance: Out-of-Network

If you use an Out-of-Network provider or facility, you will pay 50% of all Reasonable and Customary charges after you have paid the deductible shown above.

Annual Maximum

For the medical plan, there is a $1,250,000 annual maximum for you and each of your covered Dependents during the 2012 Plan Year. This annual maximum will increase to $2,000,000 on January 1, 2013. On and after January 1, 2014, there will be no limit (that is, the annual maximum will no longer be in effect). This maximum includes the combined total of all Medical Benefits..

Out-of-Pocket Maximum: Out-of-Network and In-Network

There is no Maximum Out-of-Pocket expense for Out-of-Network or In-Network benefits in any calendar year, except for the In-Network Inpatient Hospital Copayments.

SECTION 4. HEARING CARE BENEFIT

The Benefits Fund provides a hearing health care benefit for all active, retired, COBRA, and widow/widower Participants.

PROVIDERS

University of Connecticut - Speech and Hearing Clinic
Telephone Number: (860) 486-2629

University of Maine at Orono - Speech and Hearing Clinic
Telephone Number: (207) 581-2009

University of Massachusetts (Amherst) - Speech and Hearing Clinic
Telephone Number: (413) 545-2565

Northeastern University (Boston) - Speech and Hearing Clinic
Telephone Number: (617) 373-2492

Other Hearing Care Benefit Providers

The Plan will consider as Covered Charges the charges for all services, including hardware, provided by a Provider who participates with the Anthem Blue Cross Blue Shield Nationwide Network, and is contracted to dispense hearing aids if such charges are consistent with fees charged by one of the Speech and Hearing Clinics retained by the Benefits Fund and listed in this Section.

The Hearing Aid benefit for an Anthem Blue Cross Blue Shield audiologist and for all Out-of-Network providers who are not contracted to dispense hearing aids, benefits will be reimbursed at a rate comparable to the rates charged by one of the authorized Speech and Hearing Clinics , listed above, up to the Fund's maximum reimbursement.

Effective February 1, 2009, Cochlear Implant Processors will be considered and paid as an In-Network benefit.

BENEFITS

The Hearing Care Benefit will reimburse you for up to 100% of Covered Charges, after you satisfy a $20 Copayment, per Hearing Aid, from the facilities listed above, only, which include charges for necessary examinations, fittings and hearing appliance(s), and includes:

- Evaluation of hearing loss (once every twenty four (24) months or as recommended by the clinic or a physician)
- The prescribing and fitting of ear molds and hearing aid(s), if appropriate
- Hearing aid(s) and ear molds, as recommended by the clinic's audiologist and purchased through the clinic, up to a maximum of $2,500 per aid.
- Repair or replacement of hearing aid(s) as determined necessary by the clinic's audiologist
- Rehabilitative services

Replacements for lost or damaged hearing aids are not covered.

SECTION 5. PRESCRIPTION DRUG PLAN

SAV-RX PROGRAM

The Fund has contracted with Sav-Rx to administer its prescription drug plan. Your medical identification card includes the Sav-Rx information. The drug program has three "tiers":

1. Generic Drugs,
2. Brand Name Drugs, and
3. Brand Name Drugs with a Generic Substitute.

The benefits in this third category apply when a Participant chooses to receive the brand name drug even though a generic formulation is available.

The Copayments for each of these tiers for both retail pharmacy and mail order pharmacy appear in the following table:

	Retail Pharmacy[14]	Mail Order Pharmacy[15]
Generic	**$10**	**$10**
Brand Names (with no Generic substitute)	**$25**	**$25**
Brand Names with a Generic substitute	**$60**	**$90**

Through the Mail Order Service, you can purchase a 90-day supply of prescription drugs for one Copayment. Please contact the Fund Office for Mail Order envelopes.

Note: If your provider prescribes a controlled substance or an expensive prescription, Sav-Rx is authorized to verify the prescription and there may be a delay in filling that particular prescription.

The following is a brief overview of covered and non-covered items under the Sav-Rx drug plan. Call the Fund Office at (800) 832-6538 for a more comprehensive description of benefits.

Please remember that the Fund will not cover a prescription filled at either Walmart or Sam's Club.

[14] Maximum 30 day supply
[15] Maximum 90 day supply

COVERED DRUGS	NON-COVERED DRUGS
• Analpram-Hc 2.5% Cream • Bee Sting Kits • Certain Diabetic Supplies • Children's Vitamins/Prescription • Cholesterol Lowering Drugs • Diabetic Lancets • Diabetic Tablets • Diaphragms • Federal Legend Drugs • Fertility Drugs (up to a Lifetime Maximum of $20,000) • Glucometers - Diabetic • Imitrex • Immunization Agents (Serum) • Injectable Contraceptives • Insulin by Prescription • Lupron • Mental Health Drugs • Needles and Syringes • Oral Contraceptives • Pre-Natal Vitamins/Prescription • Prescription Birth Control • Ritalin, Adderall • Smoking Deterrent Medications • Prescriptions for Erectile Dysfunction • Injectable Drugs	• Diet Medications • Growth Hormone Therapy • Investigational/Experimental Drugs • Over-the-Counter Medications • Rogaine • Unauthorized Refills

BABY FORMULA

Baby formula that requires a prescription is covered by the Benefits Fund. The Fund requires a $25 Copayment for any such prescription, each time it is filled. After this Copayment, the baby formula is covered at 100% of its cost, directly from the Benefits Fund. This prescription *is not* Part of the Sav-Rx Prescription Drug Program. Baby formula that is available over-the-counter *is not* covered under this Fund. Periodic updates will be requested from the Benefit Fund.

SECTION 6. VISION CARE PLAN

VISION ANALYSIS SERVICES

Vision analysis services include, but are not limited to, the following:

- Case history;
- Visual acuity, near and far;
- External examination, including biomicroscopy or other magnified evaluations of the anterior chamber;
- Objective and subjective examinations - distance and near;
- Binocular measure;
- Opthalmoscopic examination;
- Summary and findings;
- Recommendations

Vision Expense Benefits

Vision Care Benefits are payable **once** per calendar year, unless otherwise specified

Vision Care Benefit	This Fund Pays
Examination (including refractions)	$60.00
Single Lenses (per pair)	$65.00
Bifocal Lenses (includes progressive lenses) (per pair)	$100.00
Trifocal Lenses (includes progressive lenses) (per pair)	$145.00
Frames	$100.00
Contact Lenses (calendar year dollar maximum)	$150.00

Note 1: contact lenses *are not* in lieu of prescription eyeglasses.

Note 2: Safety Glasses *are* in lieu of prescription eyeglasses.

Corrective Eye Surgery

The reimbursement for corrective surgery has a Lifetime Maximum of $1,000 (includes both eyes). Corrective eye surgery, and this limitation, includes coverage for Conductive Keratoplasty and flexible corrective lenses.

Eye Refractions – Medicare Retirees Diagnosed with Diabetes

Effective February 1, 2010, the Plan will cover eye refractions for Retirees who are diagnosed with diabetes, regardless of whether Medicare approves and pays for these services up to a maximum $60.00 benefit, per calendar year.

Limitations

Payment for covered services will be limited in the following manner:

- Payment for a visual analysis, lenses, and frames will be available once each calendar year for each covered person.
- Payment for frames, lenses, and/or contact lenses not supplied by a doctor will be made only if prescribed by a doctor. In such case, payment will be made to the covered person.
- The reimbursement for corrective surgery has a Lifetime Maximum of $1,000 (includes both eyes). The benefit includes coverage for Conductive Keratoplasty and flexible corrective lenses.

Exclusions

- Examinations or materials that are not listed in this Section as a covered service or item
- Any lenses that do not require a prescription
- Replacement of lost, stolen, broken, or damaged lenses, contact lenses, or frames
- The cost of any insurance premiums indemnifying the covered person against losses for lenses or frames
- Sunglasses not requiring a prescription
- Medical or surgical treatment of the eye which would be considered under the Medical benefits of the Plan
- Drugs or any other medication
- Procedures determined by the Fund to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, and tonography
- Services for any condition covered by Workers' Compensation or similar legislation except to the extent required by law
- Services, the cost of which has been recovered in any way pursuant to any insurance claim or claim for damages, including settlement or compromise of such claim; if the Participant may have such a claim in the future, the Plan will not cover related expenses unless the Participant has executed a form consenting to the Fund's lien on any proceeds from such claim and agreeing to reimburse the Fund for any expenses paid by the Fund out of such proceeds
- Services performed before the effective date of coverage
- Services performed after the date the covered person ceases to be covered hereunder except for lenses and frames prescribed before such termination and delivered within 31 days from such date
- Diagnostic x-ray, medical, or pathological examinations.

SECTION 7. DENTAL PLAN

Dental disease exists in nearly everyone and is cumulative in its destructive effect. Delayed oral examinations or poor dental health habits may progress from tooth decay to severe oral complications. More extensive and expensive dental treatment may be the consequence.

The Fund's dental plan described in the following pages has been designed to:

- Encourage diagnostic treatment
- Eradicate existing dental disease
- Provide preventative dental care
- Supply reasonable assistance toward major restoration and replacement services

The dental plan's emphasis is on preventative services such as routine examination, cleaning and scaling of teeth, application of topical fluoride solutions, and prevention of severe tooth destruction or loss of teeth. These preventative measures lessen the need for extensive tooth restoration, or replacement services; treatments that are costly to both the Participant and the Benefits Fund.

Any benefits payable under the medical plan will be excluded under the dental plan.

DENTAL NETWORK

Effective September 1, 2010, members have a new alternative for dental care. The dental plan maximum benefit (as described elsewhere in this document) will remain at $1,500 per year, but the Plan now uses the Anthem Dental Network to take advantage of discounts from Anthem network dentists.

Under this new arrangement, the fees that you are charged by participating dentists will, generally, be lower than those charged by dentists outside the network. If a cleaning normally costs $150, but the Anthem dentist has agreed to charge $100, you'll spend less on this service, and leave you more of the current $1,500 maximum to spend on other dental services. You are not required to change dentists, but if your current dentist is already in the Anthem network, or you do decide to change to a dentist in the Anthem network, your coverage will go further.

To locate an ANTHEM DENTAL PROVIDER who participates with Anthem: Go to: www.Anthem.com

- Go to **www.anthem.com**
- On the right hand side of the screen click on **Find A Doctor**
- Scroll down to **Advanced Search**
- On this next screen: Select from the drop down box on the left hand side of screen **Dental Providers** and then select the Zip Code for the location you are searching
- On this same screen, to the left: click on **Insurance Plan Information** Enter "What state do you live in?" From the drop down box you will always select **Connecticut**, as Connecticut is the State in which this Plan originated. The system will automatically populate the next two fields with **Dental Plan** and **Copayment/Full Pay/Flex Dental**. Click on Search.

- A listing of Dental providers will populate for review or you may print off the list. Always be sure to confirm with the Dental provider that they are participating in Anthem's Copayment/Full Pay/Flex Dental plan.

DENTAL BENEFIT

Calendar Year Maximum $1,500

Benefits Payable	**This plan pays**
Preventative Procedures (Type A)	100%*
Restorative/Surgical Procedures (Type B)	80%*
Prosthodontic Procedures (Type C)	50%*

Orthodontia (Type D) – For Dependent children up to age 19 (Adults are eligible for this benefit if it is deemed medically necessary by the Fund's outside consultant)

Lifetime Maximum $1,500

Benefits Payable 50%*

*of Reasonable and Customary or Anthem's allowance

ELIGIBLE EXPENSES

Eligible expenses are the usual, customary, and reasonable charge for the services for dental care. The usual, customary, and reasonable charge for a service will be the fee charged by the dentist, but only to the extent that the fee is reasonable taking into consideration the prevailing range of fees charged in the locality for similar services by dentists of similar training and experience; and/or up to the Anthem dental allowance.

DENTAL SERVICES RECEIVED ON AN OUTPATIENT HOSPITAL BASIS

In certain instances, under strict guidelines, the Fund will consider the facility and anesthesia charges for a participant or a dependent child, based upon their age and circumstances as well as the services involved, the medical necessity of the situation, and confirmation by Health Care Strategies. In addition, the Fund will consider the facility and anesthesia charges for Participants who have suffered a major accidental injury to sound natural teeth.

TYPE A: PREVENTIVE, DIAGNOSTIC, EMERGENCY OR PALLIATIVE SERVICES / CORRECTIVE SURGICAL PROCEDURES

Once in any five-month period:

- Recall oral examinations
- Bitewing X-Rays
- Prophylaxes
- Topical fluoride application for Dependent Children under age 19

No more than four times in a calendar year:

- Periodontal maintenance/cleaning

Once during any 24-month period:

- One complete initial oral examination, diagnosis, and charting
- Once complete series of X-Rays, or panographic X-Rays

In addition, to the above, as required:

- Emergency or specified examinations
- X-Ray to diagnose a symptom, or to examine progress of a particular course of treatment, other than X-Rays required for root canal therapy
- Required consultations with another dentist
- Emergency or palliative services
- Diagnostic tests and laboratory examinations, other than X-Rays, study models, or similar records prepared for root canal therapy
- Sealants for Dependent Children under age 19
- Provision of space maintainers for missing primary teeth

TYPE B: RESTORATIVE AND SURGICAL PROCEDURES

- Fillings: amalgam, composite, acrylic, or equivalent
- Removal of teeth, other than boney impacted teeth (Boney impacted teeth are covered by the Medical benefits of the Plan
- Preformed stainless steel crowns, and repairs to preformed stainless steel crowns
- Endodontics (root canal therapy)
- Periodontics (treatment of the gums, and other supporting tissues of the teeth)
- Oral surgery and related anesthesia

TYPE C: PROSTHODONTIC PROCEDURES

- Inlays
- Crowns and repairs to crowns (other than preformed stainless steel crowns, which is a Type B expense)
- Bridges or dentures and their repair
- Complete dentures or the rebase or reline of an existing partial or complete denture
- Prosthodontic services - Tooth Loss: The Plan covers treatment for natural teeth that are lost, regardless of when the loss occurred.
- Dental implants

TYPE D: ORTHODONTIC PROCEDURES

Note: these procedures are available to Participants who are under age 19 when received

- Interceptive, interventive, or preventive orthodontic series other than space maintainers, which are a Type A expense
- Fixed appliances for primary or permanent (or a mixture of both) teeth, including diagnostic procedures, formal full-banded treatment and retention
- Removable appliances, for primary or permanent (or a mixture of both) teeth, including diagnostic procedures, removable appliance therapy, and retention

Effective January 1, 2009, for an adult Participant for whom orthodontia is determined to be Medically Necessary, orthodontia coverage will be considered an eligible expense up to the Plan's Lifetime Maximum. The determination of "Medical Necessity" will be confirmed by the Fund Administrator, who will have each diagnosis reviewed by a dental professional.

Note that if you submit proof that you made payment for orthodontia services in full, you will be reimbursed in one payment (up to the Fund's Lifetime Maximum Benefit).

INELIGIBLE DENTAL EXPENSES

The Fund will not pay for any of the following:

- Dental care not included in the list of eligible expenses, or that does not meet the standards of dental practice accepted by the American Dental Association
- Dental care that is furnished while a Participant is confined in a hospital operated by the United States government or any agency thereof, or dental care for which the Participant would not be required to pay if there were no insurance
- Dental care that is provided by employer-related facilities
- Dental care that is provided by a HMO or similar organization
- Dental care that is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists
- Any charges in excess of Anthem's negotiated rate or the usual, customary, and reasonable charge of a less-expensive alternative service or material consistent with adequate dental care, when such alternate services or materials are customarily provided
- Charges for appointments not kept, for completion of claims forms, or for treatment by other than a dental practitioner
- Expenses related to services or supplies normally intended for sport or home use
- Charges, in respect of any dental care directly or indirectly due to or resulting from:
    - War, insurrection, or the hostile action of the armed forces of any country
    - Any cause for which indemnity or compensation is provided under any Workers' Compensation Law or similar legislation
- Charges for
    - Drugs administered by the attending dental practitioner
    - Periodontal splinting
    - Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene, or dental plaque control
- Charges for the treatment of Temporomandibular Joint (this is covered by the medical portion of this Benefits Fund).
- Service received or supplies purchased outside the United States except for Canada.
- Charges for:
    - Replacement of an appliance or prosthetic device, crown, cast restoration or a fixed bridge within five years of the date it was last placed. This exclusion will not apply if replacement is necessary due to an accidental injury received while insured.
    - Duplicate bridges or dentures or any other duplicate dental appliances
    - Replacement of bridges or dentures lost, misplaced, or stolen

- Appliances or restorations to increase the vertical dimensions or restore occlusion or splinting
- Dental care to correct congenital or development malformation
- Charges for bony impacted wisdom teeth are covered under the Medical Benefit.
- Accidental injuries to sound natural teeth are covered by the Medical benefits of the Plan.

SECTION 8. LIFE INSURANCE

Life Insurance protection for you and your family is a significant part of your family's long-term financial welfare. The Fund has contracted with an insurance company to provide Participants with life insurance coverage. In addition, the Fund will provide life insurance coverage to a Participant's Eligible Dependents. The following description summarizes this coverage under the Plan. Additional information is available in the Certificate(s) of Insurance from the contracted insurance company, and from the Fund Office.

BASIS OF INSURANCE

This insurance is provided on a non-contributory basis. Life insurance for Participants is payable through an insurance contract between the Benefits Fund and the insurance carrier. Life insurance to a Participant's Eligible Dependents is paid directly from the Benefits Fund (on a self-Funded basis).

AMOUNTS OF INSURANCE

Active employee $50,000

Dependent spouse of an active employee $5,000

Dependent child of an active employee (over 6 months) $1,000

Dependent child of an active employee (over 14 days, under 6 months) $500

Retired Employee, under age 65 ..... $20,000

Retired Employee, age 65 and older* $10,000

Dependent spouse of a retired employee $2,000

COVERAGE REDUCTION AT AGE 70

*On the January 1 that occurs on or next following the date a Participant attains age 70, the Life Insurance coverage reduces to $5,000.

SECTION 9. ACCIDENTAL DEATH DISMEMBERMENT, AND LOSS OF SIGHT BENEFIT

The Fund provides you with additional insurance in the case of accidental death, dismemberment, and loss of sight. The Fund has contracted with an insurance company to provide Active and Retired Participants with this coverage. The following description summarizes this coverage under this plan. Additional information is available from the Certificate(s) of Insurance from the contracted insurance company, and from the Fund Office.

BENEFITS

You will receive a benefit if:

- You suffer accidental bodily injury while your insurance is in force; and
- A loss results directly from such injury, independent of all other causes; and
- Such a loss occurs within 90 days after the date of the accident causing the injury.

No benefit will be paid for a loss caused or contributed to by:

- Sickness; or
- Disease; or
- Any medical treatment for items (1) and (2) of this Section regarding reasons for which no benefit is payable; or
- Any infection, except a pyogenic[16] infection of an accidental cut or wound; or
- War or any act of war, whether war is declared or not; or
- Any injury received while in any armed service of a country that is at war or engaged in armed conflict.

SCHEDULE OF LOSSES AND BENEFITS

The benefit payable for any loss is shown opposite the loss in the schedule below. The "Maximum Benefit" is the amount of life insurance described in the "life insurance" Section of this Summary Plan Description. No benefit is payable for any item not shown in the schedule below.

Description of Loss	**Benefit**
Loss of Life	Maximum Benefit
Loss of a hand	One-half of Maximum Benefit
Loss of a foot	One-half of Maximum Benefit
Loss of an eye	One-half of Maximum Benefit
More than one of the above, resulting from one accident	Maximum Benefit

Loss of a hand or foot means that it is completely cut off at or above the wrist or ankle joint. Loss of an eye means that sight in the eye (a) is completely lost and (b) cannot be completely recovered or restored.

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SECTION 10. EXCLUSIONS AND LIMITATIONS

This Fund does not pay benefits or costs for any of the following:

- Surgical procedures, services, supplies, or appliances that are experimental and/or not generally accepted, as determined by the Outside Fund Professional
- Services that are not medically necessary to diagnose or treat an illness, injury, symptom or complaint, as determined by the Benefit Fund's Outside Fund Professional.
- Claims submitted more than one year from the date of service
- Over-the-counter medical supplies including non-prescription drugs or medications
- Nutritional supplements, vitamins, and weight loss/gain diet programs, or medications
- Over-the-counter baby formula (prescription baby formula *is* a covered expense under the medical benefit).
- Muscle enhancement drugs
- Physician telephone calls in lieu of an office visit
- Exercise, aerobic, meditation programs and gym memberships
- Routine foot care by a podiatrist such as trimming of corns and calluses, except for participants diagnosed with diabetes.
- Reversals of vasectomies or tubal ligations
- Services related to the procurement or storage of donor sperm, sperm banks, embryo storage, embryo freezing and charges related to surrogate mothers
- An injury, illness, or disease suffered while in the military service or resulting from such military service
- Any treatment or charge incurred while the covered person is incarcerated in a county, state, or federal prison.
- Psychiatric services for a condition that is not a mental disorder
- Any breast reduction or implant surgery for other than reconstructive surgery that is medically necessary following mastectomy for female Participants. Note that such medically-necessary breast reduction surgeries are covered under this plan.
- Any breast reduction or implant surgery for teenage male participants, unless such breast reduction surgery deemed medically necessary by the Benefit's Fund outside consultant.
- Cosmetic surgery or plastic surgery, removal of tattoos, face lifting, rhinoplasty, and similar cosmetic procedures unless:
    - Treatment or surgery rendered by a licensed physician for injuries sustained in a non-occupational accident while covered for benefits by this Fund that has resulted in a functional defect

    - Treatment or surgery for a congenital disease or anomaly that has resulted in a functional defect

- No benefits are available for services that are meant only to change or improve your appearance. This includes cosmetic, reconstructive, or restorative services intended to improve your emotional outlook or to treat your mental disorder.
- Charges for which the covered person is entitled to benefits under any other group medical plan which is primary
- Any charges related to an act or omission by another person and the Participant has not complied with the lien reimbursement and subrogation procedures or notice requirements for benefits described on Page 55 within one year of the date that such compliance is requested
- Charges incurred because of a court order; such as: drunken driving programs, substance abuse programs, spousal/child abuse counseling programs
- Any charge exceeding the Reasonable & Customary value of such services and supplies as determined by the Trustees of the Fund
- Blood testing for marriage or paternity tests
- Personal comfort items including, but not limited to, telephone, radio, television, air conditioners, saunas, non-prescription items, or personal care services
- Special home construction to accommodate a disabled person
- Expense of travel, whether or not prescribed by a physician
- Hypnosis and Bio-feedback
- Core evaluations, intelligence testing, services for Chapter 766 eligibility/early intervention services
- Custodial care, including room and board charges in a nursing home, rest home, hospice, old age home or in a school like setting
- Custodial, education or training, and/or room and board charges in a facility primarily for the physically or mentally challenged
- Charges that the insured individual is not required to pay
- Charges incurred before the effective date of coverage under the Fund, or after coverage is terminated
- Any expenses or charges incurred in connection with sex changes or sexual dysfunction (except for certain prescriptions covered by the prescription drug benefit)
- Any hospital, medical or dental treatment services, or supplies payable by an insurance carrier under a compulsory plan of "No Fault" automobile insurance. If you live in a state that requires you to have "No Fault" automobile insurance, this exclusion will apply even if you do not have such coverage.
- An illness, injury, or disease which the Benefits Fund determines arose out of and in the course of your employment unless you have filed a Workers' Comp. claim (or similar state

law claim) and your employer has denied liability and you have complied with the lien reimbursement and subrogation procedures or notice requirements as described on Page 55 for benefits within one year of the date that such compliance is requested

- Any treatment, surgery, medicines, supplies or drugs not approved by the American Medical Association and/or the Federal Drug Administration
- Child birthing classes; breast pumps
- Services provided by an immediate family member
- Any medical charges incurred because of committing or attempting to commit a felony or felonious act
- Wigs or hair prostheses, unless prescribed due to loss of hair resulting from chemotherapy, radiation therapy, burns, lupus, alopecia totalis, or fungus
- Corrective shoes, back supports, pillows, and mattresses
- Procurement and storage of blood and DNA
- Services not covered by the Benefit Fund's stop loss carrier

SECTION 11. PLAN AMENDMENT AND INTERPRETATION

The Trustees reserve the right to change from time to time or to discontinue all or any part of the Fund, including but not limited to the right to change eligibility requirements or benefits for Participants and Dependents, including Retirees, whenever, in the sole judgment of the Trustees, conditions so warrant. The Trustees also reserve the right to adopt and amend from time to time any rules, policies or regulations they may deem appropriate.

The Trustees shall have complete and exclusive discretionary authority to:

- Determine eligibility for benefits ; and
- Construe and interpret the terms of the Fund (including ambiguous or disputed terms) and any other instruments, forms, policies, or other matters of the Trust or relating to such Trust including but not limited to the terms of this Fund document. Such decision, construction, or interpretation by the Trustees shall be binding upon each Participant, Dependent, and beneficiary.

SECTION 12. COORDINATION OF BENEFITS

In many families today both the husband and wife work and are covered under more than one group health plan. In many instances, this results in duplication of coverage: two plans pay benefits for the same hospital and medical expenses. Duplicative payments could result in a loss of health care dollars to the Fund. For that reason, the Fund has adopted a Coordination of Benefits ("COB") provision. Under the Coordination of Benefits provision, if you or your Dependents are also covered under another group health plan, the total payment received from all such programs combined for a claim may not amount to more than 100% of the allowable expenses. For example, if your spouse who is covered by another plan incurs a $1,000 charge, your spouses' plan allows $800 and pays at an 80% coinsurance rate (or pays $640.00). When the claim is received by the Benefits Fund it is determined that the Anthem Allowance would have been $850, therefore, the Benefit Fund will pay the difference between the Primary Insurance Allowance of $800, making a payment of $160.00. Allowable expenses are any necessary and reasonable expenses for medical services or supplies covered by one of the Funds under which the individual is insured. This Coordination of Benefits is designed to conserve health care costs and insure that providers are not overpaid. **If used correctly, the Coordination of Benefits can reduce your out-of-pocket costs for health care**.

Participants must report any duplicate group health coverage for themselves or Dependents to the Fund Office.

WHO PAYS FIRST

1. The Fund with no Coordination of Benefits provision pays first. The Fund with a Coordination of Benefits provision is secondary.
2. The Fund that covers the Participant based on his or her employment pays first. If your spouse has a group health plan through your spouse's employer, that plan would pay first for your spouse, even if your spouse is covered as a retiree and even if that plan is a "reimbursement plan."
3. If both your plan and your spouse's plan cover your children, the plan of the parent whose birth date (month) falls first during the year will pay first. This is the "Birthday Rule."
4. If a child's parents are divorced or separated, the parent's plan will pay in the following order:
    a. First, the plan of the parent who has financial responsibility for the child's health care expense pursuant to a Qualified Medical Child Support Order ("QMSCO"), court decree or administrative order;
    b. Second, the Fund of the parent with custody of the child;
    c. Third, the Fund of the step-parent married to the parent with custody of the child; or
    d. Fourth, the Fund of the parent not having custody of the child;
5. The Fund that insures the Participant against a particular injury (e.g. sports insurance) will pay first when treatment is sought for such an injury covered under that plan.
6. This plan will not provide coverage if the plan that covers the Participant or Dependent first has denied coverage because the Participant or Dependent has not complied with that plan's rules.

MEDICARE: COORDINATION

If You are Working in Covered Employment

If you or any of your Dependents are eligible for Medicare;

And you remain eligible for benefits from the Fund because you are working in Covered Employment and contributions are being made to the Fund on your behalf by your employer pursuant to a Collective Bargaining Agreement or other document;

Then the Fund will continue to pay for your benefits and your Dependents' benefits as the primary payer (pursuant to the other Coordination of Benefit rules and other provisions of the Plan) UNTIL you retire. After you retire or after 104 weeks of disability, Medicare will be the primary payor.

However, if you (or your Eligible Dependent) are eligible for Medicare solely because of "end stage renal disease" ("ESRD") and your employer employs 20 or more individuals for each day of 20 or more calendar weeks in the current and previous calendar years, the Plan will pay as primary for the first 30 months of such eligibility. After 30 months, Medicare will be the primary payor.

If You are Retired

Medicare is the primary carrier for retirees and/or spouses age 65 and over who are otherwise eligible for Medicare. With the exception of prescription drug claims, retirees and/or their spouses who are covered by the Medicare Supplemental Benefit Program must first submit their hospital and medical claims to Medicare. Upon payment of the expenses, Medicare will electronically send your claim to the Fund Office, as long as the Fund Office has your Health Insurance Claim (HICN) Number and the provider has the Medicare Crossover number, which is CB00180. Please see the "Medicare Crossover" Section following this Section.

MEDICARE CROSSOVER

IMPORTANT: If you are retired and on Medicare you must provide the Fund Office with your Health Insurance Claim (HIC) Number. The easiest way to inform the Fund Office is to send in a copy of your Medicare Card. The HIC Number is on the front of the card and consists of nine (9) numbers immediately followed by a letter. All nine (9) numbers and the letter are required by the Fund Office to ensure that Medicare knows that you are participating in the New England Electrical Workers Benefit Fund Medicare Supplemental Program.

Please give your medical providers the Medicare Crossover Number, which is CB00180. This number will identify you to Medicare so that they will electronically send your claims to the Fund Office.

Unlike the Coordination of Benefits provisions for Participants covered by the Plan based on active employment, Medicare is considered "Primary" (pays first) for covered medical and hospital expenses for Retirees. Your retiree benefits through the Benefits Fund are "Secondary" (pays second). The benefits provided under the Retiree Medicare Supplemental Benefit Program will be coordinated with the benefits payable under Medicare for the same expenses. If a retiree or spouse of a retiree is 65 or over, or otherwise eligible for Medicare, reimbursement will first be made under Medicare. If there are any unpaid covered expenses remaining, the Fund will pay these expenses at 100%, including Medicare deductibles, subject to the limitations and exclusions of this Fund.

It is important to note that the benefit levels, limitations, and exclusions for Medicare Part A and B coverage are subject to change by the Federal Government. The Benefits Fund shall only reimburse under Medicare rules in effect at the time you or your spouse incurs the claim.

The Fund requires Retired or Inactive members to purchase BOTH Medicare Part A and Part B when they become eligible. If a member is eligible to purchase Medicare and does not, t**he Fund will not provide Medical Coverage for either Medicare Part A or Medicare Part B services until the retiree shows proof of Medicare coverage.**

SECTION 13. ASSIGNMENT AND SUBROGATION

The Fund is a self-funded "employee welfare benefit plan" as that term is defined in ERISA and, as such, it is governed by rules of ERISA. ERISA pre-empts any state law purporting to restrict the Fund's rights to reimbursement as outlined below.

The Fund does not cover any expenses related to an injury, illness, or loss due to an accident or other occurrence that is the result of an act or omission by another person. This exclusion applies if the injury, illness or other loss occurred during or prior to coverage under the Fund. However, the Trustees, in their sole discretion, may advance payment for such expenses if certain preconditions are met, as outlined below.

If the Fund incurs expenses related to such an illness, injury, or loss, the Fund has the right to be fully reimbursed from, and holds a lien on the proceeds of any recoveries, settlements, or judgments obtained by the Participant or Eligible Dependent against any another person or insurance carrier, however described or allocated. The plan shall be reimbursed from recoveries, settlements, or judgments to the full extent of its expenses (ahead of the Participant, his or her attorneys, and any other person and without reduction for attorney's fees or other costs or expenses and without regard to the "common fund" doctrine). Such recoveries, settlements, or judgments shall constitute plan assets to the extent of the benefits paid or to be paid by the Fund, and any person in possession of such assets shall hold them in trust for the Fund. The requirement to repay the Fund and the Fund's lien apply whether or not:

- Proceeds are received by you or by someone acting on your behalf, such as your attorney;
- Proceeds make you whole for all of your damages and medical expenses; and
- Proceeds are received by way of settlement, judgment, payment from an insurance company or individual, arbitration award or administrative decision.

The requirement to reimburse the Fund and to honor the Fund's lien also applies if you receive or are entitled to receive payment under any no-fault, underinsured, or uninsured motorist insurance policy or from a homeowner's insurance policy.

When automobile insurance, including no-fault, is mandated by state law and you do not have it, the Fund will consider your claim as if you did have it and determine your eligibility for benefits accordingly.

Any Participant acknowledges that these reimbursement, assignment and subrogation rules are binding upon the Participant, his or her attorneys, or the agents, assigns or heirs and executors of the Participant. The Participant is required to pay his or her legal expenses and the Participant is required to notify his or her attorney of these provisions and assignment.

IF YOU INCUR CLAIMS BECAUSE OF A THIRD PARTY

In order for the Trustees to consider advancing benefits to you and/or your Eligible Dependent related to such an injury, illness, or loss, you are required to notify the Fund Office within seven (7) days (or a reasonable time frame) of the accident or other occurrence. You and/or your Eligible Dependent must complete such forms, including a "Reimbursement Agreement and Consent to Lien" form, and supply such information as may be requested by the Fund Office. If you or your Dependent retains an attorney, he (and any successor) must also sign the "Reimbursement Agreement." If you do not initially hire an attorney, but change your mind and subsequently retain one, you must inform the Fund immediately and he must sign a "Reimbursement Agreement." A "Reimbursement Agreement" executed by you and/or your Dependent and attorney, if you have retained one, is binding upon you, your Dependent and attorney. The Fund will

not pay claims arising from the accident or other occurrence if you, your Eligible Dependent, and your attorney do not complete such forms or provide such information as is required by the Fund.

However, the failure of any Participant or attorney to sign any form shall in no way affect the Fund's right to enforce these provisions and to be reimbursed from the proceeds of any recoveries, settlements, or judgments, as described above. By accepting benefits from the Fund, you agree to reimburse the Fund and to the terms of this and all other provisions of the Fund. The Participant or Eligible Dependent is required to notify the Fund Office of any claim made by the Participant or Eligible Dependent for damages or other recovery against another person or insurance carrier. The Participant is required to notify the Fund Office immediately of any recoveries, settlements, or judgments recovered against any source (for example, the person at fault, any insurance company, etc.). The Fund shall be reimbursed from such recoveries as stated herein.

SUBROGATION RULES / SUBROGATION AGREEMENT

If the Fund incurs expenses on behalf of a Participant or Eligible Dependent who suffers an injury, illness, or loss due to an accident or other occurrence that is the result of an act or omission by another person, the Fund shall subrogate to any rights of the Participant or Eligible Dependent to the extent of such expenses. The Trustees may intervene in or be subrogated to any related claim or cause of the Participant may have against another person or insurance carrier in order to secure reimbursement of the Fund's expenses.

ASSIGNMENT RULES

By accepting payment of work-related claims or claims related to an injury, illness, or loss due to an accident or other occurrence that is the result of an act or omission by another person, you and/or your Eligible Dependent agree to assign your rights to receive payment of any recoveries and/or the proceeds from any settlement, judgment or administrative decision to the Fund.

ENFORCEMENT PROCEDURES AND REMEDIES

In addition to any legal or equitable remedy that may be available under applicable law, the Trustees may exercise the following remedies if a Participant fails to comply with the rules herein:

- Refuse to pay any benefits related to the Participant's injuries or illness;
- Disqualify the Participant from participating in the Fund;
- Recover from the Participant benefits already paid through deducting any overpayments from claims otherwise payable. The Trustees may also offset claims payable to any Eligible Dependent of the Participant. In regard to an Eligible Dependent, the Trustees may also offset claims payable to any other Eligible Dependent or the Participant;
- Assess interest on the outstanding benefits or the amount of claims paid at a rate of 12 percent per annum, compounded annually, until paid, or
- In the event the Trustees institute litigation to enforce these provisions, the Participant, and any other responsible person, shall be required to pay the Fund's costs and attorneys' fees, liquidated damages, any investigation fees, in addition to the costs of the claims and interest.

Any recoveries, settlements, or judgments against another person or insurance carrier resulting in reimbursement to the Fund shall be considered the final resolution of all claims related to that injury, illness, or loss. The Fund will not be responsible for any subsequent expenses related to the accident or other occurrence.

WORKERS' COMPENSATION

The Fund does not cover expenses directly or indirectly related to a work-related injury, illness, or loss, unless the Workers' Compensation Commission denies the Participant's claim. Any such expenses you or your Dependent may incur must be submitted through your employer for Workers' Compensation coverage.

The Board of Trustees, in their sole discretion, may advance payment for such expenses if you provide the Fund Office with a copy of the notice that your employer is contesting liability for these expenses in addition to complying with all other provisions of this Section.

NO-FAULT

The following applies to Participants and Eligible Dependents in states that have a no-fault insurance law. If you or your Dependent are involved in an automobile accident in a state where there is a no-fault insurance law, your automobile insurance carrier will be liable for lost wages, medical, surgical, hospital and related charges and expenses up to the greater of:

1. The maximum amount of basic reparation benefit required by applicable law; or
2. The maximum amount of applicable no-fault insurance coverage in effect.

The Trustees may, in their sole discretion, consider payment of any excess charges and expenses under the provisions of the Plan, if you comply with all applicable provisions of this Section.

The Trustees may promulgate rules and regulations to govern procedures hereunder.

SECTION 14. GENERAL INFORMATION

CARRY-OVER OF DEDUCTIBLE

If you have not met your annual Out-of-Network deductible by December 31 of any year, any charges that would be applied to the yearly Out-of-Network deductible and were incurred in October, November, or December of that year will be applied towards your deductible for the following year.

The Out-of-Network deductible amount is subject to change based upon the discretion of the Trustees. You will be notified by the Fund Office of any plan changes.

OUT-OF-COUNTRY MEDICAL CHARGES

If a Participant is on vacation or lives outside the United States, all claims submitted by the Participant or the Participant's Eligible Dependents are considered and paid as "Out-of-Network," except for any emergency services.

All emergency care received outside of the United States will be considered and paid as "In-Network".

If you are traveling out of the country and use the services of a hospital, physician, or other covered medical provider, you may be required to pay for them yourself. When you make payment please obtain itemized bills that are written in both the foreign language and in English. The Fund Office may reimburse you if the services are covered under the Fund.

RIGHT OF RECOVERY

If the amount of payments made by the Fund is more than it should have paid under this Summary Plan Description, the Fund may recover the excess. The Trustees may recover from you, your spouse, or Eligible Dependent any overpayments or payments made in error because of any misrepresentation or failure by you, your spouse, or Eligible Dependent to notify the Fund Office as requested in the Fund. The Trustees may, in their discretion, set off any amounts you, your spouse or your Eligible Dependent owe to the Fund or to which the Fund has a right of recovery against payment of medical or other benefits to which you, your spouse or Dependents may be otherwise eligible, until all amounts owed the Fund have been recovered.

CHANGE OF STATUS

Please notify the Fund Office of any change in your family status: when you get married, have a new baby, adopt a child, there is a death, you get a divorce or a legal separation. The Fund requires a copy of all documents to support this change: your marriage certificate, a baby's birth certificate, etc. When you divorce, the Fund requires a copy of the certificate of divorce. Your former spouse may then elect to continue coverage under the Plan's COBRA rules. If you wish to change your beneficiary, please notify the Fund Office in writing so that we can supply you with the proper cards.

When you change your address, you must notify the Fund Office in writing with a copy of a Photo ID.

SECTION 15. HOW TO FILE A CLAIM

Remember, as a Participant, you have agreed to be bound by the Fund's rules and regulations described in this booklet and implemented by the Board of Trustees.

A claim for benefits is a request made in accordance with these claims procedures for the Fund to pay benefits as outlined in this Summary Plan Description. General inquiries about the Fund's provisions or eligibility questions that are unrelated to any specific benefit claim or requests to add or improve the Plan's benefits are not be treated as claims for benefits. In addition, a request for proof of coverage of a benefit is not a claim for benefits.

The Fund Office processes all claims under the Fund. In the vast majority of cases, your provider(s) will bill the Fund directly. If they do not and you have incurred an expense that is covered under the Fund, send the claim form that you get from your provider(s) to the Fund Office. If you do not have a claim form, please contact the Fund Office.

The following procedure applies to medical **Pre-Service Claims**, **Post-Service Claims**, **Concurrent Claims**, and **Urgent Care Claims**, as well as claims for Disability Benefits, Life Insurance, Accidental Death & Dismemberment, Death Benefits and disability determinations:

CLAIMS FROM PARTICIPANTS

In rare instances, you will file a claim for benefits from the Fund, for instance, if you paid a provider directly and are seeking payment of the benefit from the Fund. In most circumstances, providers will bill the Fund, directly. Generally, if you receive bills or statements from a provider for more than the appropriate Copayment, please call the Fund office.

All of the following information must be completed on the claim form you submit in order for your request for benefits to be a claim, and for the Fund to be able to process your claim:

- Participant's name and Alternate Identification Number
- Participant's address
- Participant's date of birth
- Participant's marital status
- Spouse's name and social security number (if applicable)
- Spouse's date of birth and employment status (if applicable)
- Name, address and telephone number for Spouse's employer
- Patient name and address (if different from Participant)
- Patient's relationship to Participant
- Patient's date of birth
- Patient's sex
- Patient's student status
- Was condition related to patient's employment, or accident?
- Date of service
- Date patient able to return to work
- Date of total/partial disability
- Hospitalization dates, if applicable

- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology*, Fourth Edition or later, as maintained and distributed by the American Medical Association)(your provider will give you this information)
- ICD-9 (the diagnosis code found in the *International Classification of Diseases*, 9th Edition or later, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services)(Your provider will give you this information)
- Billed charge, amount paid and balance due
- Federal taxpayer identification number (TIN) of the provider
- Provider billing name and address
- Coordination of benefits information

The Fund Office will not accept photocopies, unless the copies are being submitted to document payment from a primary insurer when the Fund is secondary.

Your spouse or an authorized representative may complete the claim form for you, if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. If you need one, a form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care claim without your having to complete the special authorization form.

You are responsible for reviewing the Explanation of Benefits statement (EOB) you receive every time a benefit is paid to you or to your provider. In the event the EOB reflects expenses for services you do not believe you received, you must contact the Fund.

CLAIMS FROM NETWORK PROVIDERS

Claims from providers participating in the medical and mental health/substance abuse provider networks are submitted to the Fund through the network. It is not necessary for you to submit a claim to the Fund.

Network claims are paid directly to the provider. However, the provider may require you to pay Copayments, at the time the services are provided.

CLAIMS FROM NON-NETWORK PROVIDERS

Claims from providers who are not participating in the Fund's provider networks should be submitted by that provider according to the instructions on the back of your identification card. Please tell your Non Network Provider to clearly mark the claim as OUT OF NETWORK before sending it to the Fund Office.

WHEN CLAIMS MUST BE FILED

Claims must be filed within twelve (12) months from the date the charges were incurred. However, all claims for benefits should be submitted as soon as possible. No claim will be paid if first submitted more than twelve (12) months after you received treatment or, in the case of Disability benefits, more than six (6) months after you lost income because you could not work.

In the event that a claim is denied for lack of information, you will be informed of the additional information necessary to complete the claim. You must submit the requested information no later than twelve (12) months after the date that it was requested. No claim will be paid if the Fund receives this information more than twelve (12) months after it is requested.

Claims for a Death Benefit are not subject to the twelve (12) month claim filing period. The beneficiary of a Death Benefit available under the Fund, or his representative, should send a certified copy of the death

certificate to the Fund Office. In addition, if the beneficiary is the spouse of the deceased, a copy of a marriage certificate must be submitted to the Fund, as well. If the beneficiary is the parent of the deceased, a birth certificate must be submitted.

WHEN A CLAIM IS CONSIDERED RECEIVED BY THE FUND

A *Post-Service Medical, Disability, Accidental Death & Dismemberment or Death Benefit Claim* is considered received on the first business day when the claim is received by U.S. mail or hand-delivered to the Fund Office, or, on the first business day when the claim is received electronically by the Fund Office.

Concurrent, Pre-Service and Urgent Care Claims are generally requests for pre-certification of a treatment or hospital stay. (The Plan does not require pre-certification of any services.) A Concurrent, Pre-Service or Urgent Care claim is considered received when a telephone call is made to the Fund Office at the telephone number in this SPD, or your provider electronically contacts the Fund Office at its electronic address requesting pre-certification.

DEFINITIONS OF CLAIM TYPES

These definitions are also include in SECTION 25 Definitions

Concurrent Claim A claim for additional treatment or hospital days that is being considered concurrently with the provision of treatment and results in a reduction, termination, or extension of a benefit. It also means a claim that is reconsidered after an initial approval was made. (An example of this type of claim would be an inpatient hospital stay originally approved for five days that is reviewed at three days to determine if the full five days is appropriate.)

Post-Service Claim A claim that is not a Pre-Service, Urgent Care, or Concurrent Claim (for example, a claim submitted for payment after the services or treatment have been obtained).

Pre-Service Claim A claim for a benefit for which pre-approval of the benefit (in whole or in part) is required before medical care is obtained. The Fund does not require pre-certification for any services.

Urgent Care Claim A claim for pre-certification of benefits for treatment that, if not received, (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (2) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

SECTION 16. ADVERSE BENEFIT DETERMINATIONS

If you believe benefits provided for under the Fund have been improperly denied or if your eligibility was improperly rescinded, you are entitled to a full and fair review of your claim.

Notice of Claim Denial

If a claim for Fund benefits is denied, in whole or in part, or if your eligibility is rescinded, the Fund, with the authority granted by the Board of Trustees, will give written notice to the claimant of such denial or rescission. Such notice will include the following:

1. A clear explanation of the reason for the denial or rescission;
2. Reference to the specific provisions of the Summary Plan Document (this booklet) or amendment, where appropriate, on which the denial or rescission is based;
3. A description of any additional material or information, if necessary for you to pursue your claim and, where appropriate, explanation of why the material or information is necessary; and
4. An explanation of the Fund's claim review procedure, including applicable time limits, a statement of your right to sue under Federal law following an adverse determination or review, and a statement that you may make an appeal if your claim is denied, if your eligibility has been rescinded or if you have not been notified of action taken on your claim within the applicable time period.

Request for an Appeal

In the event that an eligible Participant is denied a benefit or claim, in whole or in part, or if eligibility is rescinded, the Fund will follow this notice and appeal procedure:

1. The Fund will notify the Participant of the denial or rescission in writing by First Class United States mail, addressed to the Participant's last address on record with the Fund, within the period of time after the denial of the benefit or rescission of eligibility shown on the table on Page 63 of this SPD. Such notice will include the specific reason or reasons for the denial and will be written in a manner anticipated to be understood by the Participant.
2. The Participant (claimant) will have 180 days following receipt of notification of the denial or eligibility rescission to file an appeal. Such appeal shall be made by letter addressed to the Fund Office.
3. The claimant's letter of appeal must state, in general terms, the grounds on which the appeal is being made and what is considered to be erroneous in the original decision. The claimant also may submit written comments, documents, records, and other information relating to the claim. Claimants shall be provided, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the claim. The claimant will be advised within 10 days of the receipt of the letter of appeal when the Board of Trustees is scheduled to review the appeal.
4. The Fund will provide, free of charge, any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the appeal, as soon as possible and sufficiently in advance of the date on which the Trustees will review the appeal to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the Trustees can act on an appeal based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which

the Trustees must act on the appeal to give the claimant a reasonable opportunity to respond prior to that date.

5. The Board of Trustees will make a final decision within the period of time after the receipt of the appeal shown on the table that follows. If the appeal is denied, the denial will contain the same information as described above for an initial adverse benefit decision.

The Fund is required to maintain your coverage until a decision is made on your appeal of a rescission. If you are not notified within the appropriate time period of the action taken of review of your appeal, you may treat the appeal as "denied" and may initiate a lawsuit as described under "Your Rights under ERISA," beginning on Page 68.

Time Limits for Claims

	Health Claims	**Disability Claims**	**All Other Claims**
Notice of Failure to Follow Claims Procedure for Filing a Pre-Services Claim	N/A	N/A	N/A
Notice of Incomplete Claim	N/A, but may extend deadline for initial claim decision by 15 days	N/A, but may extend deadline for initial claim decision twice, for periods of up to 30-days each	N/A, but may extend deadline for initial claim decision by 90-days
Claimant Furnishes Missing Information	At least 45 days	At least 45 days	N/A
Fund Notice of Initial Claim Denial Decision	**30-days** after receiving the initial claim **45 days** after receiving the claim if Fund needs more claimant information and if Fund provides an extension notice during initial 30-day period.	**45 days** after receiving the initial claim **75 days** after receiving the claim if Fund needs more claimant information and if Fund provides an extension notice during initial 45-day period. **105 days** if Fund needs another extension	**90-days** after receiving the initial claim **180 days** after receiving the claim if Fund needs more claimant information and if Fund provides an extension notice during initial 90-day period.
Claimant Deadline to Complete Non-Urgent Claim	**45 days** after receiving extension notice	**45 days** after receiving extension notice	**N/A**

Time Limits for Claims			
	Health Claims	**Disability Claims**	**All Other Claims**
Claimant Deadline to Appeal Decision	**180 days** after receiving claim denial	**180 days** after receiving claim denial	**60 days** after receiving claim denial
Trustees Action on Appeal on Post Service Claims	**No later than date of meeting of Board of Trustees next following Fund Office's receipt of appeal request.** If appeal request is received within 30-days of the next meeting, determination will be made by date of second meeting next following receipt of appeal request. If extension of time is needed, then decision will be made by date of the third meeting following receipt of appeal request.	**No later than date of meeting of Board of Trustees next following Fund Office's receipt of appeal request.** If appeal request is received within 30-days of the next meeting, determination will be made by date of second meeting next following receipt of appeal request. If extension of time is needed, then decision will be made by date of the third meeting following receipt of appeal request.	**No later than date of meeting of Board of Trustees next following Fund Office's receipt of appeal request.** If appeal request is received within 30-days of the next meeting, determination will be made by date of second meeting next following receipt of appeal request. If extension of time is needed, then decision will be made by date of the third meeting following receipt of appeal request.
Trustees Action on Appeal on Concurrent Claims	**Within 30 days**	**N/A**	**N/A**
Trustees Action on Appeal on Pre Service Claims	**Within 30 days**	**N/A**	**N/A**
Trustees Action on Appeal on Urgent Claims	**Within 24 hours**	**N/A**	**N/A**
Fund Notice of Appeal Decision on Post Service Claims	**As soon as possible, but no later than five (5) days from the date the appeal is acted upon**	**As soon as possible, but no later than five (5) days from the date the appeal is acted upon**	**As soon as possible, but no later than five (5) days from the date the appeal is acted upon**

Time Limits for Claims			
	Health Claims	**Disability Claims**	**All Other Claims**
Fund Notice of Appeal Decision on Concurrent Service Claims	**As soon as possible, but no later than 30 days from the receipt of the appeal**	**N/A**	**N/A**
Fund Notice of Appeal Decision on Pre-Service Claims	**As soon as possible, but no later than 30 days from the receipt of the appeal**	**N/A**	**N/A**
Fund Notice of Appeal Decision on Urgent Care Claims	**As soon as possible, but no later than 24 hours from the receipt of the appeal**	**N/A**	**N/A**

SECTION 17. PLAN INFORMATION REQUIRED BY ERISA

The following information together with the information contained in this Summary Plan Description is being provided to you in accordance with government regulations

Reference to Collective Bargaining Agreements

This Fund is maintained pursuant to Collective Bargaining Agreements between Local Union Nos. 7, 35, 42, 104, 223, 300, 488, 490, 567, and 1837 of International Brotherhood of Electrical Workers, AFL-CIO and Local Unions who subsequently become parties to the Trust Agreement and Signatory Employers and the North Eastern Line Constructers Chapter of NECA and Employers who subsequently become parties to the Trust Agreement. A copy of these Collective Bargaining Agreements may be obtained by Participants and beneficiaries upon written request to the Trustees and are available for examination by Participants and beneficiaries at the Fund Office. Participants and beneficiaries may receive from the Trustees, upon written request, information as to whether a particular employer or employee organization is a Contributing Employer and/or a sponsor of the Fund.

Type of Fund

The Fund provides medical benefits, prescription drug benefits, dental benefits, vision benefits, hearing benefits, life, Weekly Accident, and Sickness insurance.

Funding Medium/Source of Contribution of the Benefits Fund

The assets and reserves of the Fund are held in trust by the Trustees in a trust fund pursuant to an Agreement and Declaration of Trust.

The Fund is funded through contributions to the Fund by Contributing Employers at the hourly rates established by the Collective Bargaining Agreements between the Union and participating employers and in accordance with the provisions of such Agreements, and by investment income earned on a portion of the Fund's assets. Contributions are held in a trust fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. Under certain circumstances, Participants and beneficiaries losing eligibility under the Fund may maintain eligibility for a limited period of time on a self-pay basis.

Eligibility

The Fund's requirements with respect to eligibility for Participants and for beneficiaries, as well as circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of any benefits are described in this Summary Plan Description. Also, please note any restrictions or requirements in relation to particular benefits are set forth in the Sections of this Summary Plan Description that describe those benefits.

Description of Benefits

The benefits provided by this Fund are set forth in this Summary Plan Description. The complete terms of any insured benefits provided through an insurance company engaged by the Fund are provided in a certificate of coverage. This certificate, if applicable, is available to Participants and beneficiaries from the Fund Office upon request.

Termination Provisions

The New England Electrical Workers Benefits Fund shall continue during the term of the Collective Bargaining Agreements referred to herein and during the term of any renewal or extension of the Agreements as long as there are available assets. In the event that the obligations of all the participating employers to make contributions and negotiations therefore terminate, the Trustees, by unanimous agreement will determine how any assets, which may remain after expenses have been paid, will be disposed of. The distribution made by the Trustees shall be made only for the benefit of former eligible Participants and for legitimate Fund purposes; for example, the purchase of insurance benefits, the provision of benefits in any other form, or the transfer to another trust fund.

Claims Procedure

The procedure for filing a claim for benefits is set forth in this Summary Plan Description. If all or any part of your claim is denied you may appeal that decision. A Participant or Eligible Dependent must submit the claim within one (1) year of the date on which the services were rendered.

Amendment to the Fund/Trustees Right to Change or Discontinue the Fund

The provisions of this Fund may be modified or amended by the Trustees at their sole discretion at any time. Without limiting the foregoing, the Trustees expressly reserve the right to add to, subtract from, modify, or discontinue any benefits hereunder, and to modify eligibility rules for all benefits hereunder. Such amendments may be retroactive at the discretion of the Trustees. The Trustees also reserve the right to adopt and amend from time to time any rules, policies, or regulations they may deem appropriate.

SECTION 18. STATEMENT OF RIGHTS UNDER ERISA

As a Participant in the New England Electrical Workers Benefits Fund, you are entitled to certain rights and protections under ERISA[17]. ERISA provides that all Fund Participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine (without charge) at the Fund Office and at other specified locations – such as work sites and union halls – all documents governing the Fund. These may include insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of documents governing the operation of the Fund, including insurance contracts, Collective Bargaining Agreements, and copies of the latest Form 5500 annual report and updated Summary Plan Description by writing to the Fund Office. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Fund's administrator is required by law to furnish each Participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for you, your spouse, or your Dependents if there is a loss of coverage under the Fund due to a qualifying event. You, your spouse, or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Fund for the rules regarding your COBRA continuation rights.
- Reduce or eliminate 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 such plan, when you become entitled to elect COBRA continuation coverage, 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your coverage enrollment date.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Fund Participants, ERISA imposes duties upon the people who are responsible for the operation of the Fund. The people who operate the Fund, called "fiduciaries," have a duty to do so prudently for the purpose of providing benefits and in the interest of you and other Fund 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 or exercising your ERISA rights.

[17] The Employee Retirement Income Security Act of 1974

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce your above rights. For instance:

- If you request a copy of the Fund documents or the latest annual report from the Fund Office 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 Fund's 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 that is denied or ignored - in whole or in part - you may file suit in federal court.
- If you disagree with the Fund's decision or lack of response to your request concerning the qualified status of a medical child support order, you may file suit in federal court.
- If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file suit against the Fund, 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 if, for example, it finds your claim to be frivolous.

Help with Your Questions

If you have any questions about the Fund, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund's administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You may also obtain certain publications regarding your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration's Employee and Employer Hotline at (866)444-EBSA(3272), by logging on to the Internet at http://www.dol.gov/ebsa/publications/main.html, or by contacting the EBSA field office nearest you.

SECTION 19. HIPAA PRIVACY AND SECURITY RULES

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

The Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 (as amended) provides privacy protection of your verbal, written, and electronic records under a company-sponsored health care benefits plan. On April 14, 2003, in compliance with HIPAA requirements, this Fund introduced new privacy policies and procedures to protect you and your family's health information under the various health plans maintained at the Fund Office. Please read the privacy notice carefully and share the information with family members as appropriate. If you have any questions, please call the Fund Office at (800) 832-6538.

Introduction

Title II of HIPAA imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as "Protected Health Information," or "PHI," includes virtually all individually identifiable health information held by the Fund, whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the New England Electrical Workers Benefits Fund.

THE FUND'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Fund is required by law to maintain the privacy of your health information and to provide you with this notice of the Fund's legal duties and privacy practices with respect to your health information. It is important to note that under Title II of HIPAA, these rules apply to the Fund, not to any participating union or any contributing sponsor to this Fund. Different policies may apply to other Fund programs or to data unrelated to this Health Fund.

HOW THE FUND MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an "authorization") for purposes of health care treatment, payment activities, and health care operations. Here are some examples of these purposes:

Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers**. For example, the Fund may share health information about you with Physicians who are treating you.**

Payment activities include activities by this Fund, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. **For example, the Fund may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.**

Health care operations include activities by this Fund (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities,

customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development**. For example, the Fund may use information about your claims to review the effectiveness of wellness programs.**

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA rules. The Fund may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

HOW THE FUND MAY SHARE YOUR HEALTH INFORMATION WITH THE FUND OFFICE

The Fund may disclose your health information without your written authorization to the Fund Office for plan administration purposes. The Fund Office may need your health information to administer benefits under the Fund. The Fund Office agrees not to use or disclose your health information other than as permitted or required by the Fund documents and by law. Only the Fund Administrator will have access to your health information for plan administration functions.

Here is how additional information may be shared between the Fund and the Fund Office, as allowed under the HIPAA rules:

- The Fund may disclose "summary health information" to the Fund Office if requested, for purposes of obtaining premium bids to provide coverage under the Fund, or for modifying, amending, or terminating the Fund. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information have been removed.
- The Fund may disclose to the Fund Office information on whether an individual is participating in the Fund.

In addition, you should know that the Fund Office cannot and will not use health information obtained from the Fund for any employment-related actions. However, health information collected by the Fund Office from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, disability income programs, or Workers' Compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care.

Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the opportunity to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed to your legal representative without authorization.

The Fund is also allowed to use or disclose your health information without your written authorization for the following activities:

Workers' Compensation	Disclosures to Workers' Compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to

	fault, as authorized by and necessary to comply with such laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Fund reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Fund believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Fund's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Fund may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Fund's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits,

	inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Fund's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if the Fund has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the Fund has already made.

It is the Fund's procedure, upon request for assistance, to disclose your health information to your spouse or your domestic partner (if applicable), and your spouse's or your domestic partner's (if applicable) health information to you, and to disclose the health information of your over-age enrolled Dependent (for example, your Child who is over the age of 21) to you or your spouse or your domestic partner (if applicable), unless the person whose health information would otherwise be disclosed chooses to opt out of this default procedure. For example, if you and your spouse are enrolled for Fund benefits and believe that the Fund has paid only a portion of the service fee it should have for a service provided to your spouse, the Fund will work with you to obtain the correct payment for the service rendered, even if doing so requires sharing with you some health information about your spouse. (And the reverse would be true: your health information would be shared with your spouse in such a situation.) You may request the Fund not share your health information with your spouse or your domestic partner (if applicable) by opting out of this default procedure. To opt out, you must contact the Fund Office at (800) 832-6538. Your spouse, domestic partner (if applicable), and/or your over-age enrolled Dependent may also opt out of this procedure by contacting the Fund Office at (800) 832-6538. Once an individual has opted out of this default, the Fund generally will not disclose any of the individual's health information to family members, unless some other part of the HIPAA regulations permits or requires it (for example, that individual becomes incapacitated). Any individual may change the opt-out election at any time by contacting the Fund Office at (800) 832-6538.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Fund maintains. These rights are subject to certain limitations, as discussed below. This Section of the Summary Plan Description describes how you may exercise each individual right.

Right to request restrictions on certain uses and disclosures of your health information and the Fund's right to refuse

You have the right to ask the Fund to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Fund to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have

the right to ask the Fund to restrict use and disclosure of health information to notify those persons of your location, general condition, or death, or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Fund must be in writing.

The Fund is not required to agree to a requested restriction. And if the Fund does agree, a restriction may later be terminated by your written request, by agreement between you and the Fund (including an oral agreement), or unilaterally by the Fund for health information created or received after you are notified that the Fund has removed the restrictions. The Fund may also disclose health information about you if you need emergency treatment, even if the Fund has agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Fund will accommodate reasonable requests to receive communications of health information from the Fund by alternative means or at alternative locations.

If you want to exercise this right, your request to the Fund must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Fund uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Fund must be in writing. Within 30-days of receipt of your request (60 days if the health information is not accessible onsite), the Fund will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Fund expects to address your request.

The Fund may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Fund may also charge reasonable fees for copies or postage.

If the Fund does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

You have a right to request that the Fund amend your health information in a Designated Record Set; however there are certain exceptions. The Fund may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by

the Fund (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Fund must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Fund will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Fund expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the Fund has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for 6 years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Fund must be in writing. Within 60 days of the request, the Fund will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Fund expects to address your request. You may make one request in any 12-month period at no cost to you, but the Fund may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Changes to the Information in this Notice

The Fund must comply with these new privacy requirements as of April 14, 2003. However, the Fund reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Fund maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Fund's privacy policies described in this notice, you will be provided with a revised privacy notice that will be sent to you in the same manner as this notice was provided.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of Health and Human Services and or with the Fund. You will not be retaliated against if you file a complaint. To file a complaint with respect to a violation of your privacy rights, please contact the Privacy Official or its designee.

CONTACT

For more information on the Fund's privacy policies or your rights under HIPAA, please call the Fund Office at (800) 832-6538.

The Fund supports your right to the privacy of your protected health information. The Fund will not retaliate against you in any way for filing a complaint with it or the U.S. Department of Health and Human Services.

SECTION 20. MEDICARE PART D

Important Notice from New England Electrical Workers Benefits Fund about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with New England Electrical Workers Benefits Fund and new prescription drug coverage available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.
2. New England Electrical Workers Benefits Fund has determined that the prescription drug coverage offered by the New England Electrical Workers Benefits Fund is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.
3. Read this notice carefully; it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. New England Electrical Workers Benefits Fund has determined that your prescription drug coverage with New England Electrical Workers Benefits Fund is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

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

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 through December 31.

If you do decide to enroll in a Medicare prescription drug plan and drop your New England Electrical Workers Benefits Fund prescription drug coverage, be aware that you may not be able to get the New England Electrical Workers Benefits Fund coverage back.. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the Funds offering Medicare prescription drug coverage in your area.

Please see Page 36, "PRESCRIPTION DRUG PLAN" for information about the prescription drug benefits offered by the Benefit Fund.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of you current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with New England Electrical Workers Benefits Fund and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage.

For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage, contact the Fund Office for further information:

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1 800 MEDICARE (1 800 633 4227). TTY users should call 1 877 486 2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1 800 772 1213 (TTY 1 800 325 0778).

SECTION 21. OTHER LEGAL REQUIREMENTS

WORKERS' COMPENSATION COVERAGE

Medical expenses covered by the Benefits Fund are generally for services and supplies received for the treatment of non-occupational bodily injuries and illnesses. If you incur a work related injury or illness (one which arises out of or in connection with your employment), your claim for any charges related to that injury or illness must be submitted through your employer for Workers' Compensation coverage. No benefits are payable by the Fund for such charges, unless the claim is denied by the Workers' Compensation Commissioner and is otherwise eligible for payment.

However, if you have been notified that your employer is contesting liability of your Workers' Compensation claim, the Fund will pay related Hospital and medical expenses provided a copy of the "Notice to Contest Liability" is submitted to the Fund Office. Weekly Disability Income Benefits will be paid as long as a signed, written Agreement, which gives the Fund the right to recover from the claimant the full amount of benefit paid, has been executed. The Fund must be promptly reimbursed in full or the claimant will have additional liability for interest and all costs of collection, including reasonable attorneys' fees incurred by the Fund. Before related claims will be paid through the Fund, you will be required to sign a Subrogation Agreement as discussed on Page 55.

Although charges relating to an occupational injury or illness must be submitted to Workers' Compensation, the Life Insurance and other medical benefits will continue for yourself and your Eligible Dependents for charges incurred due to non-occupational accidental bodily injuries or illnesses, as long as you are receiving Workers' Compensation payments and contributions are paid for the injured.

Where a claim for Workers' Compensation is settled by stipulation or Agreement, you cannot claim benefits for the same disability from the Fund. If benefits are paid in error, the Benefits Fund must be reimbursed for any payments to you or your Dependents or providers, and all costs of collection, including attorney's fees and court costs.

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

Under this federal law, you may have the right to take up to 12 weeks of unpaid leave in a 12-month period for the birth or adoption of a child; to care for a spouse, child, or parent with a serious health condition; and when you are unable to work because of a serious health condition. If you are out of work because of a qualified Family and Medical Leave Act leave of absence, you may choose to continue coverage during your leave of absence, or you may choose to suspend coverage during your leave. If you continue coverage during your leave of absence you and your Eligible Dependents will be covered under your plan while you are absent from work. The coverage will continue as if you were actively working until the earlier of the expiration of your FMLA leave or the date you give notice to your employer that you will not return from your leave. You are required to pay the employee's portion of the cost of medical coverage, where applicable.

However, if you choose to suspend coverage during your absence, you and your Eligible Dependents will become covered immediately upon your return to work without being required to give evidence of insurability. If you decide to take a FMLA leave of absence, contact the Fund Office for further information and election forms.

CONTINUATION OF HEALTH COVERAGE UPON MILITARY LEAVE ("USERRA")

The Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 continues the protection of civilian job rights and benefits for veterans and members of Reserve components. If you are absent from employment due to service in the United States Armed Forces, you may be eligible to continue medical coverage under this Fund for you or your eligible dependents on a self-pay basis for the period of your military service (to a maximum of 24 months). Please contact the Fund Office for additional information.

THE NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT ("NMHPA")

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT ("WHCRA")

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan as described in the Schedule of Benefits.

Contact the Fund Office for further information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Fund Office shall enroll for immediate coverage under the Fund any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") or a National Medical Support Notice ("NMSN") if such an individual is not already covered by the Fund as an Eligible Dependent once the Fund Office has determined that such order meets the standards for qualification set out in the paragraph below.

The following definitions shall apply for these purposes:

- **"Alternate Recipient"** means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Fund as the Employee's Eligible Dependent. For purposes of the benefits provided under The Fund, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and

disclosure requirements under ERISA, an Alternate Recipient shall have the same status as an employee.

- **"Medical Child Support Order"** means any judgment, decree, or order (including approval of a domestic relations settlement Agreement) issued by a court of competent jurisdiction that (1) provides for child support with respect to an employee's child or directs the employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law), or (2) enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.
- **"Qualified Medical Child Support Order"** is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which an employee or Eligible Dependent is entitled under the Fund. In order for such an order to be a QMCSO, it must clearly specify (1) the name and last known mailing address (if any) of the employee and the name and mailing address of each such Alternate Recipient covered by the order; (2) a reasonable description of the type of coverage to be provided by the Fund to each Alternate Recipient, or the manner in which such type of coverage is to be determined; (3) the period of coverage to which the order pertains; and (4) the name of this Fund and the Fund. However, such an order need not be recognized as "qualified" if it requires the Fund to provide any type or form of benefit, or any option, not otherwise provided to employees and Eligible Beneficiaries without regard to this Section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).
- **"National Medical Support Notice"** is a notice issued by an appropriate agency of a state or local government similar in form, content, and legal effect to a Qualified Medical Child Support Order that directs the Fund Office to effectuate coverage for an Alternate Recipient as the dependent child of the noncustodial parent who is (or will become) an employee covered by the Fund pursuant to a domestic relations order that includes a provision for health care coverage.

Upon receiving a Medical Child Support Order or National Medical Support Notice, the Fund Office shall-as soon as administratively possible- (1) notify the employee and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Fund's procedures for determining whether the order qualifies as a QMCSO, and (2) make an administrative determination if the order is a QMCSO and notify the employee and each affected Alternate Recipient of such determination. To give effect to this requirement, the Fund Office shall (1) establish reasonable, written procedures for determining the qualified status of a Medical Child Support order; and (2) permit any Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to the order.

Within twenty (20) business days after the date of the NMSN, the Company shall provide the Fund Office with the notice. Within forty (40) business days of the date of the notice, the Fund Office shall: (1) notify the state or local agency issuing the NMSN whether coverage is available to the child who is the subject of the notice and, if so, whether the child is covered under the Fund, and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by an official of the issuing agency) to effectuate coverage, and (2) provide to the custodial parent (or official of the governmental agency involved in the notice) a description of the coverage available and any forms or documents necessary to effectuate the coverage.

Contact the Fund Office to obtain, without charge, a copy of the Fund's QMCSO procedures and further information.

SECTION 22. FREQUENTLY ASKED QUESTIONS

1. What is a "Copayment"?

A copayment is an amount you pay to an In-Network doctor, hospital, or pharmacy for services you receive. After you have paid your copayment, the Fund pays 100% of all remaining charges for the doctor, hospital, or pharmacy; you pay nothing more. When you have either In-Patient or Out-Patient hospital stays, the copayment is larger than the standard amount because you are paying for a broad range of services and many doctors. So, instead of paying a copayment for each service or to each doctor, you pay a one-time (per stay) copayment. See the Schedule of Benefits beginning on Page 24 for more information.

2. Do I need a referral to see a specialist or another doctor?

No. The Fund contracts with Anthem which is a Preferred Provider Network, not HMO. You may use any doctor within the network or outside the network. However, if you choose to use a provider outside the network you will incur out-of-pocket expenses.

3. What if I have a balance due from the health care provider after the Fund has paid my bill?

Please call the Fund Office should you receive a balance due bill from a provider.

4. My wife just had a baby. How do I enroll the new baby for health coverage?

First, notify the Fund Office and inform them of the baby's name and date of birth. You must submit a copy of the baby's full birth certificate as soon as it becomes available.

5. Which card is my health plan card?

You should have one (1) card, which will enable providers to identify the type of health plan you have for medical and dental services, and prescriptions:

This card is printed with the participant's name and Alternate Identification Number, and identifies the Plan's medical network. All covered family members may use this card. Give this card to your doctor, hospital, pharmacist, dentist, etc., at the time of service.

If you do not have a card or find incorrect information printed on it, please contact the Fund Office.

6. If I get injured on the job, who pays my medical bills?

Any injury that has occurred on the job should be reported immediately to your employer. An accident report should be filled out promptly. Please notify the Fund Office about work-related injuries as soon as possible. We will be alerted to any medical bills that were incurred because of a work-related injury and contact the providers as to where to submit them for proper payment. All work-related charges should be covered with your employer's workers' compensation carrier. The Fund does not cover work-related charges.

7. If I travel out of state or out of the country, will I have coverage for any medical care?

Yes, if it is a covered medical service under the Fund. You may have to pay for services up front, if the provider refuses to submit billing to the Fund Office. Please be sure to ask for an itemized bill in English.

8. How often do I need to fill out a claim form?

The Fund Office requires one claim form be submitted each year for each family member. Only the top portion of the claim form needs to be completed. You do not need to bring this form to your physician.

9. How long will my Dependent Children be covered under the Fund?

A dependent child who does not have coverage offered from employment is covered until age 26. Dependents who have coverage offered from other employment are covered until age 19 (age 23 if the dependent is a full-time student in an accredited post-secondary institution).

10. Why do I need to give the Fund Office details of any accident I may have been in?

The Fund Office will request from time to time, how, when, and where an injury may have occurred to yourself or a member of your family. The Fund Office needs detailed accident information to determine if this is a work-related injury that would be covered by your employer's workers' compensation carrier or an auto accident that would be covered by your auto insurance carrier.

If the Fund Office determines that a third party may be responsible for the accident, you will have to complete a "Reimbursement Agreement and Consent to Lien" form. This means that the Fund has the right to be reimbursed for its expenses related to the accident, should you receive any judgment, settlement, or repayment for such expenses.

11. Why does the Fund Office inquire about my spouse's work status?

Every year the Fund Office will ask if your spouse is currently employed. Please submit the complete name and address of your spouse's employer to the Fund Office as promptly as possible. We may contact the employer to inquire about other insurance coverage. It is important to remember that if your spouse has coverage under another health insurance carrier he/she should be using that coverage first. The Fund Office needs to determine its liability before any benefit payment. This is a cost saving measure for the Fund.

12. Does the Fund cover baby formula?

Yes, but the baby formula must be prescription baby formula. The Fund will not pay for any baby formula that is sold over-the-counter. See SECTION 5 for additional information.

SECTION 23. COST SAVINGS ADVICE PROGRAM

According to recent studies, up to 90% of all hospital bills may contain errors. The Benefits Fund can be most effective if it pays only for those expenses that are actually incurred by our members and their dependents. Therefore, members should carefully review any medical or prescription drug bills.

The Benefits Fund implemented a "Cost Savings Advice" program on January 24, 2003. Under this Program, if you find a charge for a service or medication that was not provided, and, if the participant facilitates the Fund receiving a credit for that item, the Fund will pay the participant Twenty Five Percent (25%) of that credit, up to a maximum of One Thousand Dollars ($1,000).

Please contact the Fund Office for more details about this Program.

SECTION 24. HINTS FOR EFFECTIVELY USING THE BENEFITS FUND

See your doctor regularly

There is no substitute for preventive care, such as annual physicals, annual flu shots, and having your children receive immunizations. By visiting your doctor regularly, you help your doctor notice any early signs of problems, which will allow you to receive preventive treatment and review before the problem becomes more severe.

Consider using generic equivalents to name-brand drugs

Generic drugs are equally as effective as their name-brand counterparts, and cost both you and the Fund less.

Consider using "mail order" to fill your prescriptions

This is especially true if you are on a maintenance drug, or one that you are taking regularly. Examples include drugs intended to reduce high levels of cholesterol and those intended to reduce high blood pressure. Our plan encourages your use of mail order by making your cost of prescriptions less if you have your prescriptions filled in this way.

Use an Emergency Rooms for only true medical emergencies

Our plan is designed to encourage you to use your regular physician because we believe treatment from your own doctor is more cost-effective and personalized than at an Emergency Room. Receiving Emergency Room care is only appropriate when your symptoms are life-threatening or severe.

Review your medical charges and all bills and invoices from your providers

Although mistakes from your providers are probably rare, you can help the Fund by reviewing all bills and invoices to ensure that the listed services were actually performed.

Make sure you understand what is and is not covered by this plan of benefits

Your health is important, and knowing what coverage you have can help you be a smart, health consumer.

When you travel, make sure to review the In-Network hospitals under this plan

The Anthem Blue Cross/Blue Shield program applies to hospitals and physicians across the country. These providers are considered "In-Network" for this Fund. By reviewing the hospitals available at your destination before you leave, you will help yourself by using In-Network facilities and care. You can find additional information about which hospitals are Part of the Anthem Blue Cross/Blue Shield network by logging on to www.bcbs.com and following the directions given.

Use In-Network doctors, hospitals, and services whenever possible

The Fund has negotiated with In-Network providers to provide high-quality, cost-effective service. Your costs are less when you use In-Network care, so choosing this option benefits both you and the Fund.

Live a healthy lifestyle

Many medical problems can be traced to poor eating habits, excessive smoking, lack of exercise, and other poor habits. By taking control of your own health, you will feel better, and could reduce your need for medical services.

SECTION 25. DEFINITIONS

Accident

An unfortunate occurrence or mishap especially resulting in an injury that occurs suddenly and at a definite place and time.

Adverse Benefit Determination

A denial, reduction, termination of or failure to make payment (in whole or in part) for a benefit, including but not limited to, a negative decision regarding eligibility to participate in the Fund or a negative decision by the Fund's provider networks or the Fund's medical or dental review consultants.

Alternate Identification Number

An identification number, in lieu of a member's Social Security number, which uniquely identifies a plan member.

Anesthesiologist

A currently licensed Physician trained in the administration of anesthetics and in the provision of respiratory and cardiovascular support during anesthetic procedures.

Children

See "Dependent Eligibility" (Page 6)

Chiropractor

Any person currently trained and licensed in chiropractic medicine who treats disease or injury by manipulation of the vertebral column.

Coinsurance

The amount the Fund and the member will share for a covered expense, usually defined as a percentage.

Concurrent Claim

A claim for additional treatment or hospital days that is being considered concurrently with the provision of treatment and results in a reduction, termination, or extension of a benefit. It also means a claim that is reconsidered after an initial approval was made.

Coordination of Benefits

"Coordination of Benefits" or "COB" is a provision that establishes the order in which health insurance plans pay claims when more than one plan exists. The terms "primary" and "secondary" insurance indicate, respectively, the first and second (plan) that will provide insurance coverage.

Contractual Rate

The Fund's payment for covered medical services, which have been agreed upon by medical providers and Anthem, the Fund's PPO network and dental providers and the Anthem.

Contributing Employer or Participating Employer or Employer

An employer having a Collective Bargaining Agreement with the Participating Union requiring contributions to the Benefits and any other employer as is approved for participation by the Trustees.

Contributing Employer also means the Participating Unions to the extent they have agreed to contribute to the Fund on behalf of their employees.

Copayment

The portion of a covered medical bill for which the patient will be responsible.

Covered Employment

Work performed under a Collective Bargaining Agreement or other agreement with the Trustees providing for contributions to the Benefits Fund or work performed for a Participating Union for it has agreed to contribute to the Benefits Fund.

Covered Expenses

That part of expenses that the Fund will pay for.

Covered Services and Supplies

To be covered by this Fund, the services or supplies must be for the treatment of non-occupational accidental bodily Injury or disease and described in this Summary Plan Description. Expenses not described in this Summary Plan Description or specifically excluded are not covered.

Custodial Care

Any service or supply, including room and board, which: (1) is furnished mainly to help a covered person meet that person's daily needs; and (2) can be furnished by someone who has no professional health care training or skills. Custodial Care is excluded from coverage even if a covered person is confined to a hospital or other recognized facility.

Deductible

The amount of covered medical charges incurred from January 1 to December 31 for any calendar year through a non-network provider for which the patient will be responsible before payment by the Fund will begin. For example, if the Fund has an out-of-network deductible of $1,000 (note that this is an example; the current deductible is noted on Page 33), a member will pay the first $1,000 of such out-of-network coverage, after which the plan will begin payment (subject to any coinsurance percentages).

Dental Hygienist

A person who is currently licensed to practice dental hygiene by the government authority having jurisdiction over the licensing and practice of dental hygiene and who works under the direct supervision and direction of a Dentist.

Dentist

A currently duly licensed dentist practicing within the scope of the dentist's license and any other Physician furnishing any dental services that the Physician is licensed to perform.

Durable Medical Equipment

Equipment that has been prescribed by a physician and which: (1) can withstand repeated use; (2) serve a medical purpose; (3) is not useful to the patient in the absence of illness or injury; (4) can be used in the home.

Eligible Dependent

Family members and others besides the Participant who are eligible for coverage (See "Eligibility Rules for Spouses/Dependents", Page 6).

Employee Assistance Program

This program is designed to provide prompt, professional assistance for participants and eligible Dependents needing treatment for mental health related problems, alcohol and drug abuse, family concerns, illness of a family member, financial pressure, and job stress.

Emergency Admission/Medical Emergency

The immediate admission of a patient to a hospital for treatment of the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could endanger health and result in permanent disability. Examples include, but are not limited to heart attack, stroke, serious burns, and poisoning. A hospital admission or surgery made or performed for the convenience of the physician or patient is not a medical emergency.

Experimental Treatment/Procedure

Generally, the Plan does not cover treatments that are deemed to be "experimental" in nature. Before a treatment is determined to be medically necessary, appropriate, and non-experimental, the following minimum criteria must be met:

1. There must be an appropriate governmental regulatory agency giving final approval. The item must be used in accordance with the final guidelines.
2. There must be conclusive scientific evidence of the technology's or treatments positive effect on the medical care and treatment of the health condition. Such evidence would include publication in scientific review journals, evidence that treatment favorably altered the health outcome and substantiation of facts by nationally recognized medical publications, medical panels, opinions, and evaluations.
3. There must be evidence of general acceptance by physicians within the relevant medical specialty of the efficacy of the technology or treatment.
4. There must be a demonstrated improvement in the health outcome that must clearly outweigh any harmful effects.
5. The evidence must demonstrate that the new technology or therapy improves the health outcome as much, if not more, than established methods.
6. While the outcome in the investigational setting may have demonstrated acceptability, there must be the same outcome outside of the investigational setting.
7. The Trustees of the Fund have determined that the experimental treatment/procedure is an eligible expense.

Explanation of Benefits ("EOB")

A statement that details the claim(s) you have submitted and the amount of benefits payable by the Fund, including an explanation of the reason for any particular charge's not being covered.

Extended Care Facility

An institution that:

1. Operates pursuant to law and is primarily engaged in providing room and board and skilled nursing care to inpatients who are convalescing and require medical care due to injury, illness or disease;
2. Provides 24-hour-a-day nursing service under the supervision of a full-time employee/licensed registered nurse;
3. Maintains clinical records on all patients;
4. Requires that every patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of emergency;
5. Is licensed, if an institution is in any state in which state or applicable local law provides for the licensing of institutions of this nature. In no event shall "Extended Care Facility" include any institution or part of any institution primarily for the care of mental illness, drug addiction, alcoholism, or tuberculosis, or which is primarily engaged in providing domiciliary, custodial, or educational care, or care of the aged.

Benefit Fund

The New England Electrical Workers Benefit Fund is a 501(c)(9) Trust as defined by ERISA

Hospital

An institution that meets each of the following requirements:

1. Holds a license as a hospital if a license is required in the domicile of the state;
2. Is operated primarily for the reception, care, and treatment of sick, ailing, or injured persons as inpatients;
3. Provides 24-hour-a-day nursing service by registered or graduate nurses;
4. Has a staff of one or more licensed physicians available at all times;
5. Provides organized facilities for diagnostic and major surgical procedures;
6. Is not primarily a clinic, nursing or convalescent home, or similar establishment nor, other than incidentally, a place to treat persons suffering from an alcohol addiction, drug addiction or a mental illness.

Illness or Sickness

Any bodily disorder or disease that manifests symptoms that require treatment by a physician. Illness includes any birth defects of a newborn child covered by the Fund of benefits. All such conditions existing concurrently or successively which are due to the same or related causes shall be considered as one sickness or illness.

Injury

All damage to a person's body due to an accident or accidental means, and all complications arising from that damage.

Intensive Care Service

Services of a physician and of a hospital, rendered for the treatment of an unusual aspect or complication of an illness or injury.

Medicare

The federal government's health care program for those individuals totally disabled before age 65, and those retired individuals age 65 and over provided by Title XVII of the Social Security Act, as amended from time to time.

Medicare Part D

The Prescription Drug Benefit offered under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA")

Medically Necessary

"Medical Necessity" occurs only when a specific surgical procedure, medical care, treatment, service, or supply incurred upon the advice and approval of a physician is reasonably consistent, commonly and customarily recognized by physicians as appropriate, essential, and medically required for the treatment or management of a diagnosed medical condition, illness or injury; other than for educational, experimental, or cosmetic purposes, and not solely for the patient's convenience or the patient's family or the medical provider, and furnished in the least intensive type of medical care setting or facility required by the patient's condition. The fact that the patient's physician or some other provider has furnished, prescribed, ordered, recommended, or approved a service, treatment, surgical procedure, or prescription does not of itself make the aforementioned service, treatment, etc. medically necessary. The determination of being medically necessary will be made solely by the Board of Trustees based on a review of the patient's medical records.

Mental Hospital

An institution (other than a hospital or separate Part of a hospital as defined by this Fund of Benefits) which specializes in the diagnosis and treatment of mental illness or functional nervous disorders that is operated pursuant to the law in which it is domiciled and meets all of the following requirements: (a) It is approved by Medicare to give medical treatment; (b) It is operated under the supervision of a physician; (c) Provides nursing services by registered graduate nurses or licensed practical nurses; (d) Provides, on the premises, all necessary facilities for medical treatment; (e) It is not, other than incidentally, a place of rest, a place for the aged, a place for convalescent, custodial or educational care.

Network Provider - Preferred Provider Medical Network or PPO

Those providers or facilities that have fee payment contracts that have been negotiated on behalf of the Fund. All covered charges billed by a network provider are generally paid at 100% minus the contractual discount and/or appropriate Copayment. Please call the Fund Office if you are balance billed by a network provider for charges.

Non-Medical Network or Non-PPO

Providers, services, or facilities that do not have payment contracts with our preferred provider network. All covered charges billed by a non-network provider are applied to the deductible and paid at 50% of Reasonable & Customary charges. All balance billing, after the Fund's payment, is the patient's responsibility.

Occupational Therapist

A person who is currently licensed in using purposeful activity to maximize independence, prevent disability and maintain health with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, poverty and cultural differences, or the aging process.

Optometrist

A person duly licensed to practice optometry by the governmental authority having jurisdiction over the licensing and practice of optometry in the locality where the service is rendered.

Optometry

The practice or profession of examining the eyes, by means of suitable instruments or appliances, for defects in vision and eye disorders in order to prescribe corrective lenses or other appropriate treatment.

Orthodontia

The branch of dentistry concerned with irregularities of teeth and malocclusion.

Orthodontic Procedures

Movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

Other Hospital Services and Supplies

Services and supplies furnished to the individual and required for treatment, other than Room and Board, the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Out-of-Pocket

The dollar amount a Participant will pay for medical expenses for a calendar year. It does not include payments made for:

- Expenses the Fund does not cover
- Charges in excess of the Reasonable & Customary charge
- Reductions in benefits due to Fund limitations
- Penalties the Participant must pay due to non-compliance with the Fund.

(Active) Participant

A person who is eligible under the Fund's provisions, as described in SECTION 1, ELIGIBILITY RULES.

Physical Therapist

A person who is currently licensed to assist in the examination, testing, and treatment of physically disabled or handicapped people through the use of special exercise, application of heat or cold, use of sonar waves and other techniques.

Physician

The term "Physician" includes, with respect to any particular medical care and services, any holder of a certificate or license authorizing the holder or licensee to perform the particular medical or surgical services. This definition of Physician includes a licensed psychologist for the treatment of mental and/or nervous disorders only, and treatment by a licensed social worker with a Master's degree under the direct supervision of a psychiatrist, and including a registered psychiatric nurse as required by state statute.

Plan or Fund

The New England Electrical Workers Benefit Fund as set forth and described in this Summary Plan Description.

Post-Service Claim

A claim that is not a Pre-Service, Urgent Care, or Concurrent Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

Pre-Service Claim

A claim for a benefit for which pre-approval of the benefit (in whole or in part) is required before medical care is obtained. The Fund does not require pre-certification for any services.

Podiatrist

A person currently trained and licensed in podiatry (the study and care of the foot, including its anatomy, pathology, medical and surgical treatment).

Placement for Adoption or Being Placed for Adoption

Means, in connection with adoption proceedings, the assumption and retention by a health plan Participant or beneficiary of the legal duty for the total or partial support of a child to be adopted. The child's placement with such person terminates whenever the legal duty likewise terminates.

Radiologist

A Physician certified by the American Board of Radiology who specialized in the branch of medicine concerned with radioactive substances and various techniques of visualization, with the diagnosis and treatment of disease using any of the various sources of radiant energy.

Reasonable & Customary

The charges incurred for the services, treatment, and supplies that are medically necessary, to the extent that such charges are within the median range of charges made by physicians of similar training and experience for the same treatments, services, and supplies. The Trustees shall determine the reasonableness of the charges incurred and the amount of payment to be made to a provider. The determination of whether a charge meets these requirements shall take the following into consideration: (a) fees and prices charged; (b) treatment rendered; (c) therapeutic practice followed; (d) supplies furnished according to the usual practice of physicians; (e) locality where the treatment is rendered.

Room and Board

Room, board, general duty nursing, and any other services regularly furnished by a Hospital or other facility as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians or intensive care by whatever name called.

Second Surgical Opinion

An opinion of a qualified independent physician for evaluating the medical necessity and advisability of a specific surgical or diagnostic procedure proposed by another physician. The second examination must be performed after the first qualified physician has produced a diagnosis, including a diagnosis that no surgical or diagnostic procedure be performed. Each physician must be an independent practitioner neither associated with each other nor a member of the same professional medical corporation.

Skilled Nursing Facility

A facility that is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility that is part of a Hospital, as defined.

An institution fully meets the definition of "Skilled Nursing Facility" if it meets all the following tests:

1. It is operated in accordance with the applicable laws of the jurisdiction in which it is located; and
2. It is under the supervision of a licensed Physician, or registered graduate nurse (RN), who is devoting full-time to such supervision; and
3. It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Sickness; and
4. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician; and
5. It is authorized to administer medication to patients on the order of a duly licensed Physician; and
6. It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics, drug addicts or the mentally ill; and
7. It is not a Hospital, as defined, or part of a Hospital.

Speech Therapist

A person currently trained and licensed in speech pathology who treats people with disorders affecting normal oral communication.

Third Party Reimbursement

Any direct or indirect payments to a covered person for injury or illness from any source, by way of settlement, judgment, or any other manner including, but not limited to, reimbursement from Workers' Compensation insurance, uninsured motorist, and no-fault automobile insurance coverage.

Urgent Care Claim

A claim for pre-certification of benefits for treatment that, if not received, (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (2) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.